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TOWARD A PSYCHOSOCIAL UNDERSTANDING OF SUICIDE IN AMERICAN LITERATURE AND CULTURE OF THE 1990'S

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**TOWARD A PSYCHOSOCIAL UNDERSTANDING OF SUICIDE IN
AMERICAN LITERATURE AND CULTURE OF THE 1990'S**

BY

SARA E. MURPHY

**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF**

DOCTOR OF PHILOSOPHY

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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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**UNIVERSITY OF RHODE ISLAND
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ABSTRACT

As a means of rectifying the problematic absence of multidisciplinary scholarly work on suicide, this dissertation project interrogates suicide in American literature and culture of the 1990's across disciplines within the humanities, medicine, and the social sciences. Utilizing a psychosocial approach to the study of suicide – that is, an understanding of suicide as produced both by one's psychological development *within* and by one's social relationship *to* his or her environment – I address what I have identified as a unique trifurcated suicide response that arose in American culture in the 1990's as it emerged through major societal and legal events and as it coalesced through major literary texts of the period. While suicide has had a presence in virtually every culture across history, the convergence of these societal and legal events in this decade with a radically-changing perspective on suicide in medical theory and research emergent in the 1980's and 1990's created a culture of suicide unique to its time and place.

The five essential problems that this project addresses are: (1) ascertaining the origins of the rise of preoccupation with suicide throughout the 1990's as seen through mass suicide events; increased social debate, political action, and legal movements for the right to die, and as suicide attempts, completions, and bereavements increased across the decade; (2) determining the ways in which grieving suicide was complicated by the degree to which survivors or the public were able to make meaning of these deaths, simultaneous to psychological theories uncovering the importance of meaning making in unresolved grief; (3) interrogating the cultural intersections of power and privilege which altered the perceived suicide risk for and attention to

members of groups disenfranchised due to sexual identity during the AIDS crisis; (4) examining the ethical and historical importance of the assisted suicide movement in the 1990's; and (5) exploring the implications of American cultural inheritances of suicide in the contemporary moment.

The significance of this study rests upon three key points in addressing the deficiency in scholarship about suicide in this period. First, this project makes important interventions in the field of literature by incorporating the work of scholars practicing in the disciplines of gender and sexuality studies, history, medicine, nursing, psychology, sociology, and thanatology in order to understand and explicate more fully the pervasive and particular presence of suicide in this decade. Whereas scholars of literature or cultural studies may reference or bridge theories of medicine or social sciences in their projects, there has been an absence of solidly interlocking lenses produced from these major fields through which to consider suicide as a cultural and literary presence in the 1990's. Vast space exists in which a multifocal discussion of suicide across the major fields of literature, social sciences, and medicine is not only possible but, indeed, necessary. Second, in synthesizing theoretical frameworks across disciplines while engaging in textual analyses of the literature in which this project is grounded, I provide a multifocal argument for the particularly troubled culture of suicide that was both reflected in and further developed by American literature in the 1990's. Third and finally, this study will notably increase the understanding of readers in approaching suicide as a psychosocial phenomenon and in approaching suicide in literature as both historically and culturally informed.

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me the glorious Transcendentalists. Particular thanks are also owed to Dr. Donna Schuurman of the Dougy Center, The National Center for Grieving Children and Families, for her indelible contributions to my development as a suicidologist.

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DEDICATION

This project is dedicated to all persons who have been affected by suicide in their lives: those who teach and study suicide, those who seek to assist in easing the pain of individuals and families suffering due to suicide, those who have survived the deaths of their loved ones to suicide, and particularly those who live every day with suicidal histories or preoccupations.

It is written in memory of those who have lost their lives to suicide.

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Introduction

The Stigma and Silence of Suicide

There is no death in American culture as silenced and stigmatized as a death of suicide. Over the last century, attitudes and responses to suicide have evolved; however, the sustained presence of suicide as a national epidemic and the problematic absence of multidisciplinary scholarly work on suicide have caused me to pursue the ways in which historical understandings of suicide that stigmatize and silence those affected by it may continue to influence how it is conceptualized today. Therefore, this dissertation project interrogates suicide in American literature and culture of the 1990's across disciplines within the humanities, medicine, and the social sciences. Utilizing a psychosocial approach to the study of suicide – that is, an understanding of suicide as produced both by one's psychological development *within* and by one's social relationship *to* his or her environment – I address the unique culture of suicide that arose in America in the 1990's as it emerged through major societal and legal events and as it coalesced through seminal literary texts of the period. While suicide has had a presence in virtually every culture across history, I argue that the convergence of these societal and legal events of this decade with a radically-changing perspective on suicide in medical theory and research emergent in the 1980's and 1990's created a culture of suicide unique to its time and place – a distinct culture preoccupied with suicide as a means of fascination and entertainment yet resistant to embracing an understanding of its causes and effects.

At the close of the 19th century, the concurrent emergence of psychoanalysis as a school of theory and sociology as an academic discipline initiated two distinct and divergent approaches to suicidal behaviors that would extend through most of the 20th century. The sociological model of suicide is based on the developments of Émile Durkheim in his extensive case study Suicide (1897); the psychological model of suicide has been rooted in the theories of Sigmund Freud first explicated in “Mourning and Melancholia” (1917). Scholars began pursuing an integrated approach to suicide only in the 1990’s; noted amongst these suicidologists is sociologist David Wendell Moller, who argues that explanations for suicide are a “psychosocial collage” (192). Affirming his work, I approach the texts within this project by modeling integrated approaches to suicidal ideation, execution, completion, and aftermath. Whereas other scholars of literature or cultural studies may reference or bridge theories of medicine or social sciences in their projects, there has been an absence of solidly interlocking lenses produced from these major fields through which to consider suicide as a cultural and literary presence in the 1990’s. Vast space exists in which a multifocal discussion of suicide across the major fields of literature, social sciences, and medicine is not only possible but, indeed, necessary. It is into this chasm that I offer my arguments. Therefore, in this project, I do not show particular interest in literary criticism of the texts being presented, as I recognize the lack of grounding in suicide studies with which the authors of such critical engagements approach their literary subjects. Rather, my work provides an intervention in the usual practice of literary study by incorporating and problematizing the theories of thanatological scholars

while offering original readings of literary texts through a postmodern thanatological critical lens.

The significance of this study rests upon three key points in addressing the deficiency in scholarship about suicide in this period. First, this project makes important interventions in the field of literature by incorporating the work of scholars practicing in the disciplines of gender and sexuality studies, history, medicine, nursing, psychology, sociology, and thanatology in order to understand and explicate more fully the pervasive and particular presence of suicide in this decade. Second, in synthesizing theoretical frameworks across disciplines while engaging in textual analyses of the literature in which this project is grounded, I provide a needed multidisciplinary argument that illuminates the particularly troubled culture of suicide that was both reflected in and further developed by American literature in the 1990's. Third and finally, this study will notably increase the understanding of readers in approaching suicide as a psychosocial phenomenon and in approaching suicide in literature as both historically and culturally informed.

Avoiding Stigmatizing Language

As this project takes works of American literature as cultural artifacts in order to explore suicide in the 1990's, it is important to foreground this work by reflecting on the ways in which American culture stigmatizes and silences suicidal individuals through the language used to refer to suicide and those who suffer from it. It is essential that we consider conventional terminology: people say that "John killed himself" or "John committed suicide"; both of these statements show nothing but

ignorance for the complexity and devastation of suicidal preoccupation, rendering the subject a virtual criminal. Within our cultural context, we “commit” crimes – murder, theft, rape. If we “kill,” our cultural values assert that we ought to be punished.

Criminalizing suicide through language is a barrier to understanding the pain of the suicidal individual. People may also refer to someone who has died of suicide *as* his or her mode of death, a phenomenon we rarely witness in regard to other means of death: “John was a suicide.” Of course, we would never say, “Mary was a cardiac arrest.” Similarly, popular rhetoric often turns suicide into a verb – “John suicided.” Would we ever think of saying, “Katie cancered”?

The historically-grounded cultural misunderstanding of suicide as a destructive act of free will renders such language choices problematically acceptable, yet I argue that the use of terms such as “died of suicide” is preferable as it furthers a dynamic and empathic attunement to the complexity of suicide. Therefore, throughout this project, the language with which suicidal individuals are discussed is reflective of my purposeful decriminalization of the terms generally used to describe suicide. In this way, my language aligns with that of Donna Schuurman, Executive Director of the Dougy Center, The National Center for Grieving Children and Families, who writes in Never the Same: Coming to Terms with the Death of a Parent:

You may notice that I have not used the common terminology “committed suicide.” It’s because I believe this phrase incorrectly and unfairly accuses the suicide victim of an act over which they had no control. . . . I strongly believe that, because the suicidal person’s mind is not working properly, there is a moment where suicide is no longer a

choice. . . . If at that moment the person has access to the means to die, the suicide will happen.” (qtd. in DeSpelder & Strickland 415)

Resisting Cultural Myths

Most of the myths that have circulated historically in American culture continue to pervade scholarly discussions of suicide today. As this project will illustrate, advances in thanatology and mental health research have brought about an evolving understanding of suicidality since the 1990’s; however, both popular and academic culture often cling to these myths as a means of simplifying or essentializing the experience of suicide. I will expand upon what are perhaps the five most common cultural myths, listed below, in order to clarify the resistance to such stigmatizing misunderstandings with which this project was undertaken:

- 1.) Suicide is always the result of clinical depression;
- 2.) Suicide is a “quick fix” for problems that could easily be solved;
- 3.) Not every suicide attempt is real; rather, some are “cries for help”; similarly, people who threaten suicide do not attempt suicide;
- 4.) If we talk about suicide, we may risk becoming suicidal or causing another person to become suicidal;
- 5.) Suicide is an act of cowardice or personal weakness; while everyone feels bad sometimes, suicide is “wrong.”

First, although clinical depression and suicide have a long-studied relationship, since the 1990’s, we know medically that not all suicide attempts are resultant of what

we clinically term “depression.” It is also important to remember that while everyone may feel depressed from time to time, perhaps following the loss of a loved one, the loss of a job, the end to a romantic relationship, or other real or perceived losses, clinical depression is *not* the same as situational depressed feelings, nor does one necessarily grow out of the other. Today, we should recognize that not all suicide attempts are linked so easily with clinical depression or, even for persons suffering from clinical depression, to that depression *alone*. It is important to remember, then, that leading to a suicide attempt, there are a multitude of pressures at work on an individual, both social (including cultural, environmental, and interpersonal) as well as psychological (including one’s personal and familial mental health history, one’s losses, and one’s coping mechanisms for responding to suffering and trauma). We should not essentialize the experience of suicide, just as we should not generalize the effects of suicide.

Because suicide continues to be an act surrounded by attempts to place blame, whether on the victim, his or her family, or the medical community, if we seek less to find an outlet for blame and more to identify contributory forces on the individual, we may recognize that “the suicidal [person] is perennially distraught . . . isolated, lonely, and powerless. [He or she] feels trapped and impaired by oppressive circumstances” (Moller 199). To treat suicide as a “quick fix” or “easy way out,” as is often done, is to fail to recognize the pain with which the suicidal person suffers. While we all experience pain, loss, and obstacles in our lives, individuals who attempt suicide may not be able to respond to their pain in healthy ways – often due to the same psychosocial forces that led to their suicidal preoccupation initially. It is helpful to

view suicidal individuals not as people who want to die in order to attain a “quick fix” for their problems but as people who are suffering from such extreme pain that they feel driven to do anything to end that pain. Correlatively, when discussing suffering as an experience within this project, I am treating it as defined by Eric J. Cassell and am referring to the integrated and unquantifiable combination of physical, emotional, and mental pain experienced by a suicidal individual. As Cassell writes in The Nature of Suffering and the Goals of Medicine, it is important to remember that “suffering is ultimately a personal matter – something whose presence and extent can only be known to the sufferer” (34).

A third way in which cultural myths mitigate our ability to attain a psychosocial understanding of suicide is through the silencing of suicidal persons by discrediting suicidal warnings or attempts. I posit that the cultural adoption of suicidal language into vernacular, ironically simultaneous to our cultural silencing of suicide, is partially responsible for this stigmatizing attitude. One such example can be found in the lyrics penned by Kurt Cobain, front man of the popular 1990’s band Nirvana. Nirvana rose to iconic heights while performing lyrics such as “Load up on guns and bring your friends / It’s fun to lose and to pretend,” their opening lines to the teen anthem “Smells Like Teen Spirit” (1991) and “Look, on the bright side is suicide,” which is repeated in the chorus of “Milk It” (1993), released merely seven months prior to Cobain’s suicide in April 1994.¹ In terms of everyday language, how often has

¹ While Cobain’s death will not be treated explicitly in this project, it should be noted that the adolescent suicide contagion publicly attributed to this event has been well-explicated and disproven by the statistical quantitative research of D.A. Jobes. See Jobes’ article, “The Kurt Cobain Suicide Crisis: Perspectives from Research, Public Health, and the News Media” for his supporting data.

each of us heard a friend, relative or student use language such as, “That outfit is to die for”; “I’ve had the worst day; I want to die”; or “If I fail this course, I’m going to kill myself”? The continued popular acceptability of such language rests upon a larger societal mitigation of suicidality. Suicidal acts are often labeled as attention-seeking attempts or, more troublingly, as “cries for help.” Here, popular language again fails, this time in recognizing that every suicidal threat or act is equally serious and deserving of attention. Instead, disturbingly, those persons whose acts are labeled “cries for help” are often those least helped at all. Taken less seriously than high-lethality attempts (such as gunshot or bridge-jumping), attention to low-lethality suicidal attempts (such as wrist-slitting or overdose) also speaks to the continuation of patriarchal assumptions within our culture, as these are the means most chosen by women who attempt suicide. Researchers Lynne Ann DeSpelder and Albert Lee Strickland have noted that “when low-lethality suicidal behavior is met with defensive hostility or attempts to minimize its seriousness . . . the risk of suicide may increase, along with the possibility that a future attempt will be lethal” (429). Similarly, the silencing through non-response to which the suicidally-verbal person is subjected supports mythic assumptions that people who threaten suicide do not engage in the actual act of suicide; however, recent research has found that “most people who engage in suicidal acts do communicate their intentions to others as hints, direct threats, preparations for suicide, or other self-destructive behaviors” (DeSpelder & Strickland 449).

Problematically, suicide is often still treated culturally as a contagious problem. Historically, it was believed that if one spoke openly about the suicide of a

family or community member, he would risk “infecting” himself or others by presenting suicide as an option. We still see effects of this misguided theory today; for example, we rarely, if ever, see the word “suicide” in an obituary or hear it at a memorial service for one who has died of suicide. Similarly, school communities are divided between communicating effectively with their students about the loss of a student to suicide and remaining fearful of romanticizing the death and presenting it as a possible “way out” for other students. Although contagion theory has been reexamined over the last decade and the idea that suicide is “infectious” is well on its way to being disproven, the idea that one can contract suicide from another person, as one would a virus or bacterial infection, still circulates in our contemporary culture. I argue that attachment to this simplistic explanation for suicide, particularly adolescent suicide, is merely an additional means by which cultural institutions seek to sidestep acknowledgment of suicide as an untreated epidemic.

Finally, in terms of stigmatizing myths, one of the most dangerous ways in which we bar understanding of those who have died of suicide is to treat their means of death as a personal failure. DeSpelder and Strickland note that because “many people are not aware of the role of brain disease in suicide,” individuals “tend to treat suicide as a failure of personal responsibility and as a matter of shame” (426). While I agree with their assessment of the negative treatment outcomes inflicted upon suicidal persons, I would extend their conception of its causality beyond individuals’ ignorance of brain disease. Rather, I argue that historically-inherited cultural norms teach members of our society that a person who attempts suicide is weak, cowardly, and unfit to pursue and achieve the “American dream.” As the result of a myriad of social,

psychological, and biological factors that have nothing to do with “giving up” or “choosing death,” suicide is not about cowardice; it isn’t about weakness. The representation of the suicidal individual as a coward is one that has been firmly rooted in conceptions of suicide; however dynamic we may recognize suicide to be in contemporary American society, the suicidal individual still bears this traditionally-inherited stigma.

Methods and Aims of this Project

Because suicide is one of the most under-recognized and overlooked causes of death in our society, American culture has stigmatized and silenced suicide with devastating results for individuals and communities. There is great danger in remaining personally and academically silent about suicide, just as there is great danger to our culture in remaining willfully ignorant to an epidemic that leads to so many losses around us. Understanding suicide is crucial to preventing suicide, to honoring the lives of those lost to suicide, and to developing praxes for responding to suicide in helpful and educated ways. It is with a desire to make important interventions not only in the field of literary studies but also in our contemporary, lived cultural experiences that I have undertaken this research.

The five essential problems on which I have focused my research on suicide and that this dissertation addresses are:

(1) ascertaining the origins of the rise of preoccupation with suicide throughout the 1990’s as seen through theoretical breakthroughs and major mass death events during the decade;

- (2) determining the ways in which grieving suicide was complicated by the degree to which survivors or the public were able to make meaning of these deaths, simultaneous to psychological theories uncovering the importance of meaning making in unresolved grief;
- (3) interrogating the cultural intersections of power and privilege which altered the perceived suicide risk for and attention to members of groups disenfranchised due to sexual identity during the AIDS crisis;
- (4) examining the ethical and historical importance of the increased support for assisted suicide and the right-to-die movement in the 1990's; and
- (5) exploring the implications of cultural inheritances of suicide in the contemporary moment.

In my first chapter, “Manifestations of the Final Exit: Exploring the American Culture of Suicide in the 1990's,” I trace the convergence of research breakthroughs in grief and suicide studies with major events involving perceived mass suicide in American culture in the 1990's. After offering an extended review of the history of classical and postmodern conceptions of grief and suicide theory, I turn to the mass suicides of Branch Davidians and Heaven's Gate cult members and ground my readings of cultural responses to these events in the public inheritance of the Jonestown massacre of 1978. In considering these events, I argue that within that decade, a unique culture of mass suicide was initiated, reinforced both in public discourse and through representation via various media. While I resist traditional contagion theories of suicide, I posit instead that the particularities and pervasiveness

of the suicides which I will discuss generally garnered a contagion of public attention. More importantly, representations of these suicides – and those that will be discussed in Chapters 2-4 – contributed to what I theorize as the *trifurcated suicide response* in American culture, which I argue is existent largely due to differing relational perceptions of (1) the mental health of the deceased; (2) the physical health of the deceased; and (3) whether or not suicide was undertaken singly or collectively. For example, whereas the mass death of “cult” members prompted fear, fascination or curiosity in public consciousness, the deaths of terminally ill patients through physician-assisted suicide (which will be discussed in Chapter 4) prompted growing empathy and support within the public realm for the right to die in the 1990’s. Similarly, while a terminally-suffering literary character or individual often elicited an acceptance of suicide in a reader or witness, the death of a physically-healthy person due to suicide (which will be discussed in Chapter 2) remained disorienting and confusing within the framework of public understanding in this decade. The development of a trifurcated suicide response theory will be initiated in Chapter 1 with my discussion of mass suicide events but will extend throughout the entirety of this project.

Chapter 2, “Disenfranchised Grief and the Futility of Meaning-Making Acts in The Virgin Suicides,” focuses on historically-traced factors that complicated grieving suicide in America in the 1990’s and which are limned through my extended close reading of The Virgin Suicides by Jeffrey Eugenides (1993). Here, I illustrate the ways in which individual suicide leads frequently to disenfranchised grief, as theorized first by postmodern scholar Kenneth Doka in Disenfranchised Grief: Recognizing Hidden

Sorrow (1989) and I situate this disenfranchisement within an analysis of Eugenides' novel. The nameless male protagonists of the novel, obsessively searching for meaning following the deaths of the five Lisbon sisters who entranced them throughout their adolescence, enact both periods of stasis and grief work, which, I argue, lead to a crisis of meaning-making that is reflective of larger contemporary cultural responses to individual suicide. This chapter traces the various attempts by characters within the novel to make meaning of the deaths of suicide of the Lisbon sisters and the ways in which each of the characters falls short of attaining satisfaction in her or her attempt. From narratives that seek to criminalize the victims or their parents, to the employment of religious myths or the romanticization of the dead, the surviving characters throughout the novel grapple with assigning blame, assuming guilt, and reinforcing cultural taboo. The implications of my analysis of The Virgin Suicides point to the larger cultural framework in which it was produced; I argue that as reflective of contemporary attitudes and theories about deaths of suicide, the novel may serve as illustrative of a culture of the 1990's that insisted upon ascribing meaning following an individual's suicide even as the processes enacted to achieve that end ultimately failed.

In my third chapter, "Angels in America and Cultural Intersections of Power, Privilege, and Suicidality in the AIDS Crisis," I examine the intersection of psychosocial forces specifically in terms of power and privilege in the AIDS epidemic and as illuminated in the drama Angels in America by Tony Kushner (1991, 1992, pub. 1995). In doing so, I offer hypotheses regarding the effects of subordination from dominant culture on gay and bisexual male individuals in terms of their risk for death.

Additionally, I examine the relationship between power and suicidal ideation and execution by synthesizing the work of noted practitioners in fields concerned with queer youth and adolescent suicide; suicide risk within adult gay and bisexual populations; and the thanatological focus on “mattering” as preventative to increased suicide risk. As the major focus of this chapter, I extend the research described above in examining Angels in America in its contemporaneous political and literary moment in order to expose the ways in which psychosocial forces of power and privilege complicate not only the suicidal ideation or preoccupation with death of characters who are directly or secondarily impacted by the AIDS crisis but also, and importantly, their reception and response from dominant culture. Through my focused interrogation on privilege and oppression as relating to the disenfranchised group most affected by the AIDS crisis in the 1990’s, I argue that the palpable specter of AIDS may have altered expected outcomes for suicidality in affected environments and, resultantly, fostered community building and an embrace of hope and the transcendent, as is reflected in this seminal text. In this way, I show how we may read Angels in America as first queering, within the cultural moment in which it was written, expectations of suicidal behavior for individuals in similar positions of cultural oppression, then as bearing witness to the particular and isolating cultural responses afforded to them in the face of death.

Chapter 4, “‘No One Should Have to Live Like That’: Historical, Ethical, and Literary Implications of Assisted Suicide in the 1990’s” turns to a focused study of the legal and ethical controversies surrounding assisted suicide for terminally-ill individuals in the 1990’s and illustrates the ways in which the drama Wit by Margaret

Edson (1993) and the novel One True Thing by Anna Quindlen (1994) implicitly furthered the Death with Dignity movement, which was gaining political and popular momentum at the time of publication of these works of fiction. First, I outline the historical controversies over assisted suicide in American culture and show how conflict between supporters and opponents of the right-to-die movement rose to unprecedented legal heights during the 1990's. I discuss the works of arguably the two most well-known proponents of suicide rights in the 20th century – David Humphry, whose seminal text Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying, was published in 1991 concurrent with growing interest in right-to-die movements, and Dr. Jack Kevorkian, who assisted illegally in at least 130 suicides between 1990 and March 1999, when he was convicted and imprisoned. I consider the primary tenets of belief on which supporters and opponents of assisted suicide have rested their arguments, and I explore the major ways in which assisted suicide has been represented within the medical community. Building on this historical foundation, I focus in the second half of this chapter on thanatological readings of Wit and One True Thing. Both texts involve middle-aged female protagonists who are dying of cancer; however, the former charts the despair and hopelessness of the terminally ill patient who lacks both familial and medical support networks, whereas the latter traces the perceived impotence of family members of the patient in relieving her suffering. My analyses of these texts show that although neither text contains a literary enactment of assisted suicide, each responds to a question that is not asked of it explicitly and answers this question in support of the right to die. Through their depictions of the dying characters, notably monologues

devoted to forcing speech from spaces of suffering, the narratives of these works are intertwined inextricably with the right to die movement.

In the Conclusion of this project, “Cultural Inheritances and Contemporary Implications,” I draw from the theoretical exploration undertaken in Chapter 1 and the cultural and textual analyses undertaken in Chapters 1-4 in order to explicate the greater implications of this study in terms of the present moment. In doing so, I focus not only on the ways in which American attitudes toward suicide in our contemporary culture are directly inherited through the trifurcated cultural response to suicide that emerged in the 1990’s but also on the importance of continuing scholarly exploration of suicide through multidisciplinary lenses; furthering psychosocial theories in our treatment of suicide; and particularly, questioning the ways in which present-day American culture continues to silence and stigmatize suicidal persons and their survivors.

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Chapter 1

Manifestations of the Final Exit: Exploring the American Culture of Suicide in the 1990's

Introduction

In order to undertake thanatological analyses of literature, both as texts and as cultural artifacts, it is important for us to understand the theoretical and historically-traced psychosocial factors that complicated grieving suicide in America in the 1990's. To begin, I will provide an overview of classical grief theory, focusing on the differentiation between task-based models of grieving, first developed by Sigmund Freud, and stage models of grief, as originally introduced by Elisabeth Kübler-Ross. Next, I will discuss postmodern theories of grief that resist a classical understanding of bereavement, chiefly in terms of the centrality amongst them of the concept of meaning-making, presently understood amongst thanatologists as the processes that are undertaken by the bereaved to assign meaning, purpose, and sense to the life and death of the deceased and as essential to navigating grief successfully. Turning to postmodern suicide theory, I will illustrate the ways in which the work of Edwin Shneidman, undertaken over the second half of the 20th century, instigated a radical shift in historical understandings of suicide and its treatment that had previously rested largely upon the research of Emile Durkheim in the late 19th century.

Bridging the theoretical thanatological attitudes existent in the 1990's to the historical suicide culture of America in that decade, I will examine major mass suicide events in American culture in the 1990's: those of the Branch Davidians and Heaven's

Gate cult members, and I ground these analyses in my interpretation of the cultural inheritance of Jonestown. In considering these events, I argue that within that decade, a unique culture of suicide was initiated that garnered a contagion of mass public attention. More importantly, representations of these suicides contributed to what I theorize to be the trifurcated suicide response in American culture, based on the perceived mental health of the deceased; the understood physical health of the deceased; and whether the suicide was individually or collectively undertaken. This theory, an extension of the postmodern psychosocial theories discussed in this chapter, will be developed explicitly in the conclusion of this chapter and in those that follow.

Classical Grief Theory

Grief has not been a subject of scholarly interest until relatively recently; indeed, while mourning and grief have been experienced since the inception of human attachments and subsequent separations, these phenomena did not receive serious academic attention until 1917, when Freud published “Mourning and Melancholia.” This essay, which posits mourning as secondary to the loss both of humans and of non-tangible properties, such as values and ideals, differentiates mourning, treated by Freud as a non-pathological state in which “the world becomes poor and empty,” and melancholia, in which he argues that “the ego itself” does so (167). Freud further notes that “although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the mourner over to medical treatment,” believing “that after a lapse of time it will be overcome” (164-5). Whereas present-day theorists generally resist the notion that grief is temporally contained, in terms of its utility, “Mourning and Melancholia” not only validates the pain of

mourning while treating it as a non-morbid condition but also provides a theoretical precedent for the study and treatment of grief as a task-based process.

Classical task-based grieving theories rest upon the belief that an individual who has experienced loss must focus his or her energies upon delineated undertakings in order to recover from grief. For Freud, an individual's acceptance of the loss of a love object, "requires forthwith that all the libido shall be withdrawn from its attachments to this object" (165). His theory, therefore, is predicated on the idea that the bereaved must undertake de-cathexis of libidinal energy from the love object. He notes, "Against this demand a struggle of course arises – it may be universally observed that man never willingly abandons a libido-position, not even when a substitute is already beckoning to him" (165-6); here, Freud foreshadows the second task of the mourner: to transfer his or her libidinal energy to a new love object.

The legacy of Freud's studies of grief can be seen both in the work of subsequent classical task-based theorists, chiefly Erich Lindemann and J. William Worden, and in scholars who have rejected task-based methodology in favor of stage theories of grief, notably Kübler-Ross, John Bowlby, and Therese Rando. For fifty years following the publication of "Mourning and Melancholia," theorists and practitioners, whether of task-based or stage-based grief models, shared a significant misunderstanding of grief, first limned by Freud: the idea that grief necessitates detachment of the bereaved from the love object. In Grief and Loss Across the Lifespan: A Biopsychosocial Perspective, sociologists Carolyn Ambler Walter and Judith L. M. McCoyd write, "Freud's was the primary theoretical paradigm for early grief-work efforts. Usually couched in the language of 'letting go,' counselors have

long held to the idea that a mourner must separate from his or her attachment to the lost entity, even if she or he did not necessarily view this through Freud's paradigm of de-cathexis" (5). The long-held assumption of detachment as integral to mourning is an extension of Freudian grief work that, whether reified or resisted, has influenced the work of every thanatologist to follow.

As one of the first theorists to move beyond Freud's two tasks of de-cathexis and re-cathexis, Lindemann, studying grief responses in survivors of the Coconut Grove nightclub fire of 1942 in Boston, postulated the three tasks of grieving as "Emancipation from bondage to the deceased"; "Readjustment to the environment in which the deceased is missing"; and "Formulation of new relationships" (144-6). While his work is lacking in the benefits that may have been afforded by a broader scope of research, Lindemann nonetheless contributes an important "middle step" in Freud's theory of cathexis: that in order to release the dead and invest their energy in the living, bereaved persons must undertake activities that allow for a readjustment to the world around them, a world in which the dead are no longer present.

Of the three major task-based theorists in thanatology, only Worden, in resistance to the idea of releasing attachment to the deceased, postulates steps for grieving that reflect continuing bonds with the dead. As developed in his canonical text Grief Counseling and Grief Therapy, first published in 1991, Worden outlines the following four tasks of grieving:

Task I: To Accept the Reality of the Loss

Task II: To Process the Pain of Grief

Task III: To Adjust to a World Without the Deceased

Task IV: To Find an Enduring Connection With the Deceased in the
Midst of Embarking on a New Life. (Worden 2008)

As Walter and McCoyd have noted, “Worden adds the experience of emotional ventilation [to task-based frameworks of grieving], something that has recently become known as the grief-work hypothesis” (7). Here Worden departs from Freud, who outlined a two-step process of energy withdrawal and reinvestment, and Lindemann, who furthered bondage release and the creation of new bonds to the living, with some focus on a readjustment process. Instead, Worden underscores the necessity of *maintaining* a bond with the dead while asserting that the pain of grief, while recognized by Freud as an aspect of mourning, must be processed, not ignored, in order to move forward with one’s life. Although task-based models of grieving have been greatly critiqued by present-day practitioners of thanatology, the importance of “working through” the pain of grief and experiencing emotional ventilation remain validated by contemporary scholars.

Perhaps the most misunderstood yet culturally familiar theories of grief are those stemming from the work with dying patients undertaken by Kübler-Ross. Her work represents the first major paradigmatic shift in theorizing grief, both in terms of her departure from task-based grief models and due to her methodological approach. Concerned more with examining empirical data than prescribing tasks, Kübler-Ross incorporated the element of care in her interviews of dying patients; her work was driven by a critique of a “society in which death and dying is viewed as taboo,

discussion of it is regarded as morbid, and children are excluded with the presumption and pretext that it would be ‘too much’ for them” (20). Students across various disciplines, as well as the general public, are familiar with her five observed grief stages of Denial and Isolation, Anger, Bargaining, Depression, and Acceptance. However, the broad use of these stages in the study of those who are suffering the loss of a loved one, as opposed to those who are anticipating their own deaths, overreaches the scope and misapplies the conclusions of the research on which the five stages are based. Additionally, the stage of denial has been widely misunderstood; often treated as a stage in which a dying person must be prodded to accept the reality of death, it initially reflected a temporal period in which one facing a terminal diagnosis could elicit second opinions or maintain hope of inaccurate results. While her stage model has been misappropriated, it is important to note that with the publication of On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families by Kübler-Ross in 1969, discussions of grief were extended from clinical practice and offered to the medical, religious, and general communities, ushering into American culture a language for grief that was both accessible and centered on the lived experiences of the dying.

While Kübler-Ross remains the standard by which we adjudge classical stage-based theories, it should be noted that both Bowlby and Rando developed subsequent models aimed at assisting the bereaved in adjusting to life after loss has occurred. Bowlby, studying the effects of separation on displaced children of World War II, postulated in Attachment and Loss: Sadness and Depression (1980) that children – and, he speculated, adults – go through four stages of grieving based on their

attachment to the loss, temporary or permanent, of a loved one: Numbness; Separation Anxiety; Despair and Disorganization; and Acquisition of New Roles, also termed Reorganization. While Bowlby's contributions to attachment theory in childhood development are invaluable, his stages imply universality in grief processes across the lifespan that fails to incorporate social theories of human development.²

Classical grief theory has been the subject of much resistance in recent decades. Both task-based and stage-based models invite deserved critique for several key reasons. First, the scholarly or clinical application of any of the above canonical theories universalizes and thereby trivializes individually-experienced and unique grieving methods. Additionally, each of these theories oversimplifies the complexity of the grieving experience as a psychosocial phenomenon – that is, an experience that both shapes and is shaped by one's relationship to oneself and by one's relationship to others within his or her particular environment. Finally, while early task-based and stage-based models imply a potential completion of grief and mourning, stage-based models additionally urge “a progressive movement through the stages rather than the back-and-forth movement seen most commonly among the bereaved” (Walter and McCoyd 9).

Recognizing that stage- and task-based grief models have appeared mutually rigid and invariable in an increasingly postmodern scholarly community, Rando sought to synthesize components of both in her “phase model” of grief, introduced in her text, Treatment of Complicated Mourning, in 1993. In it, she linguistically departs

² See Erik Erikson's Identity and the Life Cycle and Identity: Youth and Crisis for foundational psychosocial development theory.

from “stages” of grief, substituting instead three “phases,” an Avoidance Phase, a Confrontation Phase, and an Accommodation Phase. While these phases, in every way but name, appear to be a paradigmatic replication of stages of grief, within each she embeds tasks for grieving, which she colloquially refers to as “The Six R’s.” If grieving is to be negotiated healthily and successfully, Rando argues, the bereaved first must recognize the loss, thereby understanding reality; then react, or respond emotionally to it; recollect and re-experience the loss by reviewing memories; relinquish, or release the dead as living; readjust by returning to daily life; and reinvest by accepting change and re-entering the world (Rando 45-6). While her blend of stage and task-based conceptions of grief implies a capacity for more individualized grieving processes, Rando’s lack of emphasis on continuing bonds with the dead and her prescriptive approach to “healthy grieving” (45) have invited contemporary criticism of her model as an attempt to discipline grief in ways not dissimilar to assessments of either classical stage- or task-based models.

Postmodern Grief Theory

Postmodern grief theories, first emergent in the early 1990’s, have developed largely as a form of resistance to the disciplining of grief, which is understood “as a means of pathologizing grief in ways that allow therapeutic intervention as a form of diffuse power, which produces conformity to societal norms” (Walter & McCoyd 13). While the scope of this project does not involve the study of the development of postmodernism per se, it is important to note that the posthumously published work on “technologies of the self” by Michel Foucault has borne significant influence on arguments against the “disciplining of grief” (Foucault 16-49). Postmodern criticism

of stage- and task-based classical grief models argue that while the bereaved subject may undertake self-improvement and self-care in these therapeutic structures, he or she is nonetheless coerced subtly into conformity by the social norms that dictate the containment of grief to a therapeutic context. These theories of grief have radically reoriented academic and clinical attention to bereaved individuals; they negate the idea that any one bereavement pattern, stage model, or set of tasks reflects accurately or holistically the variant effects of loss or disparate ways in which persons grieve. They also encourage grieving outside formal therapeutic contexts, emphasizing individually-negotiated pathways toward helpful grieving, including self-help and mutual help support groups. Postmodern theorists stress the importance of continuing bonds with the deceased and the critical role of meaning-making processes in coming to terms with loss.

Essential to these values is approaching grief not merely as a psychological state but as a psychosocial process. Walter and McCoyd have noted that “postmodern theories of grief grow from a social constructionist understanding of the world, which asserts that humans construct their understanding of the world in ways that they see as self-evident and believe to be true”; as postmodern theories of grief develop within psychosocial contexts, the authors add that these theories contribute to the “understanding that there are many truths, each created within the context of that particular individual’s society and historical milieu, his or her individual and family experiences, and his or her capacity for reflection and insight” (14). As bereaved persons are encouraged dialogically to understand their individual truths in relation to loss, the role of narrative achieves increased importance in the grieving process.

Whereas Freud supported the isolation of mourners from society and prescribed a withdrawal from discourse (excepting in cases of melancholia) (165), postmodern practitioners encourage practices of storytelling and creative expression in order to assist the bereaved not in moving forward *from* grief but in moving forward *with* grief.

In How We Grieve: Relearning the World (1996), thanatologist and philosopher Thomas Attig writes, “Losses through death hold a unique place in each survivor’s life story. When losses occur, individuals and their experiences do not suddenly fit some preordained pattern. No story of loss replicates any other” (7). His assertion is reflective of the postmodern approach to grief, and its attendant emphases – on the uniqueness of the bereavement experience to each individual, on the lack of utility in subscribing to empirically-shaky models of grief, and on the role of narrative – encapsulate major shared tenets of postmodern grief theories.

Meaning-making through narrative has been most associated with the work of Michael White and David Epston, whose text, Narrative Means to Therapeutic Ends (1990), proved groundbreaking within the counseling community by ushering narrative therapy into formal practice. Within the field of thanatology, the application of meaning-making and storytelling concepts has been extensively developed and theorized by psychotherapist and researcher Robert Neimeyer. Currently in his third decade of scholarly inquiry of meaning-making and narrative, Neimeyer has advanced the argument that attaining meaning in oneself following loss; making sense of the loss that has been suffered; and gaining insight into the life, death, and relationships of the deceased are essential, indeed primary, processes in grieving that constitute “grief work.” He writes, “meaning reconstruction in response to a loss is the central process

in grieving” (1998, 110) and has recently remarked that understanding individual paths toward meaning-making remains crucial in assisting those who have suffered loss (2014).

Neimeyer’s work has brought to postmodern theories of grief tremendous emphasis on encouraging agency in the bereaved, though it is important to note that freedom from the discipline of classical therapeutic models necessitates, then, what may at first appear to be a burdensome “trial and error” approach to coming to terms with loss. In a dialogically-based, narrative-driven therapeutic model of loss, the suffering individual may seek meaning and find none; for these individuals, Neimeyer notes, “the loss can be excruciating,” whereas “bereaved persons who find a measure of meaning in the loss fare better, rivaling the adjustment of those who never feel the need to undertake existential questioning in the first place” (2000, 549). Additionally, he writes, “even these ‘finders’ are not necessarily ‘keepers,’ . . . insofar as many of those who felt they had found answers to why the loss had occurred revisited these answers in the months that followed” (2000, 549). Although Neimeyer’s assertions certainly do not and cannot promise the results for all grieving persons that they desire, they underscore the ways in which the bereaved may undertake grief work as a dynamic and changing process. Most importantly, his findings regarding meaning-making and narrative grief work mark a necessary movement toward the clinical and cultural validation of grief as a lifelong process; an understanding that each loss in one’s life must be renegotiated across the developmental stages of his or her life; and an awareness of the centrality of attaining meaning in loss, with the knowledge that meaning-making may require many years of meaning-*seeking*.

Suicide Theory

A scholarly interrogation of suicide in American culture and literature such as the one undertaken here would be severely flawed if I did not recognize that meaning-making following death has been one of the most significant breakthroughs of postmodern grief theory and highly relevant to all study of bereavement and loss. In turning to contemporary treatments of suicide and disenfranchised grief prior to conducting literary analysis, we may seek to understand better the ways in which meaning-making processes become complicated, if not futile, following a death of suicide in the 1990's.

Scholarly treatments of suicide have only recently begun to embrace the psychosocial dynamism of this phenomenon; prior to the early 1980's, schools of thought trended toward variants either of the theories outlined in the sociological case study Suicide: A Study in Sociology by Durkheim (1897) or of the psychoanalytic death instinct theories first furthered by Freud in Beyond the Pleasure Principle (1920). Durkheim offers four sub-types of suicide based on either an individual's lack of integration in society (termed "egoistic suicide"); his or her loss of agency due to over-integration in society (named "altruistic suicide"); one's lack of regulation by his or her society (identified as "anomic suicide"); or, less frequently, his or her extreme overregulation by society (called "fatalistic suicide") (Durkheim 208, 221, 246). Freud, conversely, identifies suicide as secondary to melancholically-complicated, pre-lingual, and instinctual death drives that cannot cope otherwise with accumulated aggression toward the self. While sociological and psychoanalytic understandings of suicide developed to some degree beyond these divergent theories in the eighty and

sixty years, respectively, following their introduction, the segregation of suicide studies into two camps, social inquiry versus psychological study, remained largely supported by theorists and practitioners.

In 1985, psychologist Shneidman – who would spend sixty years of his life studying and publishing on suicide, founding the American Association of Suicidology and becoming inarguably the leading suicidologist of the 20th century – wrote in Definition of Suicide that suicide is a multifaceted event and that biological, cultural, sociological, interpersonal, intrapsychic, logical, conscious and unconscious, and philosophic elements are present in various degrees in each suicidal event (202). Coining the term “suicidology,” this text and those that followed it established the multidisciplinary nature of suicide, which by his own admission in his 2001 text Comprehending Suicide: Landmarks in 20th-Century Suicidology, has become “a mantra for suicidologists” (200). In 1993, Shneidman introduced the concept of psychache in Suicide as Psychache: A Clinical Approach to Self-Destructive Behavior based on the synthesis of decades of research and clinical practice with suicidal patients and survivors. Reflecting on psychache, he writes, “I believe that suicide is essentially a drama in the mind, where the suicidal drama is almost always driven by psychological pain, the pain of the negative emotions – what I call *psychache*. Psychache is at the dark heart of suicide: no psychache, no suicide” (Shneidman 2001, 200; emphasis in original). While intrapsychic pain is at the root of psychache, it is important to understand that its presence and degree are dependent upon social and cultural factors that lead to “a nexus of frustrated or thwarted psychological needs”

(Shneidman 2001, 201).³ Our contemporary understanding that the suicidal individual is suffering from mental or emotional pain is one that is too easily taken for granted and is a testament to the reach of Shneidman's work on psychache; we must recall that historical conceptions of suicide have often located the pain of the individual either wholly outside himself (environmental) or as present secondary to mental illness. In short, Shneidman developed and validated the idea that suicidal intent is both the product of unbearable psychic pain and contributory to that pain itself.

Sociologist David Wendell Moller furthered Shneidman's interlocking framework by positing a "psychosocial collage" existent in suicidal persons in Confronting Death: Values, Institutions, and Human Mortality (1996). In explaining the psychosocial collage approach to suicide, Moller writes that "the impulse to commit suicide typically arises from private anguish and personal turbulence. Powerlessness and feelings of guilt, depression, hopelessness, loneliness, and despair are psychological symptoms often associated with suicide"; however, these feelings "increasingly are associated with the patterns and organization of contemporary social life. The etiology of suicide, therefore, is explicitly related to a range of psychological variables and to a societal context" (Moller 192). Moller's employment of a collage trope in approaching suicide reinforces Shneidman's identification of the individual, even "idiosyncratic . . . pattern of frustrated psychological needs" within the suicidal individual (Shneidman 2001, 201).

³ In the canonical textbook The Last Dance: Encountering Death and Dying, psychologist Lynne Ann DeSpelder and thanatologist Albert Lee Strickland reinforce Shneidman's breakthrough in understanding suicide as psychosocial, noting that deaths of suicide must be read as products of psychological and social forces that culminate in a suicidal "crisis of self-concept that ultimately leads to a desire to escape the unsatisfactory situation" (427).

By now, we understand that psychological pain is inextricably entwined with one's sociological condition. However, if we are to understand the ways in which meaning-making, and thereby grief work itself, following suicide is compromised, we must approach suicide bereavement *and* suicidality – the likelihood of attempting suicide – as disenfranchised states of being. In Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice (2002), thanatologist Ken Doka expands upon the research and goals first presented in 1989, when he introduced the concept of disenfranchised grief, writing, “Someone has experienced a loss, but the grief experienced has been disenfranchised – that is, the survivors are not accorded a ‘right to grieve.’ That right to grieve may not be accorded for many reasons, such as the ways a person grieves, the nature of the loss, or the nature of the relationship. So, although the person experiences grief, that grief is not openly acknowledged, socially validated, or publicly observed” (5).⁴ Doka discusses the effects of disenfranchised grief on the bereaved, noting that “many emotions are associated with normal grief. Bereaved persons frequently experience feelings of anger, guilt, sadness, depression, loneliness, hopelessness, and numbness. These emotional reactions can be complicated when grief is disenfranchised”; he adds that studies “uniformly report how each of these disenfranchising circumstances can intensify feelings of anger, guilt, or powerlessness” (17).

Disenfranchisement of a loss from suicide occurs at every level of society; stigma, silence, and shame figure prominently in perpetuating the disenfranchisement

⁴ Just as suicide bereavement is disenfranchised, so too have individuals and institutions within American culture systematically disenfranchised the suicidal person based on socially constructed systems of privilege and inequality, which will be treated in Chapter 3.

of survivors and limiting their capacity to enact grief work to make meaning of the loss. Writing on the stigma felt by many survivors of suicide, Doka asserts that “the nature of the death may constrain the solicitation of the bereaved for support as well as limit the support extended by others”; furthering many survivors’ stigma is a shared belief “that others may negatively judge the family because of the suicide” (14). Illustrating how stigma breeds silence, Doka further observes that in suicide, “the cause of death discredits survivors – affecting and influencing their identity and marring interaction with others – thereby limiting their support”; suicide survivors “report that they often feel that others stigmatize them, and the survivors often stigmatize themselves. Survivors often report high levels of guilt and depression that inhibit their seeking support” (325). Such self-stigma and fear of stigma may be partially explained in terms of a cultural aversion to validating grief following deaths that are viewed as avoidable. Attig posits that because “violent, mutilating, or random deaths shock, horrify, and traumatize us in ways that interfere with the usual grieving processes,” when we additionally perceive deaths as “preventable or caused by human action or neglect, we frequently are distracted from normal grieving as we preoccupy ourselves with those responsible and adjust to a world we now perceive as threatening, menacing, and untrustworthy” (84). Walter and McCoyd add that “the nature of disenfranchised grief means that grieving individuals do not receive the social support and sympathy from others that has been shown to be crucial to being able to process grief and move on from it in healthy ways. The very core of this experience (for most) is to actively engage the pain of grieving”; however, many survivors “have that pain exacerbated by social isolation or rejection with little support (if any) provided” (19).

The ways in which suicide survivors are disenfranchised within society involve aversive and judgmental responses from individuals, as seen above, but extend beyond into institutional disenfranchisement in families, religious communities, and the health care field. Psychiatrist Collin Murray Parkes, in Bereavement: Studies of Grief in Adult Life (1998), observes that while “psychiatrists and other health care staff are usually at hand when someone commits suicide,” only few “take the opportunity to offer help to families bereaved by suicide”; he speculates that this lack of attention to survivors “may well be a reflection of the embarrassment which psychiatrists often feel when their patients commit suicide, but it tends to compound any problems that exist rather than to resolve them” (134). DeSpelder and Strickland note that individuals “tend to treat suicide as a failure of personal responsibility and as a matter of shame” (426). In the Handbook of Bereavement Research and Practice: Advances in Theory and Intervention (2008), thanatologist Robert Kastenbaum observes that suicide “has been constructed as criminal, weakness, madness, heroic, and rational”; cultural attitudes play an integral role in according the bereaved attention dependent on social norms toward suicide, and within a mainstream Christian tradition, such as is dominant in American culture, “suicide has long been reviled as sinful. The taint of suicide [has] distorted the family’s normal grieving process” (Stroebe 71). While concealment of suicide by families of the dead is historically situated within our culture, Kastenbaum reminds us that “physicians today are sometimes still faced with the choice between certifying suicide or easing a bereaved family by naming a more acceptable form of death” (Stroebe 74).

No longer criminalized legally in the United States, the stigma of a suicide death remained widespread in the 1990's, as it continues to be today, furthering shame in survivors and undermining the grief work necessary for them to move forward. Concurrent to thanatological research and theory emergent in the 1990's were major historical events that complicated cultural and individual understanding of suicide in that decade, including mass death events, the emergence of the controversial practice of assisted suicide versus the burgeoning Death with Dignity movement, and statistical increased suicide rates amongst discrete populations. As discussed in the introduction to this chapter, a unique culture of suicide was initiated and reinforced through media and public discourse, leading to a contagion of public attention as well as the emergence of what I argue is the trifurcated suicide response. The practice of assisted suicide and the right-to-die movement in the 1990's will be discussed in conjunction with representative literary texts in Chapter 4; responses to individuals' suicidality will be explored in Chapters 2 and 3. Here, I will illustrate the first branch of the trifurcated suicide response by examining American cultural responses to mass deaths of suicide in this decade through their historic grounding in the events of Jonestown and as contributory to a unique and disparate attitude toward collective suicide in the 1990's.

The Cultural Relevance of Jonestown in the 1990's

The death by cyanide poisoning of 913 men, women, and children in a remote commune in Guyana on November 18, 1978 was the culminating act of twenty-four years of leadership by Pastor Jim Jones. Having grown his parish, the Peoples Temple Full Gospel Church, from a small Christian evangelical fellowship in Indianapolis to a

swelling social justice community in San Francisco and finally, to the self-sustaining and troubled agricultural project named Jonestown, Jones embodied the charismatic leadership, promise for social and religious change, and messianic prophecies that have since become portentously synonymous with American perceptions of a “cult leader.” While few Americans outside of San Francisco in the 1970’s were familiar with Jones or the Peoples Temple, soon after the mass death event in Guyana, virtually the entire country would be exposed to the aftermath of both, and the legacy of Jones would pervade and influence cultural conceptions of mass death events through the 1990’s.

Author Julia Scheeres, after reviewing the tens of thousands of recently-declassified FBI documents from Jonestown, observes in *A Thousand Lives: The Untold Story of Jonestown* that “most Americans heard about Jonestown for the first time the next evening, when the networks interrupted their regular programming with special reports on the massacre”; she adds that while “the news from Guyana was sketchy in the beginning,” over the following weeks, “the mass murder-suicide would generate thousands of new stories worldwide, and photographs of the bodies would appear on *Time* and *Newsweek*. Both used the same headline: Cult of Death” (238). John Hall, who has written extensively on Jonestown and other perceived cult deaths over the last three decades, adds:

Jonestown became . . . a grotesque symbol of devastated human life. The gruesome piles of bodies huddled next to one another attained an instant place in the U.S. collective consciousness. By February of 1979, 98 percent of Americans polled said they had heard of the tragedy.

George Gallup observed, “Few events, in fact, in the entire history of the Gallup Poll have been known to such a high proportion of the U.S. public.” (289)

American public perception of Jonestown was driven by fascination and horror; cultural portrayal of Jones and his followers was largely of a demented madman and his “brainwashed zombies” of followers (Scheeres 238). As Scheeres has posited, “it was far easier to condemn Jones’s victims than to comprehend them” (238); as I argue, dehumanizing Jones’ followers by portraying them as “zombies” made their deaths more palatable. Certainly, Jones was a megalomaniacal, dangerous leader; however, as defectors and survivors have attested, Jones was also an idealist who gathered liberal-minded, intelligent, and often highly-educated people to his movement, promising racial and gender equality for those who felt palpably the discrimination of the time and founding Jonestown on the basis of collective ideals and a united purpose for social change. Scheeres notes that Jones’ followers “wanted to create a better, more equitable, society. They wanted their kids to be free of violence and racism. They rejected sexist gender roles. They believed in a dream” (250).

The betrayal of members of the Peoples Temple by Jones is evident in the video footage recovered from Jonestown, as well as the coverage of the mass death by American media. Following the murder of Congressman Leo Ryan and members of his entourage, who had visited Guyana on a fact-finding mission following pleas from relatives of Jonestown residents, Jones took to the podium in the public area of the commune, announced that the congressman was dead (though omitting that he had

ordered him murdered), instilled fear in his followers that “others” would now come after them all, and implored the community to die. Writing in 1987, Hall argued that the “mass suicide” of Jonestown residents “would be an awesome vehicle for a powerful statement of collective solidarity by the true believers among the people of Jonestown: they would rather die together than find their life together subjected to decimation and dishonor at the hands of opponents and authorities they regarded as illegitimate” (300). While some Jonestown residents appear, through the accounts amassed by Scheeres and on video, to die “willingly,” not only is it important to acknowledge the space of isolation and compulsory loyalty which Jonestown residents occupied, rendering their capacity to make resistant choices diminished, but also it is essential to illustrate that this framing of “mass suicide” fails to account for the many residents of Jonestown who attempted to flee, only to be met by armed guards.

Ironically, Jones himself explicitly disavowed the act of suicide when urging his followers to ingest their cyanide-laced cocktails. He stated, “So my opinion is that we be kind to children and be kind to seniors and take the potion like they used to take in ancient Greece, and step over quietly, because we are not committing suicide. . . it’s a revolutionary act” (Scheeres 227). Hall’s early work on Jonestown, in keeping with other accounts in the decades following the mass death, unintentionally reifies Jones’ own idealized conception of united mass death. The video footage tells another story: one of women attempting to shield babies, men being strong-armed into line to accept their cup of Flavor-aid and poison, and widespread wailing and chaos (Nelson). The tragedy at Jonestown was clearly one of murder, yet its culturally-perceived status throughout the 1980’s and 1990’s as a cult suicide event not only undermined the lives

and deaths of Jones' victims but also powerfully situated public perception of later organizations that were all-too-easily categorized as being similar to Jonestown.

Scheeres observes that today, "few Americans born after 1980 are familiar with the Jonestown tragedy"; she adds that while the colloquial phrase "'drinking the Kool-Aid' has entered the cultural lexicon, its reference to gullibility and blind faith is a slap in the face of the Jonestown residents who were goaded into dying by the lies of Jim Jones, and, especially insulting to the 304 murdered children" (250). Gullibility and blind faith – attributes commonly lent to religious groups in the 1990's whose members died en masse – render public perception of these deaths as secondary to madness and stupidity, rather than resultant of collective suffering and entrapment. Hall notes that "after Jonestown, 'mass suicide' became a term of general cultural currency, a touchstone for describing the stark danger posed by cults" (151-2). However, as we shall see, the legacy of Jonestown in the 1990's undermines public interrogation of mass death events "like" Jonestown; it erases the need for culturally-validated grieving by rendering the deceased, brainwashed "zombies" who, if they did not willingly *choose* to die, perhaps *deserved* to die – after all, following Jonestown, they should have anticipated the expected outcome of joining such a group in the first place.

Media Narratives of Waco

The standoff between self-identified prophet David Koresh (born Vernon Wayne Howell), cloistered with his followers in a large wooden residence in Mount Carmel, near Waco, Texas, and U.S. law enforcement agents from the Bureau of

Alcohol, Tobacco, and Firearms (BATF) began on February 28, 1993 and culminated on April 19, 1993 with the deaths of 76 individuals. Less than fifteen years had passed since the “cult suicide” of Jonestown, and the association of extremist religious organizations with images of violence and mass suicide was still prevalent in both popular and media consciousness. For over seven weeks, American audiences “glanced at their television sets, and were provoked or intrigued by the fresh, hot documentary footage that passed across their cool screens,” beginning with imagery not of any violent acts of Koresh but those of “federal law enforcement agents, dressed in combat gear” outside a residence for Branch Davidian followers, “scaling its walls, breaking its windows, [and] throwing grenades inside” (Reavis 11).

In the February 28 press statements transmitted to a largely surprised public – the vast majority of whom had never heard of Waco, Texas, let alone a messianic Christian fundamentalist leader named David Koresh – the government crafted an explanation both simplistic and instantly recognizable to Americans for whom memories of Jonestown lingered. Writing two years following the standoff, journalist Dick Reavis, who covered the events from Waco, identifies that the government’s justification for their attempted forced entry into the residence “was built on four concepts: Texas-Child Molester-Gun Cult-Crazies”; further, while some government agents addressed the public via the assembled press, “others cordoned the zone of conflict and cut the telephone lines that connected Mt. Carmel to the world outside. The press was denied access to the story beyond the barricades. It reported the rest of the action by telephoto lens, from a spot more than two miles away” (11). Thus, from the beginning of the siege, conjecture and unsubstantiated government claims

contributed to what became nightly reportage from Waco. Reavis recalls, “Journalists found that the news environment was so tightly managed that they could not fulfill their investigative role. Yet the press had to produce. The whole world was hungry for news” (12). What was known was that following reports of arms-stockpiling, federal agents attempted a “dynamic entry” through the windows of the residence, and four agents were fatally shot from inside the building during the failed attempt. What was unknown would be created, by government officials and press, through a lens of the Jonestown legacy.

While Koresh was no stranger to government investigation, as his defectors had lobbied officials for intervention based on allegations of child sexual abuse and the purported militant weapons amassing that eventually led to the thwarted February 28 encounter with BATF, the media had little sense of the belief system of the Branch Davidians, the rise of David Koresh as a religious leader, or the reasons behind this seemingly botched governmental intervention. Physically isolated from observing activities around Koresh’s residence, the press, as Reavis admits, became heavily reliant on government statements and cultural tropes about cults. He writes:

The press became an amplifier for bureaucratic spinmeisters. The managed nature of the news was apparent in the terminology of press reports. The religious community of Mt. Carmel was called a “cult,” and its chieftain became, quite naturally, “a charismatic leader” who ruled the followers by something called “mind control.” The community’s rambling wooden house became a “heavily-fortified

compound,” its concrete structures became “bunkers,” its children “hostages.” (12)

Writing in 2012, Hall illustrates how the deaths of Branch Davidians – which were as troubled in their “mass suicide” framing as those of members of the Peoples Temple – were simplistically predicted. He observes that “cultural opponents of David Koresh reinvented and reworked the central public meaning of Jonestown – mass suicide – in ways that shaped the conflict in Mount Carmel. There is deep irony in the early prophetic warnings by former members against Mount Carmel as another Jonestown – a ‘cult’” (Bromley & Melton 149). The association of “cult,” which in popular consciousness in the 1990’s might signify *any* separatist religious organization deemed “extreme,” and “mass suicide” as a potential conclusion for said cult is directly and problematically resultant of American attitudes toward Jonestown; indeed, the preemptive conjectures of mass suicide for the Branch Davidians, broadcast over national media, are ironic because in actuality, their deaths were indeterminable as suicide yet widely accepted as such. Simply put, “the opponents of Koresh took tropes about mass suicide, derived from the apocalypse at Jonestown, reworked them, and inserted them into accounts that they offered about the Branch Davidians” (Bromley & Melton 168).

Once the explicit relationship was framed between the newly-identified “cult” of Branch Davidians and their supposed probability for suicide, “the world’s media indulged in a feeding frenzy”; Kenneth C.G. Newport observes that as “the archetypal leader of such movements,” Koresh was reported to be “a man whose hold over his followers was complete, to the point of his being able, if he so wished, to

order them to commit suicide in the knowledge that they would do so” (2). To what degree such media reports heightened the escalation of the siege by the Federal Bureau of Investigation (FBI) is a matter of conjecture; nearly all the events of Waco have been argued and debated for over two decades to date, and it appears unlikely that we will ever know for certain the precise interplay between Koresh, his followers, and federal agents that took place on April 13. More important, for the purposes of this study, is the ease with which this event was termed a “cult suicide” and was accepted as such. Newport notes that by the final day of the standoff, when Attorney General Janet Reno ordered FBI agents to force Koresh out of his residence with tear gas, following which the compound became engulfed in flames, the “worrying point” of the 51-day standoff had become, in American consciousness, “that society was not safe while such madmen lived in its midst” (2).

The live coverage of the burning residence of Branch Davidians on April 19 was unlike any other mass death event in American history. Reavis speaks to the unique nature of this coverage, writing, “A comparable tragedy had never been played out, live and in living color, over global TV. So electrifying was the footage that viewers got the feeling that If You Can See It, You are There. The event was a national sensation, a great day for the press” (13). Unlike the carnage of Jonestown, the American public watched the site of the mass death of 76 men, women, and children (and two spontaneously miscarried fetuses) in real time, in living rooms across the country. I posit that the public was riveted by this coverage not only due to the long-standing, largely static nature of the standoff but also as secondary to the ease with which the coverage confirmed publicly-inherited suspicions about such religious

groups as extremist, violent, and culminating in self-inflicted death. Reavis recalls the coverage of April 19:

As soon as the flames were visible on camera, the government's spokesmen began explaining what was afoot, by adding two new words to the conceptual tools that they had already issued for grappling with the few bloody and now charred facts at hand: Texas-Child Molester-Gun Cult-Crazies-Commit Suicide, they – and even the President – said. The verb and its modifier had the ring of finality, and from the camera's perspective, so did the blaze. (14)

In public consciousness, “mass suicide,” as attributed to the Branch Davidians of Waco, *made sense*. The use of government force, complications regarding points of entry for the gunshot wounds of the dead, the problematic lack of information regarding the relative free will of Koresh's followers – these issues were of little interest to the media or, for a number of years, to historians. Reavis notes that “within forty-eight hours [of the fire], the press had abandoned Waco and moved on, as if the story had been only a visual event: no more besieged building, no more story” (14). And while the public remained briefly charged from the seven weeks they had spent watching, in large part, a quiet residence in the middle of Texas surrounded by immobile federal agents, they accepted the conclusion to the narrative arc of Waco, initiated by Jonestown: Koresh and the Branch Davidians had died of mass suicide – as cult leaders were, by then, expected to perpetuate and as his cult members *deserved* because they had followed him in hopes of religious salvation.

Heaven's Gate and "The Next Level"

Progressively known as "Guinea" and "Pig," "Peep and Bo," "The Two," and "Ti and Do," Bonnie Nettles and Marshall Applewhite sustained their jointly-founded religious millennial organization for approximately twenty-five years until its mass suicide of 39 men and women March 24-26, 1997 in the San Diego area of California. Following his "Awakening" and believing himself to be a relative of Jesus, Applewhite created a New Age belief system with Nettles that combined narratives of salvation and apocalypse from Christian teachings and ideas culled from popular science fiction, notably, their belief in Unidentified Flying Objects (UFOs) and the possibility of travel to other worlds and dimensions. While membership in Heaven's Gate, which was originally called Human Individual Metamorphosis (HIM), waxed and waned between the early 1970's and late 1990's, reaching at most a membership of about 200 persons, the organization itself, unlike Jones' Peoples Temple or Koresh's Branch Davidians, was well-known (though largely ignored) in mainstream media. Its primary message – that followers of Applewhite and Nettles had the opportunity to evolve to the "Next Level," thus escaping the earth before its apocalyptic "recycling" – provoked some scholarly interest, but the American public only rarely encountered Nettles, Applewhite, or Heaven's Gate and did so with little interest until its mass suicide.

Sociologist Robert Balch, who has been engaged in scholarship on Heaven's Gate for over three decades,⁵ writes with David Taylor in 2002 that "to be eligible for

⁵ See Balch, "Bo and Peep: A Case Study of the Origins of Messianic Leadership"; "When the Light Goes Out, Darkness Comes: A Study of Defection from a Totalistic Cult"; and "Waiting for the Ships: Disillusionment and Revitalization of Faith in Bo and Peep's UFO cult," all published prior to the

membership in the Next Level, humans would have to shed every attachment to the planet”; Applewhite and Nettles, like Jones before them, reinforced that their followers abandon “friends, families, jobs, possessions, and sex” in order to maintain membership (Bromley & Melton 211). Unlike Jones, or indeed Koresh, Ti and Do themselves practiced a highly ascetic life. Like at least seven of his male followers in the final group, Applewhite was castrated during his leadership of Heaven’s Gate. Physical intimacy and material pleasures were avoided by all – followers and leaders alike – as a means to self-purification for the Next Level.

While initially, Heaven’s Gate dogma insisted that humans could ascend to the Next Level only in their living bodies (which would be assumed or transcended for the higher realm), following Nettles’ death to cancer in 1985, Applewhite revised this belief and began culling his followers while preparing them for ascension through death. Balch and Taylor note that the Heaven’s Gate organization history “can be summarized as a process of progressive, deliberate disconnection from society. Initially the process was mainly social and economic, but the fundamental objective of Heaven’s Gate was to disconnect mentally from everything human, including the body”; they add that “suicide was merely the logical conclusion” (Bromley & Melton 228).

While Balch’s extensive work on Heaven’s Gate is compelling, it should be noted that suicide has been deemed “logical” for this group only *following* the suicidal conclusion to the organization. Thomas Joiner points out in 2005 that, “relevant to the acquired capacity to enact lethal self-injury, there were numerous discussions about

group’s mass suicide.

and explicit rehearsals for suicide” in Heaven’s Gate (145); however, whereas these rehearsals were not public, many of their fundamental beliefs and mission statements were. Through the 1970’s and 1980’s they traveled widely and gave talks throughout the United States to attain members; in the early 1990’s, they published pamphlets and took out full-page advertisements in newspapers such as USA Today, and importantly, in 1996 they developed a still-sustained website with hundreds of hours of video footage; position papers; and other documents describing their organization, its claims, and its membership. Although the group was secluded physically, virtually it was in plain sight.

Similarly, the group’s association to the Comet Hale-Bopp, a major talking point in press coverage of the Heaven’s Gate suicides, was framed as suicidally causal as opposed to concurrent in immediate press coverage of the event.⁶ Balch and Taylor correct this historical oversight, noting that “in the end, the suicides were not triggered by an external threat, like the government’s actions in Waco or Leo Ryan’s investigation of the Peoples Temple, but by Do’s [Applewhite’s] perception of a synchronistic conjunction of events as compelling as the coincidences that had led to his Awakening” (Bromley & Melton 227). That is, Applewhite’s led suicide of his remaining followers in 1997 *utilized* the much-discussed comet’s passing of the perihelion (point closest to the sun) on April 1, but the comet was a device in the group’s plan for exit, not its impetus. Comet Hale-Bopp became a convenient means by which Applewhite scheduled the mass suicide. Public fixation on the relationship

⁶ For two representative pieces, see “Associate of Group Member Says Deaths Linked to UFO, Hale-Bopp,” and “Apocalyptic Visions Tied to Comets Past” by Dick Wilson, both published by CNN on March 27, 1997.

between Heaven's Gate and the comet resonates with the lack of suicidality attributed to the group by observers prior to the group's demise: in short, the narrative of Heaven's Gate did not fit the pattern of historical precedents that were forged by public perceptions of Jonestown or Waco. Both the media and scholars were at a loss, retrospectively, to make sense of it vis à vis those embedded historical events.

I believe that the mass suicide of Heaven's Gate is distinguished from those ascribed to Jonestown and Waco in several distinct ways that complicated public perception of the event. First, while the group shared with the Peoples Temple and the Branch Davidians a sense of Christian origin, their heavy inclusion of science fiction narratives made the group easily framed as mentally unstable and ridiculous, less a dangerous religious sect and more a zany UFO cult. Second, in the few scholarly and media investigations of Heaven's Gate prior to the "departure," there appeared to be no evidence of the physical or sexual abuses suffered by victims of Jones or Koresh; indeed, even defectors of Heaven's Gate spoke nearly universally about the love and trust they had shared with Applewhite. Balch and Taylor, as quoted earlier, note that one particularity to Heaven's Gate was the lack of perceived external threat prior to the mass suicide; importantly, members of external society did not perceive Heaven's Gate to be a threat to *them*, either – unlike reports of Koresh as a "madman" who posed a danger to innocent Americans. Finally, even when secluded physically, as they were throughout much of their existence, Heaven's Gate did not appear as a group to practice the secretive dissociation from society that residents of Jonestown and Mount Carmel had. Ironically, though their tenets demanded abstinence from sexual contact with one another and from physical contact with former friends and

family members, the group itself was highly visible through the Internet. I posit that Applewhite and his followers were not so much hiding in plain sight as they were, virtually, plainly visible and largely ignored.

Cultural critic Paul Virilio has gone so far as to term the group a “cybersect,” owing to its heavy reliance on Internet technology in promoting its message prior to the mass suicide (41). Prior to the events of March 1997, the group published on its website recorded “exit statements” from members, as well as a number of archived written messages, including the following excerpt from their tract titled “Our Position Against Suicide”:

The true meaning of “suicide” is *to turn against the Next Level when it is being offered*. In these last days, we are focused on two primary tasks: one - of making a last attempt at telling the truth about how the Next Level may be entered (our last effort at offering to individuals of this civilization the way to avoid “suicide”); and two - taking advantage of the rare opportunity we have each day - to work individually on our personal overcoming and change, in preparation for entering the Kingdom of Heaven. (Heaven’s Gate; emphasis in original)

With repeated references to “these last days,” apocalyptic letters on preparing for “‘graduation’ from the Human Evolutionary Level,” and farewell messages recorded and published online prior to the collective suicide, the Heaven’s Gate website complicates expected outcomes, interventions, and responses to the members’ deaths.

When the bodies of 39 men and women, including that of Applewhite, were

found in their rented mansion outside of San Diego, much was made of the appearance of the members; nearly every media outlet recited the matching black sweatsuits, purple shrouds, Nike sneakers, and “Heaven’s Gate Away Team” arm bands worn by the dead. The media was similarly preoccupied in speculating as to the means by which members assisted one another in their suicides over the course of three days, covering one another with shrouds and arranging bodies after the deaths of Phenobarbital poisoning and asphyxiation. Nearly immediately, late-night talk show hosts Jay Leno, Conan O’Brien, David Letterman, and Bill Maher were using the Heaven’s Gate suicide in their comedic monologues.⁷

I argue that Heaven’s Gate’s perceived nature – as benignly unstable UFO zealots – and lack of physical threat to the public troubled the cultural trajectory about “cults” that had begun in Jonestown and continued following the Waco siege. Heaven’s Gate, quite simply, did not prompt fear – or even much desire to understand the suicide’s origins. Instead, it eased the sensitivity and fear of cults first instilled by Jonestown; moreover, it made Americans *laugh* at cults – and, problematically, at an event of mass suicide.

Making Meaning Following Mass Suicides in the 1990’s

How do mass suicides occur, and what meaning can be extracted following their execution? In the 1990’s, attention to mass suicide was hyperactivated by the cultural inheritance of the imagery and testimony from Jonestown, but meaning-making attempts throughout the decade collapsed distinguishing features from

⁷ For one contemporaneous critique of talk show hosts’ comedic responses to this event, see Chris Hicks, “Line Separating Comedy, Tragedy is Awfully Thin,” in The Deseret News.

Jonestown, Waco, and Heaven's Gate into an uber-narrative of cult death.

Psychosocially, scholarly opinion now largely aligns with Ariel Merari, whom I quote here at length:

Collective suicide cases seem to have several characteristics in common. Perhaps the most salient feature is that in all cases, the ostensibly common suicide event was primarily a matter of mass murder rather than mass suicide. Free will is questionable even in the case of seemingly consenting adult cult members. In all [these] events, the decision to die was not taken in a group discussion and vote – it was imposed on the community by the leader. Typically, cult members submit totally to the leader and obey his orders. . . . This mental condition of submissiveness is presumably the result of an interaction of certain personality characteristics that make some persons more amenable to influence than others, and living under extreme pressure by the leader and the group. (21)

Merari's consensus is rationally echoed by Balch and Taylor, who, in writing on Heaven's Gate, note that for cult members living submissively under the leader's control, "the factors leading to the suicides can be divided into three categories: (1) conditions that predisposed the group to radical action, (2) situational factors influencing the assessment of options, and (3) precipitating events that transformed suicide from an option to a reality" (Bromley & Melton 224). The unique relational pressures in cult groups, explicated both by Balch and Taylor and by Merari, are further echoed by Thomas Joiner in his epidemiological and clinical study, Why

People Die By Suicide, in which he adds that “people in both groups [Jonestown and Waco] endured considerable pain and provocation” (145).

It is important to note here that even amidst these considered scholarly opinions exists a drive to universalize mass suicide events. Aside from the problematic nature of defining a “cult,” excepting the ease with which a group is labeled as such by the media following an event of mass death, there are a number of ways in which the organizational structures, paths toward suicide, and aftermath of Jonestown, Waco, and Heaven’s Gate differed. Two of the leaders adopted violent and allegedly abusive tactics towards its members; two apparently did not. All purported to further Christian teachings, yet their adoption and interpretation of Biblical texts varied widely. All controlled, to some degree, its members actions and activities; however, the degree to which members were free to leave the organization varied widely. We inherit footage of Jonestown residents facing armed guards if they did not ingest poison and farewell videos of Heaven’s Gate members seemingly cheerfully preparing to die. Within the framework of religious extremist secluded organizations led by messianic leaders, vast disparities existed, yet the public and scholarly insistence on crafting a singular suicide cult narrative problematizes the postmodern theories of suicide emergent in the 1990’s.

Simply put, American cultural response to mass suicide is as divergent from its responses to suicide in terminally ill populations as it is to individual suicides from psychache – and it is, as the first of three branches of the trifurcated suicide response, the only one in which public grieving is neither demanded nor expected by the late 1990’s. Based on my readings of these mass suicide events, which spanned nineteen

years of recent American history, I conclude that the 1997 Heaven's Gate suicides were a culmination in the development of a distinct cultural response to mass suicide in the 1990's and served simultaneously to deflate comedically previously-held cultural fears of cults; to reify an essentializing conception of any non-normative religious group as "cult-like," therefore potentially dangerous to its members; and consequently, to make validating the lives and grieving the deaths of cult members unnecessary.

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Chapter 2

Disenfranchised Grief and the Futility of Meaning-Making Acts in The Virgin Suicides

Introduction

It didn't matter in the end how old they had been, or that they were girls, but only that we had loved them, and that they hadn't heard us calling, still do not hear us, up here in the tree house, with our thinning hair and soft bellies, calling them out of those rooms where they went to be alone for all time, alone in suicide, which is deeper than death, and where we will never find the pieces to put them back together.

(Eugenides 243)

With the above lines, given by the collective male narrators of The Virgin Suicides (1993), Jeffrey Eugenides closes his novel and opens his reader to the possibility that grieving suicide, here deemed “deeper than death,” may perpetuate a quest for understanding that is at once unstoppable and futile. The text, recounted through shared memory, describes the thirteen months in the small Detroit suburb of the narrators' youths in which the five Lisbon sisters died of suicide. Both the arc of the novel and the framing of its narration illustrate the frustrating, impossible task of locating meaning in the girls' deaths, suggesting that following completed acts of individual suicide, the bereaved “will never find the pieces to put [the dead] back together”; moreover, as I will argue, in their attempts to do so, they also experience a

form of grief that is invalidated, or disenfranchised, socially and psychologically and that renders the search for meaning a ceaseless task.

The narrators' obsessive search for answers following the deaths of the sisters who entranced them throughout their adolescence speaks to their chronic and unfulfilled grieving throughout the novel. I argue that this quest both perpetuates and is perpetuated by a crisis of meaning-making that is reflective of larger cultural responses to individual suicide for physically healthy individuals in the 1990's. In this chapter, I will trace the various attempts by characters within the novel to make sense of the deaths of suicide of the Lisbon sisters and the ways in which each of them falls short of attaining satisfaction in his or her attempt. These characters, each of whom can be read as representing an ideological and attitudinal system of either the institution of the family, the neighborhood community, the educational system, religious institutions, the media, or the medical community, fail to achieve meaning-making in responding to the Lisbon deaths. In this way, I continue my exploration of the ways in which American culture developed and perpetuated a trifurcated response to suicide in the 1990's by examining societal perceptions of suicide in physically-healthy individuals as a second branch of vastly divergent responses to collective "cult" suicide; suicide secondary to psychache; and suicidality in the terminally ill.

The implications of my analysis of The Virgin Suicides will point to the larger cultural framework in which it was produced. Reflective of contemporary attitudes and theories about deaths of suicide, the novel serves as illustrative of a culture of the 1990's that insists upon ascribing meaning through narrative following individual suicides even as the processes enacted by the bereaved and other members of society

to achieve that end ultimately and inevitably fail. I find it essential to underscore that this critical reading is undertaken not only to approach scholarly issues of disenfranchisement and meaning-making in the novel as a literary text but also to illustrate the ways in which we may encounter the novel as a theoretically-reflective thanatological document in itself.

Collective Storytelling of Loss in The Virgin Suicides

Suicide as escape is not a newly-understood concept; however, suicide as secondary to unbearable psychic pain was introduced by Edwin Shneidman only in 1993, the same year in which Eugenides' novel was published. In Suicide as Psychache: A Clinical Approach to Self-Destructive Behavior, Shneidman argued that "suicide is not a disease; suicide is not a special physiological state. . . . The internal mental drama relating to the pain of negative emotions (shame, guilt, revenge, hopelessness, etc.) is surrounded by a syllogism that sees only escape as the acceptable solution" (1993, qtd. in Shneidman 2001, 200). He further noted that "a majority of suicide cases tend to fall into one of four clusters of frustrated psychological needs" – "thwarted love, acceptance, or belonging"; "fractured control, excessive helplessness, and frustration"; "assaulted self-image and avoidance of shame, defeat, humiliation, and disgrace"; and "ruptured key relationships and attendant grief and bereftness" (1993, qtd. in Shneidman 2001, 202-3). However, this psychosocial understanding of suicide – accepted today as both groundbreaking and innovative – was not pervasive within American culture in the 1990's. A suicidological reading of The Virgin Suicides, then, is necessarily complicated by the tension between the relatively limited

understanding of suicide at the time of its publication and our expanded understanding of it today.

As we will see in my study of The Virgin Suicides, the attention paid to detailing vividly the deaths, the importance placed on collecting mementos of the deceased, the centrality of characters' memories and perspectives on reasons for the deaths, and, indeed, the entire narrative framework of the novel may all be read as reflective of the ways in which the bereaved may validate "many truths" while engaging in storytelling as grief work and to maintain bonds with the dead. The "trial and error" meaning-seeking identified and developed recently by Robert Neimeyer (1998, 2000) is central to The Virgin Suicides, as the narrators engage in interviews with every person remotely connected to the Lisbon sisters over a period of decades in order to attain answers, each of which proves unsatisfying. Prior to my exploration of the ways in which various representative characters in the novel enact futile and disparate attempts to attain meaning following the deaths of the female protagonists, as well as the implications of disenfranchised grief due to these attempts for the male protagonists, I will provide a summary of the narrative arc of the novel in order to illustrate the ways in which the text itself reflects the significance of storytelling for bereaved persons, as discussed in Chapter 1 primarily in relation to Neimeyer's work on the centrality of narrative in grieving.

The narrative of The Virgin Suicides is posited as temporally contemporaneous to the publication of the novel; a plural male voice recounts through memory the narrative arc which spans thirteen months of their adolescence two decades earlier. Focusing on the lives and deaths of the five Lisbon sisters – Cecelia, Lux, Bonnie,

Mary, and Therese – who are ages thirteen through seventeen, progressively, at the opening of their story, the collaborative male protagonists trace Cecelia’s first suicide attempt; their own and others’ responses to her attempt; her second, completed attempt three weeks later; and the eleven months following her death. The novel culminates with the quadruple suicide attempt by remaining sisters Lux, Bonnie, Mary, and Therese, which is lethal for all but Mary, and Mary’s second and completed attempt one month later.

Throughout the novel, Eugenides’ aging male protagonists demonstrate a united purpose to their audience, as they make repeated reference to the dozens of interviews and hundreds of mementos regarding the Lisbon sisters that they have collected and preserved throughout and following this period of their adolescence. They term each memento – whether a photograph, coroner’s report, or used lipstick – an “exhibit” and identify them numerically, as in a court of law. In the opening of the novel, the narrators note, “We’ve tried to arrange the photographs chronologically, though the passage of so many years has made it difficult. A few are fuzzy but revealing nonetheless. Exhibit #1 shows the Lisbon house shortly before Cecelia’s suicide attempt” (3). The collection of these exhibits may be read as a purposeful attempt to build a case for the girls’ deaths; while the reader can never see or touch the evidence collected by the narrators, he or she is compelled nonetheless to consider that the entire narrative is wrought from a desire on the part of the male protagonists to serve justice to the Lisbon sisters, and thereby make meaning of their deaths.

The bulk of the novel focuses on the eleven months following the death by impalement of Cecelia. She survives her first suicide attempt, after “slitting her wrists

like a Stoic while taking a bath” (1); two weeks following her rescue and hospitalization, “Mr. Lisbon persuade[s] his wife to allow the girls to throw the first and only party of their short lives” (21), and it is during this party that Cecelia throws herself out a second-story window, impaling herself fatally on the metal fence below. As having been guests at the party, the male narrators recount their anticipation for an event at the home of five girls whom they already considered mythically alluring, noting, “Our amazement at being formally invited to a house we had only visited in our bathroom fantasies was so great that we had to compare one another’s invitations before we believed it” (21). The narrators also describe their collective avoidance of Cecelia during the party in the Lisbon basement, about whom they recount, “We knew to stay away from her. The bandages had been removed, but she was wearing a collection of bracelets to hide the scars. . . . Scotch tape held the undersides of the bracelets to Cecelia’s skin, so they wouldn’t slide” (24).

When the party “was just beginning to get fun,” Cecelia asks her mother, who is chaperoning the teenagers, if she can be excused; the narrators remember that “it was the only time [they] heard her speak, and [they] were surprised by the maturity of her voice. More than anything she sounded old and tired” (26). Not ocular but auditory witnesses to her death, the narrators describe Cecelia’s suicide in terms of the sounds they heard as she “succeeded, on the second try, in hurling herself out of the world” (28):

Halfway up the staircase to the second floor her steps made no more noise, but it was only thirty seconds later that we heard the wet sound of her body falling onto the fence that ran alongside the house. First

came the sound of wind . . . this was brief. A human body falls fast. The main thing was just that: the fact of a person taking on completely physical properties, falling at the speed of a rock. . . . The wind sound huffed, once, and then the moist thud jolted us, the sound of a watermelon breaking open, and for that moment everyone remained still and composed, as though listening to an orchestra, heads tilted to allow the ears to work and no belief coming in yet. Then Mrs. Lisbon, as though alone, said, “Oh, my God.” (27)

As the first of four deaths to which they will be within hearing distance yet unable to view the dying bodies until they have taken on only “completely physical properties,” Cecelia’s death of suicide prompts the heightened attention of the then-adolescent boys toward the living Lisbon girls, even as they attempt to distance themselves from the bereaved sisters just enough to begin to study and parse out their responses to Cecelia’s death – and the responses of peers and community members surrounding them. They note that “the girls didn’t miss a single day of classes, nor did Mr. Lisbon,” who taught at the local high school “with his usual enthusiasm” (61). They add, “who knew what they were thinking or feeling” (62) and detail the girls’ abandonment by their peers, which prompts their rise to isolated community cult figures as people simultaneously recede meaningfully from them.

Teachers and classmates largely avoid discussing Cecelia’s suicide with the remaining Lisbon girls and, as I will later illustrate, the educational system and other social institutions provide little outlet for grief work for them, thereby isolating them, as a group of four, in their bereavement. However, the narrators identify teenage

lothario and local heartthrob Trip Fontaine as the only person to approach, and thereby make accessibly engaged, the Lisbon girls. Trip – “no boy was ever so cool and aloof” (73) – pursues Lux Lisbon, convinces her father to allow him to take her to the Homecoming dance on the provision that he secure dates for her three sisters, and effectively, though temporarily, frees them from the isolation they are experiencing at home and school. The narrators, not among those chosen by Trip to escort Mary, Bonnie, and Therese to the dance with him and Lux, “tried to grill the boys in order to participate vicariously in the date, but they wouldn’t leave the girls alone for a minute” (126). They recall that “never before had the Lisbon girls looked so cheerful, mixed so much, or talked so freely” (127) and analyze a recovered photo of the girls with their dates prior to the dance, in which they believe “an air of expectancy glows in the girls’ faces. Gripping one another, pulling each other into the frame, they seem braced for some discovery or change of life. *Of life*. That, at least, is how we see it” (114; emphasis in original). They remember Mary telling her date, “I’m having the best time of my life” (127) and detail their memory of Lux and Trip being elected Homecoming King and Queen.

Here in the narrative, the male protagonists shift in their storytelling, for following their election, Lux and Trip disappear from the dance. The narrators recall viewing Lux arriving at her home, alone, in a taxi, two hours past her curfew later that night; to fill in the temporal gaps of their narrative, they interview Trip, who is in residence at a drug and alcohol rehabilitation center, decades later. The narrators illustrate his reluctance to share the events of the night as he says initially only, “I’ve never gotten over that girl, man. Never” (71). However, from him, they determine that

Lux had gone to the high school football field to have sex with Trip, saying in the middle of coitus, “I always screw things up. I always do,” before beginning to sob (133). Frustrated, Trip put her in a cab and walked home, never to speak to her again. Baffled even years later by his own mercurial attitude toward the girl whom he had wooed and won, “Trip Fontaine told [the narrators] little more” (133).

Following Lux’s transgression, the narrators note, the Lisbon house goes into virtual lockdown. They explain, “Everyone expected a crackdown, but few anticipated it would be so drastic (137). The girls are pulled out of school, a decision for which the narrators question Mrs. Lisbon years after the sisters’ deaths. They report that “Mrs. Lisbon maintained that her decision was never intended to be punitive. ‘At that point being in school was just making things worse. . . . The girls needed time to themselves. A mother knows. I thought if they stayed at home, they’d heal better’” (137). In addition to isolating the girls from peers in the educational system, Mrs. Lisbon forces Lux to destroy her rock music records and, other than all six of them going to church weekly and Mr. Lisbon going to work, they do not leave the house.

At this point in the recollected story, the boys begin to notice, then to watch pointedly, as Lux commences a period of seemingly compulsive, nightly sex on the roof of the Lisbon house with a series of adult men. While the narrators note that they “never knew how Lux met them” because “from what [they] could tell, she didn’t leave the house,” they gathered nightly, huddled at the bedroom window of one of their homes, to watch “the men sweating, risking statutory rape charges, the loss of their careers, divorce, just to be led up the stairway, through a window, to the roof” (141). Recollecting those voyeuristic vigils of adolescence, they add, “even now . . . it

is always that pale wraith we make love to” (142). The narrators further observe that she did not seem to enjoy the sex and “oscillated wildly in her contraceptive vigilance” (144), which is why they were not surprised when “three weeks into Lux’s airborne displays, the EMS truck appeared yet again”; however, when the EMS workers emerged from the house, the narrators recall being unprepared to see “Lux Lisbon, sitting up, very much alive” (145). Officially diagnosed with indigestion though secretly treated for pelvic inflammation and a sexually transmitted infection, Lux returns home from the hospital, shortly after which, the narrators note, all four sisters begin “wasting away” (155).

Isolating their family further, Mr. and Mrs. Lisbon restrict their own movements and those of their daughters, keeping them on their private property, having groceries delivered to the house, ceasing to attend religious services and, for Mr. Lisbon, leaving his job as a teacher. Monitored and unable to move, in daylight, further than their yard, the sisters order travel brochures for “exotic vacations,” that become temporarily intercepted and ordered also by the boys, who obsessively imagine vacationing with them as they seek ways to keep the sisters close to them (164). They note, as adults, “we would have lost them completely if the girls hadn’t contacted us” (182). Months into their virtual house arrest, the sisters begin leaving laminated prayer cards depicting the Virgin Mary in bushes and trees on their street, assumed by the boys to be messages to them; the girls flash the Chinese lantern in their bedroom window in what the boys believe to be undecipherable Morse code; finally, they leave letters in the boys’ mailboxes, which the narrators describe as

“expressing various moods . . . all were brief. . . the longest said: ‘In this dark, there will be light. Will you help us?’” (186-7).

Following these missives, the narrators explain that they “racked their brains for a way of contacting the girls. . . . In the end, the answer was so simple it took a week to come up with,” calling them on the telephone (187). Their protracted separation from the Lisbon sisters, both within their school and in their neighborhood, coupled with their fascination with them as moving objects just out of reach, render the boys unable to speak to the girls; instead, they spend a week playing songs back and forth on the phone, using the music to communicate their feelings for them and to respond to the messages they extract from the sisters’ song choices. Their musical communiqué culminates with the sisters playing the song “Make it with You” by Bread, which leads the boys to believe that “the girls might love us back” (192). At this point, the narrators explain, they began to think of themselves as the potential saviors of the Lisbon sisters:

We thought only of Mary, Bonnie, Lux, and Therese, stranded in life, unable to speak to us until now, in this inexact, shy fashion. . . . Who else did they have to turn to? Not their parents. Nor the neighborhood. Inside their house they were prisoners; outside, lepers. And so they hid from the world, waiting for someone – for us – to save them. (193)

By the time, then, that the boys receive a final note from the sisters, which says only, “Tomorrow. Midnight. Wait for our signal” (195), they have already assumed the role of prospective emancipators. Believing they are going to help the girls escape from

their repressive home and community, the narrators describe, over the course of seven pages of the novel, their anticipation in waiting together the following night for midnight to arrive. One had stolen his mother's car keys; another fantasized about exotic places they may drive the girls. The narrators recall, "None of us remembers thinking anything, or deciding anything, because at that moment our minds had ceased to work, filling us with the only peace we've ever known"; they add, "for the first time ever we felt like men" (199).

When they arrive at the Lisbon home, Lux meets them at the door, smoking. She flirts with them in the dark house, telling them that her sisters are coming shortly but are still packing. The narrators remember that her face "didn't seem alive: it was too white, the cheeks too perfectly carved, the arched eyebrows painted on, the full lips made of wax," until "she came closer and we saw the light in her eyes we have been looking for ever since" (205). Lux suggests they take her mother's car, as it is bigger than the one they are offering, and then unbuckles the belt of one of the boys before leaving to wait in the car. Recreating their auditory-enhanced anticipation, the narrators note, "We waited. We weren't sure where the other girls were. We could hear sounds of packing upstairs, a closet door opening, a suitcase jangling bedsprings. Feet moved above and below. Something was being dragged across the basement floor. . . . We understood that we were only pawns in this strategy, useful for a time, but this didn't lessen our exhilaration" (206-7). Finally, they decide to go down to the basement to see if whichever sister they had heard downstairs is ready to go and in doing so, they "traveled back to the day a year earlier when [they] had descended those same steps to attend the only party the Lisbon girls were ever allowed to throw .

. . the room was just as [they] had left it: Cecelia's party had never been cleaned up" (208).

Confused, the boys discover in the dim light that "hanging down amid the half-deflated balloons were the two brown-and-white husks of Bonnie's saddle shoes. She had tied the rope to the same beam as the decorations" (208). Reflecting on this moment of discovery, the narrators recall, "it took a minute to sink in. . . the doctors we later consulted attributed our response to shock. But the mood felt more like guilt, like coming to attention at the last moment and too late, as though Bonnie were murmuring the secret not only of her death but of her life itself, of all the girls' lives. She was so still" (209-10). They add, "We had never known her. They had brought us here to find that out" (210). Following their discovery of Bonnie's body and horrified flight from the basement, the narrators claim that they, as boys, "already. . . knew the rest – though [they] would never be sure about the sequence of events" and "argue about it still" (210). They describe in chilling detail their conjectured timeline of the four suicide attempts:

Most likely, Bonnie died while we sat in the living room, dreaming of highways. Mary put her head in the oven shortly thereafter, on hearing Bonnie kick the trunk out from under herself. They were ready to assist one another, if need be. . . . Therese, stuffed with sleeping pills washed down with gin, was as good as dead by the time we entered the house. Lux was the last to go, twenty or thirty minutes after we left. Fleeing, screaming without sound, we forgot to stop at the garage . . . they found her in the front seat gray-faced and serene, holding a cigarette lighter

that had burned its coils into her palm. She had escaped in the car just as we expected, but she had unbuckled us, it turned out, only to stall us, so that she and her sisters could die in peace. (210-11)

Mary Lisbon is the only survivor of the quadruple suicide attempt; immediately following his other daughters' deaths, Mr. Lisbon puts their house on the market and hires someone to clear everything – furniture, mementos, and his daughters' belongings – out of the house. Several weeks later, while the boys are at a coming-out party “to forget about the Lisbon girls” (229), Mary, “the last Lisbon daughter, in a sleeping bag, and full of sleeping pills” (Eugenides 232), attempts suicide again and dies. The narrators note that “no one attended the final mass burial of the Lisbon girls other than Mr. and Mrs. Lisbon” (233), following which, the Lisbons leave town in the middle of the night.

Meaning-Making Attempts in The Virgin Suicides

As mentioned earlier in this chapter and discussed more fully in Chapter 1, attempts to make meaning following a loss are undertaken in order to come to terms with one's grief, but we must understand that they are complicated by the individual circumstances of the loss, the culture within which the loss occurs, and the relationships surrounding the loss. We must bear in mind that losses of death are often secondary to other developmental or traumatic losses – in The Virgin Suicides, identifiable losses include those wrought not only by the deaths of the five sisters but also by the ways in which cultural institutions make interventions into and about the Lisbon sisters following both Cecelia's initial suicide attempt and her second,

completed attempt. Complicating further the web of losses within the novel, the narrators offer the reader disparate rationales and responses to suicidality that are undertaken by characters whom I argue serve as representatives of major cultural institutions and reflect various institutional attitudes toward suicide; moreover, these characters simultaneously can be read as individually seeking meaning in the girls' suicidality and deaths while remaining bound to the values and attitudes of their respective cultural institutions. In addition to examining the responses to suicide enacted by the neighborhood community and by the narrators, then, I will focus on the cultural institutions of the family, religion, the educational system, the media, and health care in order to unpack both the individual responses that contribute to the narrators' failure to succeed in meaning-making attempts as well as the ways in which such responses are reflective of attitudinal approaches to suicide contemporaneous to the novel's publication.

The responses of the Lisbon family – primarily, Mr. and Mrs. Lisbon – to their daughters' suicide attempts and deaths illustrate the avoidance, isolation, and hyper-vigilance that were typical in families in which children ideated or executed suicide, not only in the 1970's, when the narrative takes place, but also in the early 1990's, the temporal space from which the narrators attempt to tell their story. Eugenides' narrators trace the parental responses that consistently failed the sisters in hindsight, provoking the reader to question whether some, if not all, of the Lisbon sisters may have survived if it were not for the extreme measures taken by their parents, ironically, for their protection.

Following Cecelia's initial suicide attempt, the narrators note that "Mr. and Mrs. Lisbon shut themselves and the girls in the house, and didn't say a word about what had happened"; when pressed by a neighbor to discuss what had occurred, Mrs. Lisbon makes reference to "'Cecelia's accident,' acting as though she had cut herself in a fall" (12-3). Whereas publically, Mr. and Mrs. Lisbon appeared to be in denial regarding their youngest daughter's suicide attempt, their heightened vigilance following it speaks to their private fear of a repeated attempt. Confined to the parameters of their property in the days and weeks after her wrist-slitting and hospitalization, "one of her sisters always accompanied her"; when allowed outside, Therese "look[ed] up whenever Cecelia strayed to the edge of the yard" (14-5).

At this point, the narrators explain, "the Lisbon house began to change" (19). No longer the lively home of five teenage girls and their doting parents, the house begins to resemble, to the boys and others, a decaying fortress. It is important to note that throughout the novel's narrative, the parental intent of the Lisbon home as a shield and protectorate can be read as warring progressively with its lived reality as a prison. David Balk has argued that "at times of traumatic grief within the family, the environment for recovery is bolstered when family members or the public at large can be reassured as to the restoration of stability and safety. . . . the return to normal routines as soon as feasible can also bring significant comfort" (287). For Mr. and Mrs. Lisbon, both the fear brought on by Cecelia's first suicide attempt and the grief following her death render them incapable of restoring stability and safety for their surviving daughters; while safety is assumedly their goal, the extreme interruption of

routine and stability undercuts their attempts and, I argue, may contribute greatly to the increased suicidality of the four remaining sisters.

Avoidance factors heavily into Mr. and Mrs. Lisbon's responses to Cecelia's initial suicide attempt. Not only do they not discuss it with friends, clergy, or community members but also they cut short the recommended psychiatric interventions following her hospitalization. The narrators note that when they met with Mr. Lisbon years later, "he told us his wife had never agreed with the psychiatrist. 'She just gave in for awhile,' he said" before removing Cecelia from outpatient therapy and keeping her home (20). The party that culminates with her death is the parents' sole attempt at encouraging social integration as a means of returning to "normalcy," although the Lisbons were not prone to hosting parties prior to Cecelia's attempt. The narrators admit that "little is known of Cecelia's state of mind on the last day of her life"; however, "according to Mr. Lisbon, she seemed pleased about her party" (41). At the party, "the rattling of her bracelets comforted her parents because it allowed them to keep track of her movements like an animal with a bell on its collar" (42). Heavily chaperoned in the basement of their home, Cecelia and her sisters briefly experience the false freedom of normative adolescent social interaction; however, as the impetus for the party is Cecelia's suicide attempt, Mr. and Mrs. Lisbon perform further denial as they track her movements while maintaining the conviction that she is "pleased" about her party.

In Ambiguous Loss: Learning to Live with Unresolved Grief, therapist and researcher Pauline Boss writes that "while denial can sometimes be healthy when it helps families to maintain their optimism, it is harmful when it invalidates or renders

people powerless” (84). Denial is particularly necessary, she argues, when experiencing ambiguous losses – losses in which one cannot determine whether or not further loss has occurred or will happen. I argue that as in the more typical ambiguous cases of prisoners of war or airline crashes, uncompleted suicide attempts provoke ambiguous loss for loved ones. The complexity of grieving a death that not only has not yet occurred but also *may or may not happen* can render those surrounding the suicidal person confused, isolated, and certainly in denial. Boss further notes that while “being in shock temporarily protects the physical body after trauma,” denial “provides a temporary respite from the harsh psychological reality of a potential loss”; further, denial, as I maintain it functions for Mr. and Mrs. Lisbon prior to Cecelia’s death, “is also a way to reduce the distress that inevitably results from uncertain absence or presence” (85).

Following Cecelia’s death, the parental hypervigilance and isolation to which Cecelia was subject in the weeks following her first suicide attempt extends and intensifies for her surviving sisters throughout the course of the novel. After her death, the remaining four daughters gradually lose contact with their neighborhood and peer communities; initially, “other than to school or church the Lisbon girls never [go] anywhere” (85); eventually, “Mrs. Lisbon shut[s] the house in maximum-security isolation,” as the narrators watch the girls removed by their parents from school and church arenas. The narrators have little sense of the Lisbon sisters’ feelings while in isolation, as their narrative is born out of their teenage observations of the girls, minimal contact with them, and their decades of interviews with survivors following their deaths; similarly, their understanding of the purpose of Mr. and Mrs. Lisbon’s

actions is limited to the brief interviews conducted after their daughters' deaths. The narrators do note that when Mary dies, several weeks following the triple suicide of Lux, Bonnie, and Therese, "neither Mr. nor Mrs. Lisbon appeared," when she was brought out by paramedics, "so it was up to us to send her off and, for the last time, we came and stood at attention" (232). The narrators' interview with Mrs. Lisbon was their most anticipated – they explain, "We wanted to talk to her most of all because we felt that she, being the girls' mother, understood more than anyone why they had killed themselves"; her response, "That's what's so frightening. I don't. Once they're out of you, they're different, kids are," renders them more lost in their search to understand than before (138). Through their public avoidance or denial of suicidality in their daughters and private acts of hypervigilance and isolation of them, the Mr. and Mrs. Lisbon offered to readers by Eugenides' narrators typify the traditional responses to feelings of impotence, unspeakability, and confusion begat by suicide in a family. As the Lisbon girls' most immediate community and assumed support system, Mr. and Mrs. Lisbon are presumed by the narrators to have insight into their daughters' deaths; that they do not know, any more reliably than anyone else, why their daughters died speaks to the futility of meaning-making attempts following suicide, even as the narrators are compelled to continue their meaning-seeking responses to the girls' deaths, seemingly ceaselessly.

While relatively little mention is made by the narrators as to the role of religious institutions in the Lisbon girls' lives, excepting insofar as they report that the girls are eventually kept home even from church services, the figure of Father Moody, Roman Catholic priest and pastor to the Lisbon family, appears in the days following

Cecelia's death in ways that speak to the continued – and continuing – tensions between religious doctrine involving suicide and theological dogma underscoring love and forgiveness. Father Moody, upon visiting the Lisbon family at home after Cecelia's death, finds Mrs. Lisbon in seclusion, the remaining Libson daughters huddled in a bedroom together, and Mr. Lisbon fixated on a baseball game on television. Perplexed and at a loss for how to broach the subject of Cecelia's recent death, he gives up on talking to the girls when "they didn't take up the subject," and sits briefly, drinking beer, with Mr. Lisbon, whom he later refers to as "that strange man" for not discussing his daughter's death (46-9). No reference is made to follow-up interventions or attempts at communication by Father Moody toward the Lisbons throughout the rest of the novel; when interviewed by the narrators years later, he claimed, "at that time, those girls had no intention of repeating Cecelia's mistake. I know everyone thinks it was a plan, or that we handled it poorly, but they were just as shocked as I was" (48).

Clearly, such dialogue offered by the priest speaks to the incapacity of Father Moody as a religious leader to communicate effectively with the Lisbon family and his offering of a palatable narrative that would absolve himself from guilt after the four "buffeted but not broken" girls remaining died over the course of the following year. Moreover, the brevity of his appearance in the novel raises questions about the long-term response of religious institutions, such as Roman Catholicism, to deaths of suicide. In a religion that purportedly supports ideologies of Christian love and understanding, suicide remained particularly stigmatized for Roman Catholics at the time of the Lisbon sisters' fictional deaths. Historically, the official stance of the

Vatican prohibited Catholic burial of persons who died of suicide, a practice that slowly dissipated following the publication of the new Catechism of the Catholic Church, first released in French in 1992, then more widely circulated after its translations into Latin and English in 1999.⁸ Assumedly for this reason, “Cecelia’s death was listed in church records as an ‘accident,’ as were the other girls’ a year later”; when the narrators question Father Moody about this, they report that he said, “We didn’t want to quibble. How do you know she didn’t slip?” (34). When they press him to explain how the subsequent deaths of Lux, Therese, Bonnie, and Mary could also have been accidents, he replies, “Suicide, as a mortal sin, is a matter of intent. It’s very difficult to know what was in those girls’ hearts. What they were really trying to do” (34).

⁸ While I argue that the text of the Catechism of the Catholic Church (CCC) does not fully destigmatize suicide or persons who suffer from suicidality, it should be understood that burial practices have changed largely due to the final of the precepts on suicide published in 1992:

2280 Everyone is responsible for his life before God who has given it to him.

It is God who remains the sovereign Master of life.

We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls.

We are stewards, not owners, of the life God has entrusted to us.

It is not ours to dispose of.

2281 Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life.

It is gravely contrary to the just love of self.

It likewise offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations.

Suicide is contrary to love for the living God.

2282 If suicide is committed with the intention of setting an example, especially to the young, it also takes on the gravity of scandal.

Voluntary co-operation in suicide is contrary to the moral law.

Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide.

2283 We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives. (CCC)

As a figure both representative of religious ideology and potentially struggling with his own failings as a theological leader to a family in his parish community, Father Moody illustrates for the reader a further way in which suicide is silenced, and therefore resistant to understanding, in the novel. Officially labeled “accidents” by religious authority, the deaths of the Lisbon sisters baffle theological comprehension beyond that of “mortal sin.” In this way, religion, like family, offers no institutional or ideological insight to the narrators as they continue their quest for meaning in the girls’ deaths.

Similar to Father Moody, representatives of the educational system fail to communicate with the Lisbon sisters in regard to Cecelia’s death, though, like him, are quick to report in interviews with the narrators that the subsequent deaths were not predictable. Although the girls are virtually isolated at school, excepting Lux’s brief romance with Trip Fontaine, the narrators report no visible interventions from teachers or administrators barring one failed school-wide attempt to address Cecelia’s death. In an interview with Miss Arndt, the art teacher, she noted that “Mary’s watercolors did possess what, for lack of a better word, I will call a ‘mournfulness.’”; however, she quickly added, “Could I foresee that she would commit suicide? I regret to say, no” (98).

Months after Cecelia’s death, Mrs. Woodhouse, the headmaster’s wife, decides that the high school needs a “Day of Grieving”; explaining it to the narrators years later, she remembers that “they kept writing about the suicide in the paper, but do you know we hadn’t mentioned it once in school all that year?” (99). The narrators recall the Day of Grieving as a failure in which “the tragedy was diffused and

universalized,” with each teacher spending three hours with his or her homeroom students passing out handouts on suicide, reading poems, speaking of “the Christian message of death and rebirth,” or, in the case of the chemistry teacher, who was at “a loss for words,” letting his students “cook peanut brittle over a Bunsen burner” (100-1). The Lisbon girls do not participate or speak in their respective homerooms, “with the result being that all the healing was done by those of us without wounds” (101).

While such responses to suicide in the secondary education setting may seem surprising, even disturbingly comical in their ineptitude given that suicide rates among teenagers tripled from 1960 to 1990, lack of response to deaths of suicide in high schools remained the norm rather than the exception through the 1990’s (Hollinger 22). While many states began to develop official guidelines for responding to adolescent loss to suicide in the early 1990’s, throughout the decade, school administrators often chose to avoid discussion of the topic; I conjecture that such avoidance was secondary to fears of romanticizing the idea of suicide or reflective of administrative beliefs in unproven theories of adolescent suicide contagion. It bears noting that many secondary education staff continue to grapple with their abilities to provide meaningful and helpful responses to their student and faculty bodies following a death of suicide and therefore avoid the topic altogether; as for the Lisbon sisters, who bore the “wounds” that were untended by their school community, such disparate or avoidant responses cannot contribute to the well-being of the bereaved. Little is known of individual teachers’ or administrators’ responses to Cecelia’s death in the novel except through the narrators’ description of the Day of Grieving, but the lack of a unified message or any attention to the life of Cecelia Lisbon speaks to another

institutional failure to assist the narrators' – and sisters' – meaning-making attempts after her death.

Whereas the educational setting in which the Lisbon girls are situated provides little education regarding suicide, the media, under the guise of a pedagogical response to Cecelia's death, provides the public with progressively desperate rationales for adolescent suicide in the community. The narrators, noting that their local newspaper did not cover Cecelia's death initially as it was deemed by the editor to be a "personal tragedy" and therefore not newsworthy, share their belief that indirectly, "it was the growing shabbiness of the house that attracted the first reporters" (Eugenides 89-90). They speculate that the neighbors, confused and disgruntled by the Lisbon home's increasing disrepair, began writing letters to the editor referencing teen suicide, attracting the attention of Linda Perl, a reporter from the largest city newspaper in Detroit.

Throughout much of the novel, Linda Perl is an intermittent though seemingly regular presence in the town; referenced frequently though usually briefly in the narrative, she is held responsible by the narrators for the media "free-for-all" that ensues locally, first a month following the death of Cecelia, then again eleven months later when the remaining Lisbon sisters attempt suicide (92). Drawing both regional and national media attention, Ms. Perl's initial and subsequent articles lead to the disruptive arrival of television crews in the neighborhood, reporters' excavation of old photos of Cecelia, media speculation on her death, and their circulation of warning signs for suicide. While the narrators observe that their parents and other members of the community seemed to accept Ms. Perl's initial assessment of Cecelia's death, their

framing of her article illustrates their skepticism regarding her understanding of suicide or, indeed, of Cecelia. They note that, “The piece solves the mystery of her death by giving way to conclusions such as these: ‘Psychologists agree that adolescence is much more fraught with pressures and complexities than in years past. Often, in today’s world, the extended childhood American life has bestowed on its young turns out to be a wasteland, where the adolescent feels cut off from both childhood and adulthood’” (92).

Later, following the quadruple suicide attempt by Lux, Mary, Bonnie, and Therese, the media, having “treated the girls as automatons, creatures . . . barely alive” in their coverage of Cecelia’s death, imply “that their deaths came as little change,” a tactic that angers the narrators, who resist even Ms. Perl’s framing of the event as “a suicide pact” (170). Ms. Perl, who seemingly stumbles upon the date of the girls’ multiple suicide – June 16 – as the anniversary of Cecelia’s wrist-slitting, prompts a second and larger media storm in the suburb, “speaking of ‘ominous foreshadowing’ and ‘eerie coincidence’” (217). Capitalizing on the deaths of Lux, Therese, and Bonnie, she writes articles “once every two or three days for two weeks” (217). The narrators remember their frustration with her coverage at the time, observing, “What she could never explain, however, was why the girls chose the date of Cecelia’s suicide *attempt* rather than her actual death some three weeks later on July 9” (218; emphasis in original). However, for other print and visual news media personnel, her theory of a copycat suicide pact is sufficiently shocking and tragic to rationalize encamping themselves in the roads and on the lawns of the Lisbon neighborhood, even

though “each day the reporters attempted to interview Mr. and Mrs. Lisbon, and each day they failed” (219).

The incapability of the media to do justice to the lives and deaths of the Lisbon sisters in light of their extensive coverage of them is both acknowledged and grieved by the narrators. Following Ms. Perl’s lead, “gradually, the reporters began referring to the Lisbon girls by first names, and neglected to interview medical experts in favor of collecting reminiscences”; maintaining speculative and sensationalist engagement in the sisters as “creatures” to be examined and dissected, they “they became custodians of the girls’ lives” – “like us,” note the narrators (219). Unlike the narrators, however, who believe themselves to “have been forced to wander endlessly down the paths of hypothesis and memory” and who do so out of self-identified love and obligation to the Lisbon sisters, the media does not “complete the job” of custodians to their satisfaction; had the reporters done so, the narrators speculate, they may never have been obligated to do so themselves (219). The media as portrayed in the novel, then, as is often the case following adolescent suicide, is shown as engaging in acts that may be interpreted less as meaning-seeking and more as what I term “meaning-coercing,” as their implied goal is not to inform the public so much as it is to lead it through a self-created arc of causality and, in doing so, package the suicide in a palatable narrative for public consumption.

Representatives of the health care community, unlike those of the media, are introduced by the narrators as generally well-intentioned in terms of both their various attempts to intervene with the Lisbon sisters and their subsequent interpretations of the girls’ suicidality. The variance of conclusions drawn by physicians treating the sisters,

however, speak not only to a realistic historical medical misunderstanding of suicide causation but also and more importantly to the impossibility of locating, after death, a single social event, psychological state, or biological determinant that can adequately explain why the suicide has occurred. In this way, the documented opinions of physicians, though considerably more learned than those of Ms. Perl, are shown to be increasingly desperate and misguided as the novel progresses. Through recreation of memory, the obtaining of medical reports, and, as usual, described interpersonal interviews, the narrators include throughout their narrative the development of medical theories by those treating the Lisbon sisters – from sociological explanations of youth development and offerings of psychosexual analysis to psychosocial interpretations and finally, the hypothesis of biological deficiency. Mimicking the tension between the theories still in circulation within the medical community in the 1970's, when the narrative takes place, and the postmodern conceptions of suicide that were beginning to be circulated in the early 1990's, the novel compels the reader to question whether any medical explanation of the Lisbon sisters' suicides sufficiently convinces not only the narrators but also himself or herself as to its validity.

While the majority of medical opinions within the novel are developed and shared by Dr. Hornicker, the staff psychiatrist at the local hospital, the first medical encounter illustrated is between Cecelia and emergency room physician Dr. Armonson immediately following her first suicide attempt. Describing their exchange, the narrators relay:

In the emergency room Cecelia watched the attempt to save her life with an eerie detachment. Her yellow eyes didn't blink, nor did she

flinch when they stuck a needle in her arm. Dr. Armonson stitched up her wrist wounds. Within five minutes of the transfusion he declared her out of danger. Chucking her under her chin, he said, “What are you doing here, honey? You’re not even old enough to know how bad life gets.” And it was then Cecelia gave orally what was to be her only form of suicide note, and a useless one at that, because she was going to live: “Obviously, Doctor,” she said, “you’ve never been a thirteen-year-old girl.” (5)

While Dr. Armonson does not offer the narrators directly his opinion regarding Cecelia’s condition at the time, his actions and words as directed toward her reflect his attempt to undermine the seriousness of a life-threatening suicide attempt in light of the age of his patient. His dialogue with Cecelia implies a belief in suicidality as contingent upon adult life experiences and social disappointments – that only one who has lived longer can know “how bad life gets.” His demeanor and words, at odds with the reality of an adolescent suicide rate that was, in fact, rising in the 1970’s, suggest a willful redirection of Cecelia’s suicidal intent into an extreme act of developmental error.

Initially, Dr. Hornicker mirrors this circuitous approach to Cecelia’s suicide attempt; whereas Dr. Armonson implies it was a mistake, he frames her wrist-slitting as an attempt to obtain attention and social assistance. In Dr. Hornicker’s report, which “takes up most of the hospital records” of Cecelia’s emergency room visit as recovered by the narrators, he wrote, “Despite the severity of her wounds . . . I do not think the patient truly meant to end her life. Her act was a cry for help” (19). While

commonly understood today to be unhelpful rhetoric that, at its least, minimizes the seriousness of a suicide attempt and disenfranchises the suicidal person who is suffering, the “cry for help” historically has been frequently employed in an attempt to distinguish “real” suicide attempts – often deemed as those employing means of higher lethality, such as gunshot or bridge jumping – from “less real” attempts – often, I argue not coincidentally, determined as those utilizing means that are typically less lethal yet are more often undertaken by women, such as wrist-slitting or overdose. Whereas completed suicides involving less lethal means are, indeed, no less lethal for those who complete them, I maintain that the cultural perception of suicide attempts involving lower lethality means is that such acts do not warrant as serious attention as those in which the risk of death is higher. Ironically, because of this very variance in means lethality, another implication of attitudes such as those exhibited by Drs. Armonson and Hornicker is that suicidal persons who warrant the most attention and intensive intervention are those who more than likely are already dead.

Upon consultation with Cecelia, who “clammed up” when he questioned her, Dr. Hornicker diagnoses her suicide attempt as “an act of aggression inspired by the repression of adolescent libidinal urges”; his recommendation to Mr. and Mrs. Lisbon in light of this psychosexual diagnosis is that she should be given “a social outlet, outside the codification of school, where she can interact with males her own age” (19). Telling them that “the aping of shared customs is an indispensable step in the process of individuation,” he notes that “Cecelia should be allowed to wear the sort of makeup popular among girls her age, in order to bond with them” (19). Presumably eager to follow the psychiatrist’s advice, Mr. and Mrs. Lisbon do arrange a party for

Cecelia in their home, during which she jumps from an upstairs window to her death and following which, the narrators note, “Dr. Hornicker called Mr. and Mrs. Lisbon in for a second consultation, but they didn’t go” (58).

Following Cecelia’s death, however, Dr. Hornicker is given the opportunity to evaluate another Lisbon sister, Lux, when she is admitted through the emergency department for tests related to abdominal pain. Although diagnosed officially with indigestion by a sympathetic attending physician who treats her for Human Papilloma Virus and cervical abrasions, Lux nonetheless is subject to psychiatric evaluation with Dr. Hornicker prior to her release. Writing about his visit with Lux following decades of professional fixation with the Lisbon sisters, Dr. Hornicker frames her “promiscuity” as a common response to emotional need; “‘adolescents tend to seek love where they can find it,’ he wrote in one of the many articles he hoped to publish. ‘Lux confused the sexual act with love. For her, sex became a substitute for the comfort she needed as a result of her sister’s suicide’” (84). Although unable or unwilling to share with the narrators anything Lux discussed in his consultation with her, he claims, “She was in deep denial . . . She was obviously not sleeping – a textbook symptom of depression – and was pretending that her problem, and by association her sister Cecelia’s problem, was of no real consequence” (151-2).

The conflation of suicidality with depression is neither uncommon nor commonly corrected in the medical community; Shneidman underscored this error best when he wrote, “The gambit used to make a field appear scientific is to redefine what is being discussed. The most flagrant current example is to convert the study of suicide, almost by sleight of hand, into a study of depression – two very different

things” (2001, 200). Yet several months later, Dr. Hornicker is no longer content with his assessment of Lux – and, by extension, though only retroactively, all her remaining sisters – as having been depressed; instead, he attaches his explanations for their “erratic behavior,” including reported incidences of “withdrawal” and “sudden fits of emotion,” to the as-yet barely-known diagnosis of Post-Traumatic Stress Disorder (PTSD), from which he believes they suffer “as a result of Cecelia’s suicide” (152). Following the quadruple suicide attempt by Lux, Mary, Therese, and Bonnie, Dr. Hornicker emphasizes that as PTSD sufferers and survivors of Cecelia’s death, the Lisbon sisters were acting out suicidal behaviors in order to come to terms with their grief, a theory that “convinced many people because it simplified things. . . . [Cecelia’s] suicide, from this perspective, was seen as a kind of disease infecting those close at hand. . . . Transmission became explanation” (152).

Interestingly, although “the final suicides seemed to confirm Dr. Hornicker’s theory that the girls had been suffering from Post-Traumatic Stress Disorder,” the psychiatrist later “distanced himself from that conclusion,” suggesting some unsubstantiated chemical link, perhaps serotonin deficiency (215). After consulting with a third Lisbon sister, and the only one still living, Mary, toward the novel’s close and following her own uncompleted suicide attempt, Dr. Hornicker notes a “slight serotonin deficit” in her blood work; eager to locate a biological determinant for the suicides of the four girls who preceded her, he conjectures that all may have suffered from genetically-inherited serotonin deficiency. He recalled to the narrators that, upon Mary’s release from the hospital, “Her future wasn’t bright, of course. I recommended ongoing therapy to deal with the trauma. But we had her serotonin up, and she looked

good,” even though when Mary returns home, “she slept late, spoke little, and took six showers a day” prior to her death by asphyxiation three weeks later (227-8).

Interestingly and perhaps tellingly, the only mental health intervention in the novel that appears to have benefitted the Lisbon sisters following the death of Cecelia is both sociologically grounded and mysterious to the narrators. Following the “Day of Grieving” haphazardly arranged by the high school administrators, a counselor, Miss Kilsem, is hired to be on staff once a week. The Lisbon girls are observed frequently visiting Miss Kilsem individually and together. Asserting only that “the therapy seemed to help” as “almost immediately, their moods brightened,” the narrators know nothing regarding the nature of the girls’ visits with her. (106). While they express that “she is one of the few people who may have been able to tell us something,” all her patient records “were lost in an office fire five years later” in “the characteristic irony of fate” (103). Perhaps more ironic, in terms of my examination here of the role of health care professionals in meaning-seeking attempts in the novel, is that the only observed positive intervention in the text is made, not by a psychiatrist, priest, or parent, but by a social worker whose “degree in social work turned out to be fake” (102).

Disenfranchisement and Chronic Grief in *The Virgin Suicides*

In considering the ways in which meaning-seeking acts lead to disenfranchisement and chronic grief for the narrators, it is necessary to trace the ways in which not only their historical excavation of the events through interviews and document collection but also their lived experiences and observations as adolescents

contribute to their collective incapacity to settle upon a satisfying narrative of the Lisbon girls' deaths. While studying their meticulous documentation of Cecelia's suicide and its aftermath in relation to her surviving sisters is essential if we are to recognize the temporally-protracted nature of their active grief, turning to their actual memories of the events surrounding the deaths is also of great import in thinking through their disenfranchisement as mourners. Largely, the narrators' memories and experiences are collaboratively limned, implying both an ongoing reliance on one another that begins in an adolescent quest for understanding, as well as a sublimated sense of individual identity or grief as adults.

The narrators note that after Cecelia's death, "Most of our parents attended the funeral, leaving us home to protect us from the contamination of tragedy" (34). While they do not indicate whether or not they had expressed interest to their parents in attending the funeral, this pithy statement speaks volumes in terms of the ways in which their parents seek to withhold experiential information from their sons. Certainly, parents often have opted to refrain from bringing their children to funeral rituals, historically and today, although contemporary scholarly opinion aligns largely with Boss when she asserts that "most people need the concrete experience of seeing the body of a loved one who has died because it makes loss real" (26). Of particular note here, however, is that the parents are represented as approaching Cecelia's death of suicide as a contagion – one that they believe could all too easily infect their sons. Ironically, though perhaps unsurprisingly, their act of exclusion does not protect the boys but instead contributes to their obsessive process of meaning seeking following her death.

During the first period of social withdrawal by the Lisbon family following Cecelia's funeral, the boys watch as their fathers labor to remove the fence on which Cecelia had impaled herself. While no one consults the Lisbons before removing their fence, seemingly viewing it as an obvious act of mercy – and perhaps a preventative measure should their children be infected with the “contamination” after all – the narrators recall that “it was the greatest show of common effort we could remember in our neighborhood, all those lawyers, doctors, and mortgage bankers locked arm in arm in the trench, with our mothers bringing out orange Kool-Aid, and for a moment our century was noble again” (50-1). This parental decision, like the choice to exclude their sons from participating in funeral rituals, is suggested to be formed not out of concern or sympathy for the Lisbon family but due to fear and self-interest. Just as fear drives the parents to leave their children home when attending Cecelia's funeral – with no reported consideration of the possible benefits of them attending, either to their sons or to the Lisbon family – so too does fear *of suicide* prompt the tearing out from the Lisbon property the fence that had been transformed from a prim symbol of suburban security into a means of adolescent death. While the narrators do not openly castigate their parents for having enacted this action, their glib references to their mothers shuttling “orange Kool-Aid” as if it is a war ration sustaining their white-collar professional fathers as they labor “in the trench” prompt speculation that they view the noble 19th century, once lost and “for a moment” regained, is temporarily possible not due to the quality of the common purpose but in the ability of *any* purpose to prompt a “show of common effort.”

While their parents remain tight-lipped regarding the suicide and seek to distance their sons from the events and even exact location of the tragedy, neighbors within the community openly share individually-created narratives that try to explain Cecelia's death; the narrators recall that as early as her first suicide attempt, "everyone had a theory as to why she had tried to kill herself" (15). They remember that many neighbors believed the thirteen-year-old jumped out of her window because of her unrequited love for a classmate, Dominic Palazzo; other hypotheses are quoted by the narrators from specific neighbors who are otherwise unmentioned in the novel; their act of naming these neighbors implies how unsettling, and therefore memorable, their words to them were decades earlier. "Mrs. Buell said the parents were to blame. 'That girl didn't want to die,' she told us. 'She just wanted out of that house.' Mrs. Scheer added, 'She wanted out of that decorating scheme'" (15). While Mrs. Buell's comment is not unusual, given the unfortunate tendency of many individuals to place blame on parents of children who die of suicide, it is Mrs. Scheer's caustic response that remains, to the reader and presumably the narrators, disturbingly memorable.

Over the course of the year between Cecelia's first suicide attempt and the quadruple attempt by her sisters, and secondary to early media speculation on Cecelia's death, the narrators recall the town Chamber of Commerce beginning an official "Campaign for Wellness," driven by implied fears of suicide contagion (95). The campaign initially distributes flyers on adolescent warning signs then quickly wanes; the flagging attention paid to what is at first treated as an urgent undertaking is mirrored in the community-wide impatience with ambiguity and protracted grieving that the boys attribute to their parents and neighbors. After the night on which Lux,

Bonnie, and Therese die of suicide, with only Mary surviving her attempt, the narrators recall that their parents “reacted to the final suicides with mild shock, as though they’d been expecting them or something worse, as though they’d seen it all before” (225). This is an extraordinary response to the concurrent deaths of three adolescent girls in a small community; it is made more extraordinary given that their sons were auditory if not visual witnesses to their deaths and, in fact, physically found Bonnie’s body hanging in the basement. We can speculate that such parental response, if we are to suspend any skepticism in its believability, may be secondary either to continued social pressures to protect their sons and thereby minimize their responses to the girls’ deaths, or to ignorance as to their sons’ emotional and literal proximity to the sisters at the time of their deaths. However, it is important to maintain that the narrators remember their parents as dismissive and underwhelmed by the deaths of Lux, Bonnie, and Therese, and their dissatisfaction with their parents’ responses is furthered by parental and community responses in the month following the deaths.

Although “technically, Mary survived for more than a month,” the narrators note, “everyone felt otherwise. After that night, people spoke of the Lisbon girls in the past tense, and if they mentioned Mary at all it was with the veiled wish that she would hurry up and get it over with” (214). In writing on the complexity of emotional responses to ambiguous losses, Boss asserts, “People hunger for certainty. Even sure knowledge of death is more welcome than a continuation of doubt” (6). Possibly in an effort to come to terms with the unsatisfying, silencing, and often casually damaging responses offered by their parents and neighbors to the deaths of the sisters they had personally idolized, the narrators reflect that to their adult counterparts in the

community, “the Lisbon girls became a symbol of what was wrong with the country, the pain it inflicted on even its most innocent citizens” (226). Intriguingly, the way in which their community finally chooses to commemorate the Lisbon sisters is shown by the narrators to have been less an act of memorialization and more a means of burying them figuratively. They note, “in order to make things better a parents’ group donated a bench in the girls’ memory to our school” (226). Such gestures are not uncommon following adolescent death and may provide some utility in the grieving and remembrance processes of mourners; however, after relaying the inscription of the plaque affixed to the bench – “IN MEMORY OF THE LISBON GIRLS, DAUGHTERS OF THIS COMMUNITY” – the narrators add, “Mary was still alive at this point, of course, but the plaque did not acknowledge that fact” (226-7).

I believe that meaning seeking for the narrators as boys becomes a collective experience because it is an isolating experience. The memories they relate throughout the novel regarding their observations of and interactions with their parents and community members suggest growing dissatisfaction with the ways in which these previously-trusted adults responded to the Lisbon sisters; they are similarly isolated from other cultural arenas as indicated by their frustration in the responses offered by institutional representatives whose meaning-seeking or meaning-coercion efforts failed to provide them with a meaningful narrative of the girls’ deaths. We may read the collective narrative, then, as born from a shared experience that unites them in grief even as said grief is disenfranchised socially and as they self-stigmatize psychically.

In examining the narrators' grief vis à vis the thanatological work on disenfranchisement emergent in the period of the novel's production and since then, it is important to treat disenfranchised grief as a psychosocial phenomenon; that is, while many of the forces that prevent grief from being recognized, validated, or supported are due to social constructions and attitudes existent outside the mourner, his or her internal response to these forces complicates the grieving process. Kenneth Doka, as discussed in Chapter 1, has provided us in recent decades with the most extensive treatment of disenfranchised grief; he has noted that "deaths that provoke anxiety or embarrassment – especially those that incur media notoriety or involve other family members – are likely to be disenfranchised" (14). While the narrators do not grieve members of their families in the novel, they grieve the loss of *a* family to which they repeatedly indicate, from their narrative's opening, an unquestioned and absolute attachment. Their treatment of the Lisbon parents as jailers and the media as vultures implies profound affect in terms of their internalized relationship to the Lisbon sisters and concern for them; moreover, the documentation of the living sisters' moods and movements may be read not only as typically-enacted male heteronormative surveillance of female love objects but also protective attempts born out of anxiety for their well-being and safety. Their adolescent *and* adult anxieties over the states of the Lisbon sisters, first as living, then as dead, speak to a self-disenfranchisement that complicates the social isolation discussed above.

The coupling of social disenfranchisement with self-disenfranchisement following suicide is an immeasurably weighty burden for any mourner to bear; not only does such a marriage indicate societal excommunication of an individual in his or

her role as a griever but also it implies an internalized conviction that he or she was responsible, in some sense, for sustaining the life of another person – and that he or she failed to do so. Doka writes, “Survivors may self-disenfranchise by ‘internalizing’ the stigma experienced by the death, or they may experience a sense of isolation, embarrassment, or feelings of low self-esteem and inadequacy” (327). Whereas the narrators are at once both isolated and bound to one another in common grief, their despair over neither being able to save the girls from suicide nor finding meaning in their deaths is delivered palpably in the entirety of the novel. In their research on self-disenfranchisement and self-stigma following suicide, Neimeyer and John A. Jordan have found that:

Suicide survivors often self-stigmatize, expecting that others are going to blame them for the suicide or at least for failing to prevent it. This expectation leads some survivors to withdraw defensively from social support to avoid the shame-producing encounters they anticipate with others. In most instances, disenfranchisement seems to emerge from the interaction of self and others, rather than from deficits in either party taken alone. (Doka 100)

There is no evidence in the narrative of the novel that suggests that neighbors in the community, their parents, their teachers, or the Lisbon girls themselves expected the boys to prevent their deaths from occurring; there is no implication of explicit external pressures on the boys to assume the roles of protectorates of the sisters. Nowhere do the narrators cite any of their interviewed subjects as suggesting they warrant any blame. Still, the resultant outcome of feeling blame and shame that Neimeyer and

Jordan identify follows the boys' survival of the Lisbon sisters. While Doka and others have supported Neimeyer and Jordan's closing assertion above that disenfranchisement is largely prompted by interactions of self and others, what happens when, as is the case in The Virgin Suicides, the disenfranchising others, in addition to being persons who overlook one's grief, are also made up of persons who constitute one's collective self?

In considering the role of self-disenfranchisement and social disenfranchisement in the grief experienced by the narrators, we must embrace the complexity of the narrators as both a grouping of individual, if unnamed, persons *and* as the singular voice with which Eugenidies presents them. In doing so, we are urged to consider that the disenfranchisement often attributed to societal sources may always already be personally originated. In this novel, self-disenfranchisement for the narrators is inextricable from their social disenfranchisement, as their binding grief has pluralized their individual identities, leading to a social microcosm in which blame, shame, and guilt are perpetuated endlessly through memorialization and narrative. In their individual lives as boys – due to their ages at the time of the Lisbon deaths, the circumstances of those deaths, and their unrecognized relationship to the sisters as love objects – they assuredly, as seen, experience social disenfranchisement of their grief, but it is their collective self-disenfranchisement that profoundly binds them to one another even as it makes impossible a resumption of their individual lives outside the confines of their bonds to the dead and to one another.

After finding Cecelia's diary following her death and meeting to analyze everything from the "cheerful" pictures in its "illuminated pages" to handwriting

characterized by “dots on the i’s” that they question as to being indicative of “emotional instability,” the boys “had to fight back the urge to hug one another or tell each other how pretty we were,” explaining that they “felt the imprisonment of being a girl” (39-40). Their adolescent male group bonding over tokens of their love objects begins with their empathic interaction with the diary but is extended and transmuted in adulthood into a binding collective imperative as they gather, catalogue, and cultivate artifacts for a grief and guilt-driven shrine to the deceased. Maintaining a “a permanent collection” of photographs, interview transcripts, and other documents pertaining to the Lisbon sisters in their childhood tree house, the narrators express to the reader their fear of its unsustainability, noting, “We haven’t kept our tomb sufficiently airtight, and our sacred objects are perishing” (223, 241).

Underscoring their anxiety over the futurity of the literal objects that hold their collective identity intact and perpetuate their chronic grief is their frustration in not being able to locate a satisfying narrative that can explain the girls’ deaths and from which they can derive meaning. They recognize that in these objects, they “had pieces of the puzzle, but no matter how [they] put them together, gaps remained, oddly shaped emptinesses mapped by what surrounded them” (241). Such a line can stand as a powerful commentary on suicide – its resistance to narrative, particularly its “oddly shaped emptinesses” forging gaps between what one believes one knows about the dead and what one wishes most of all to know: why the death occurred. The narrators relay that “drained by this investigation,” they “long for some shred of evidence, some Rosetta stone that would explain the girls at last” (164). Meeting “almost daily” to review the “exhibits” they have progressively amassed on the sisters, they add, “we

always ended these sessions with the feeling that we were retracing a path that led nowhere, and we grew more and more sullen and frustrated” (233).

Thomas Attig has argued that “dysfunctional dependence on the deceased and incomplete or arrested development of the capacity to function autonomously can compromise effective coping. By extension, it can be devastating to lose the sense of purpose in life that derives from meeting the needs of those who depend on us” (81). The chronic grief experienced by the narrators is certainly complicated further by their collective – and self-stigmatizing – sense of failure in understanding the deaths of the Lisbon sisters. Their perceived failure in doing justice to their love objects after amassing piles of evidentiary mementos and conducting volumes of inquisitive interviews speaks to the futility and fatalistic nature of their efforts. More broadly, they provide a means of reading individual suicide events in American culture in the 1990’s through a literary prism of complex disenfranchised grief and failed attempts at meaning making.

In approaching ambiguous losses, Boss provides a commentary that I believe is greatly fitting to understanding the chasm between historical responses to suicide and contemporary understandings of its frustrations. She writes:

If we ask the fundamental question, “Why did this happen?” we must be prepared to look beyond the neat equations of cause and effect and learn to live with uncertainty. We cannot know for sure why bad things happen to good people, but we do know that *not* everything that happens is a result of our actions. Learning to let go of cause-and-effect

thinking is difficult because most of us have been trained to view the world as a rational place.” (126; emphasis in original)

In The Virgin Suicides, Eugenides offers his reader a multilayered narrative of grief that is itself framed as a collective and ultimately failed attempt to make meaning out of that which cannot be understood. Grieving their understanding that whether or not the Lisbon sisters could have been “saved,” they did not save them; that regardless of the impetuses for the girls’ suicides, they cannot know them; and that beyond the narratives and responses offered by everyone around them, the sisters remained, in life and after death, unknowable, they conclude from their bereavement, “We are certain only of the insufficiency of explanations” (241). Whereas for some characters, the lasting impact of the five suicides is small, whether due to their criminalization of the victims’ parents; their employment of religious myths; or their mapping of mental pathology onto the dead, for the male survivors for whom the Lisbon girls were both peers and romanticized icons, disenfranchisement secondary to their futile attempts at meaning seeking and meaning making renders their grief lifelong – and guilt-ridden.

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Chapter 3

Angels in America and Cultural Intersections of Power, Privilege, and Suicidality in the AIDS Crisis

Introduction

In this chapter, I examine the intersection of psychosocial forces specifically in terms of power and privilege in the Acquired Immune Deficiency Syndrome (AIDS) epidemic in the early 1990's and as illuminated in the drama Angels in America: A Gay Fantasia on National Themes by Tony Kushner (1991, 1992, pub. 1995). In doing so, I posit thanatological effects of the cultural subordination experienced by gay and bisexual male individuals, not only in terms of their risk for death but also and primarily in relation to their subcultural oppressed status in relation to sexual identity. In examining Angels in America in its contemporaneous political and literary moment, I expose the ways in which psychosocial forces of power and privilege complicate not only the potentiality of suicidal ideation or death preoccupation of characters directly or secondarily impacted by AIDS but also their keenly-felt responses from dominant culture.⁹ Through my focused interrogation on stigma and oppression as relating to the disenfranchised group of persons most affected by the AIDS crisis in the 1990's, I argue that the palpable presence of the syndrome may have altered expected outcomes for suicidality in affected environments that, combined with continued forms of

⁹ In-depth treatment of other stigmatized populations, notably persons of color, is beyond the scope of this project, both in relation to AIDS specifically and potential suicidality generally, but it will be taken up in my future work relating to the intersecting axes of privilege first developed by sociologist Kathryn Pauly Morgan, which was published originally in her chapter "Describing the Emperor's New Clothes: Three Myths of Educational (In)Equality" in The Gender Question in Education: Theory, Pedagogy & Politics edited by Ann Diller, et al. (1996).

cultural oppression, may in turn have fostered community building, hope, and a promise of the transcendent, as is reflected in this seminal text.

The population I am discussing represents an important gap in the trifurcated cultural response to suicide that I theorize throughout this project. Unlike persons who die collective suicide deaths that are treated as cultural spectacles, as I examined in Chapter 1; individuals who die of psychache and whose deaths culminate in disorientation and a crisis of meaning making, as seen in Chapter 2; or *other* terminally or seriously ill persons who die of assisted suicide, as we will examine in Chapter 4,¹⁰ for gay and bisexual men living under biological threat, even a decade after the Human Immunodeficiency Virus's (HIV) introduction to American culture, suicidality is unseen. Simply put, because institutions of dominant culture – including the media, the family system, the health care industry, and the government – reinforced their historical marginalization and stigmatization of non-heterosexual men throughout the 1990's, few people in positions of power cared whether these men were suicidal, regardless of their individual statuses in relation to AIDS. There was limited medical and cultural response to AIDS in the 1980's, and even less attention

¹⁰ While physician-assisted suicide will be treated extensively in Chapter 4 and does not bear directly upon the ways in which I am treating suicidality here, some data regarding physician acquiescence to assisted suicide requests for AIDS patients in the early to mid-1990's suggests another way in which cultural expectations regarding suicide were insufficient in understanding the psychosocial particularities of AIDS response. In the article, "Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease" (1997), Lee R. Slome presents a longitudinal study that shows a disconcerting disparity in granted assistance requests for AIDS patients versus other patients. Slome notes, "Previous surveys of physician-assisted suicide have reported that 7 to 9 percent of physicians have complied with requests from terminally ill patients for assistance in suicide. We found that about one half the physicians we surveyed in 1995 reported assisting at least once in the suicide of a patient with AIDS by prescribing a lethal dose of medication. This is a surprisingly large proportion, given the possible legal and ethical repercussions of such an action" (Slome et al). I do not attempt to draw conclusions from this data; rather, I point to it as another site of complication regarding dominant cultural attitudes toward members of stigmatized populations.

paid to suicidal persons with AIDS in the 1990's. Through my study, I illustrate how we may read Angels in America as first queering, within its cultural moment, expectations of suicidal behavior for these individuals, then as bearing witness to the particular and isolating cultural responses afforded to them in the epicenter of death, and finally, as calling for change through community-building, activism, and the embrace of hope in the midst of fear.

Due to the relative lack of research on the relationship between AIDS status and suicide until very recently, as opposed to work done in previous and following chapters, I will not engage deeply in statistical analyses pertaining to my argument, insofar as the Centers for Disease Control and Prevention (CDC) and other academic studies from the 1990's decade do not provide compelling or stable sites of methodological inquiry. Psychologists Judith M. Stillion and Eugene E. McDowell note in Suicide Across the Life Span, published in 1996, "The particular nature of the relationship between AIDS and suicide is not completely understood and, frankly, fraught with controversy. Many investigators have presented evidence to support the contention that the presence of AIDS or an HIV positive diagnosis may serve as a triggering event for suicide"; they add that others "are less sanguine about the AIDS-suicide connection and have questioned the evidence suggesting such a relationship" (136). After reviewing studies on AIDS and suicide available at the time, Stillion and McDowell suggest that while "one possibility is that the presence of HIV/AIDS increases suicidal ideation in victims but not completed suicide"; knowing that this claim is not fully supportable, the authors call for "additional research" on "these complex relationships" (139). I wish to stress that such research undertaken in the

early to mid-1990's has limited value, excepting insofar as it illustrates the historical dearth of knowledge, in both clinical and academic settings, in respect to AIDS status and suicidality. These studies are useful primarily in exposing the lack of rigorous inquiry as another incidence of the cultural oppression that implicated the perceived worthlessness of the hundreds of thousands of lives lost to AIDS in the 1990's, the vast majority of which had been lived by gay and bisexual men.

To rectify the absence of scholarly attention to these issues in literary studies, I will examine three specific character-driven pressure points in Kushner's drama that call into question even our postmodern conceptions of grief and suicide by exposing the unique nature of the gay or bisexual man's relationship to death in the 1990's via AIDS as its primary interlocutor. First, I will engage in readings of scenes involving Louis Ironson, the HIV-negative partner of Prior Walter, who is suffering from AIDS; here, I will unpack specific ways in which thanatological theories discussed in Chapters 1 and 2 regarding anticipatory grief, ambiguous loss, and social disenfranchisement are problematized in the play and are reflective of its contemporaneous cultural moment. Next, I will analyze a scene in which the politically-engaged power broker, closeted homosexual, and homophobe Roy Cohn learns that he has AIDS. These scenes together call into question the little-discussed relationship between preexistent assumptions of power and privilege, the particularities of attributed subcultural epidemic, and postmodern conceptions of suicidality. Finally, I will interrogate the developmental arc of Prior Walter in Angels in America as complicating thanatological conceptions of "mattering" by tracing his responses to this illness, from those secondary to suffering and isolation to those of

hope and the embrace of the transcendent. In doing so, I argue that as reflected in this text, the cultural meaning-making acts typically enacted through dominant culture failed to acknowledge the population I am examining in the 1990's; meaning making at this time is largely unlocatable excepting from within the communities most affected. Instead, I posit that "group mattering" supplants American cultural responses to the deaths of gay and bisexual men and in doing so, offers perhaps the only meaning in the face of chaos and uncertainty: the importance of community and the mobilizing hope for change.

Angels in America and its Cultural Moment

By the time Millennium Approaches, Part I of Kushner's drama, was first performed in workshop in 1990, nearly a decade had passed since the first clinical observances of AIDS in the United States had been made in 1981. The previously-unseen combination of biological conditions, baffling epidemiological origins, and disputed means of contagion related to AIDS led to panic and disorientation within gay urban communities that was only hyperactivated by delayed, contradictory, and diffuse medical and governmental responses that bore more resemblance to ancient Greek and early modern attitudes toward tuberculosis outbreaks than to pathologies encountered in modern medicine. Referred to first only in relation to the Kaposi's sarcoma lesions most visibly associated with the disease; then later in the limited media coverage as Gay-Related Immune Deficiency (GRID); and by the CDC as the "4H Disease" as it was deemed at the time to affect only homosexuals, Haitians, hemophiliacs, and heroin users, the CDC did not begin using the term "AIDS" until September 1982. And the Band Played On: Politics, People, and the AIDS Epidemic

(1987) stands as arguably the most meticulous portrayal of the emergence, spread, and early responses to AIDS in America; its author, investigative journalist Randy Shilts, focused his study largely on failures to contain the spread of the epidemic, emphasizing governmental indifference to an initially-perceived “gay disease”; political infighting of gay activist groups, primarily in New York City and San Francisco; and the limitations of the medical community to collaborate in relation to AIDS research. Also of importance was his focus on the homophobia and general phobia of AIDS perpetuated in the media. In the introduction to this seminal text, Shilts wrote, “People died and nobody paid attention because the mass media did not like covering stories about homosexuals and was especially skittish about stories that involved gay sexuality. Newspapers and television largely avoided discussion of the disease until the death toll was too high to ignore and the casualties were no longer the outcasts” (xxii-xxiii). Public perception of AIDS in 1990, when Millennium Approaches began workshops, and in 1991, when Part II of Kushner’s play, Perestroika, was undergoing staged readings, was still guided largely by filtered, faulty, and homophobic media accounts of the syndrome.

Millennium Approaches debuted on Broadway in April 1993, with Perestroika joining it in repertory in November. Met with critical acclaim, responses to the full play, at seven hours in duration, marked a watershed moment in dramatic portrayals of AIDS in American culture that arguably furthered public reception of now-canonical artistic projects on HIV/AIDS that immediately followed for wider audiences. In September 1993, Shilts’ nonfiction work was used as the basis of a HBO television film, And the Band Played On; directed by Roger Spottiswoode, the film received

mixed critical reviews but was nominated for a historic nine Emmy awards – the most ever received to date by a single television film – and won the Emmy for Outstanding Television Movie (Academy of Television Arts & Sciences). In December 1993, TriStar Pictures released Philadelphia, the first large-budget film to discuss openly issues of homophobia and discrimination in relation to AIDS, winning Tom Hanks an Academy Award for Best Actor in a Leading Role for his portrayal of Andrew Beckett, an attorney dying of AIDS while suing his former employers for wrongful termination (Dabney). In 1993 and 1994, Millennium Approaches and Perestroika were awarded, consecutively, both the Tony Awards for Best Play (American Theatre Wing). Also in 1993, Kushner was awarded the Pulitzer Prize for Drama for Millennium Approaches (The Pulitzer Prizes). Thus, in the span of a single calendar year, three creative projects that took up the issue of AIDS, specifically in relation to gay male characters affected by HIV, received unprecedented accolades from the fields of television, film, and theatre, in addition to the one of the most highly-regarded prizes for arts and letters.¹¹ In 1987, Shilts wrote, “The story of politics, people, and the AIDS epidemic is, ultimately, a tale of courage as well as cowardice, compassion as well as bigotry, inspiration as well as venality, and redemption as well as despair. It is a tale that bears telling, so that it will never happen again, to any people, anywhere” (xxiii). As with many tales meant to be cautionary and

¹¹ Considering the impact of Angels in America in terms of theatrical scope, I should additionally underscore its influence on Jonathan Larson’s rock opera, Rent, which began workshops in 1994 prior to its 1996 Broadway debut. Also garnering a Pulitzer Prize for Drama (The Pulitzer Prizes), Larson’s masterwork may be read as the theatrical realization of Kushner’s implicative gestures due to its affirmation of subcultural community bonds, enactment of collective action as a response to institutionalized stigmatization, and focus on “living with / not dying from disease” (Larson 98).

preventative, Shilts' subject bore repeating, and the creative apotheosis of his account can be located in Angels in America.

Reflecting the inherited legacy of the early years of AIDS-related confusion and frustration that were delineated by Shilts, Angels in America, set nearly exclusively in New York City from October 1985 through February 1986, temporally picks up where Shilts' journalistic account concludes. Similarly scathing toward the administration of President Ronald Reagan and lack of comprehensive media coverage on AIDS, Kushner's drama also illustrates a historical shift in its references to increased (though still insufficient) medical understandings of HIV, including means of transmission; commonalities in the progression of the disease course; and the utility of the antiretroviral drug azidothymidine (AZT), which was then being tested in clinical trials and would become the first breakthrough in AIDS pharmacological therapy. The play also takes up aspects of Judeo-Christian archetypes, myths, and mysticism; as a "gay fantasia on national themes," fantastical voyages to Antarctica, Heaven, and San Francisco intersperse other scenes as drug-induced hallucinations, dream sequences, or quasi-Biblical corporeal assumption. While rigorous interrogation of the use of religious thematics is outside the focus of this chapter, it is useful to consider their incorporation as elements of purposeful theatricality that, I argue, render many non-fantastical scenes, several of which I will be examining, all the more compelling for their spare approach to dialogue regarding disease, suffering, death, and life.

As Ranen Omer-Sherman capaciously summarizes in his article, “The Fate of the Other in Tony Kushner’s Angels in America,” unlike other literary or dramatic texts concerned with AIDS,

The epic scope of Angels can seem especially bewildering to those who encounter it for the first time and struggle to follow the sprawling narrative that ultimately encompasses such disparate matters as the historical migration of the Mormons, the McCarthy hearings . . . the politics of the Reagan era, the supernatural presence of ghosts and angels, and even the nature of Heaven itself. But most viewers rapidly discover how well the work coheres: in tautly-written scenes the audience follows closely a web of characters, men and women, gay and heterosexual, whose ambivalent relations to those that depend on them are revealed in troubling flights from, and journeys toward, the true meaning of responsibility and community. (7-8)

Within the web of human characters, only some will be discussed in this chapter. Roy is based on the historical, notorious McCarthyite attorney Roy Cohn, who also died of AIDS-related complications following a career marked by public acts of homophobia; Joe Pitt, his protégé, is a clerk at the U.S. Court of Appeals and a deeply closeted homosexual at the drama’s opening. Joe and Harper Pitt, his wife, who suffers from agoraphobia, Valium dependency, and increasing suspicion regarding her husband’s sexual identity, will not be treated explicitly in this analysis. Louis, a clerical staff member in the Court of Appeals, is in a five-year relationship with Prior but abandons him as his AIDS symptoms worsen and initiates a new relationship with Joe, leaving

Prior angry and isolated. Belize, who is an ex-lover and close friend to Prior, also serves as Roy's nurse in the drama, and Hannah Pitt, Joe's conservative Mormon mother, becomes an unlikely confidante to Prior as well, though neither Belize nor Hannah will be comprehensively examined here either. Prior is a classical white, Anglo-Saxon Protestant of long lineage (two of the "prior" Prior Walters visit him in the fantastical scenes) who is, above all, silenced and suffering in the midst of his worsening illness and Louis' abandonment. However, as I posit in my reading of his narrative arc, the other-worldly, if unwilling, interactions Prior engages with the Angel and other heavenly beings allow for his embrace of hope in the midst of the AIDS crisis in America and actualize him to communicate that hope to the community in most desperate need of it.

By the close of the 1990's, the number of people diagnosed with HIV/AIDS in the United States was between 750,000 and 920,000, over 75 percent of whom were men, and the vast majority of men infected became ill through sexual acts with male partners.¹² Ten years later, in 2009, in the eighth edition to their canonical textbook The Last Dance: Encountering Death and Dying, thanatologists Lynne Ann DeSpelder and Albert Lee Strickland noted, "For many people, AIDS is synonymous with death: a dread disease, contagious and epidemic, a modern plague"; within our culture, they add, the syndrome "conveys multiple meanings about human vanity and pride, divine punishment, attack by an enemy from within, the terror of life in death and the despair of death in life, and the romantic exit of brilliant and beautiful doomed youth" (483).

¹² As I have noted, statistical analyses of AIDS at this time vary due to CDC tracking issues and scholarly methodological problems through the 1990's; however, this range is offered as a broad estimate, utilizing the lowest number offered by a governmental source (CDC) and a representative number from credible academic sources (Lorber and Moore 111).

As sobering as it is to consider the continued stigmatizing societal responses to AIDS outlined in the present tense by DeSpelder and Strickland, in turning to the canonical drama Angels in America, we may situate historically and better understand the unique interplay of power, privilege, and contagion in relation to AIDS in the 1990's and in doing so, implicate the ringing culture of silence surrounding AIDS-related suicidality.

Queering Grieving Expectations

Though Louis Ironson presents as a relatively unsympathetic character throughout Angels in America, it is through this figure that we may best examine the particular and unique interplay of grieving tropes first theoretically examined in previous chapters. Specifically, in the scene I unpack, Louis personifies the problematic state of simultaneously experiencing anticipatory grief, ambiguous loss, and disenfranchised loss. In doing so, he resists culturally-normative expectations for grieving while enacting grief responses that would be unsanctioned within the power structure of his dominant culture but, I argue, offer the reader a greater understanding of the complexity of disenfranchisement in grief and its risk for increased suicidality.

In the early scenes of the drama, it is late October; Louis learns that Prior has contracted AIDS in Act One, Scene 4 of Millennium Approaches and is unable to offer him comfort or support, initially denying Prior's Kaposi's sarcoma lesion as "just a burst blood vessel," then repeating "no" when Prior continues talking wryly about the lesion (27). Though they have lived together for over five years, in following scenes that span mere weeks, Louis becomes increasingly verbally uncomfortable in

their home and in Prior's presence. When Prior shares painful physical symptoms – that his leg hurts – and those that are often accompanied by embarrassment – such as “shitting blood” – Louis claims solidarity and indicates that he is “handling it” but immediately bursts into tears, asserts to Prior, “You are not going to die,” then asks, “What if I walked out on this? Would you hate me forever?” to which Prior responds, simply, “Yes” (45-6). At the close of the scene, Louis entreats Prior, who is bedridden, “Please get better. Please. Please don't get any sicker” (48).

It is easy for an audience to read Louis as a self-involved partner, one who denies Prior consistently throughout the text the dialogic affirmation and constancy of which he is deserving. Louis' interactions with Prior, including but not limited to those described above, imply several subtexts: that to Louis, Prior is perhaps loved but increasingly burdensome; that the physical deterioration of his attractive partner is revolting; and that Prior's health, clearly understood to be beyond his control, is still something that should be able to be preserved for *Louis*' sake. However, in these same instances, a thanatological reading must draw attention to the fear driving each of these dialogic responses in relation to loss. Certainly, Louis actively fears AIDS, as do most of the characters in the drama. He fears the potential loss of his partner to disease, deterioration, and death. Additionally, I suggest that he fears the inevitability of his own failures as a caretaker, a role for which he is wholly unprepared and which AIDS has made immediately needed. While discussions of postmodern understandings of anticipatory grief, ambiguous loss, and disenfranchised loss are useful in examining Louis' responses to Prior, as we will see, they are not enough in themselves to understand the ways in which Louis enacts grief in relation to stigma.

By the third week in December, Prior's condition has severely worsened. He is experiencing hallucinations and constant leg pain. Louis discovers Prior wracked with fever at home, where he has collapsed, defecated himself, and bled rectally. Bringing him to the hospital, he talks with a nurse, Emily, who has sedated Prior into unconsciousness. Attempting to make conversation, she says, "He seems like a nice guy. Cute," to which Louis responds, "Not like this," then adds, "Yes, he is. Was. Whatever" (57). Later in their conversation, he asks Emily if Prior will "sleep through the night"; she responds, "at least," and Louis indicates that he is leaving for "a walk [in] the park" (58). As he leaves, he instructs her, "Tell him, if he wakes up and you're still on, tell him goodbye, tell him I had to go" (58). We may read this exchange as another in which Louis' self-involvement and incapacity for care dominate; however, I posit that again, fear in the midst of complicated loss renders Prior neither present nor absent. "Was" he "cute" or "a nice guy"? "Is" he still present in order to be so? By this point, Louis is unable to determine even if his long-term partner *is* anymore, and I suggest that this indeterminacy drives Louis from his partner's bedside and to the anonymous sexual exchange that follows in the next scene.

Act Two, Scene 4 is a split scene; on one side of the stage, Joe and Roy are conversing about politics in an upscale bar, whereas on the other, Louis is encountering a "Man" in the Ramble (a well-known cruising area) of Central Park.¹³ In the first half of their spare dialogic interaction, it is important to acknowledge the vast disparity in the two characters' point of view. Whereas the Man – unnamed and

¹³ To preserve continuity of dialogue, interspersed lines between Roy and Joe are omitted in my quotations as they do not bear upon our focus in this scene.

undeveloped as a character – is wholly self-directed in his intent to have sex with Louis for the sake of sex, I argue that Louis, who has just left the bedside of his seriously ill partner, seeks sex with the Man not for enjoyment but as a physical manifestation of the pain of his grief. In this way, the lines exchanged between them simultaneously follow acceptable sexual scripts for men engaging in anonymous same-sex acts in the 1990's *and* subvert dominant cultural ideas regarding grief and pain. The Man opens the exchange by asking, “What do you want?” (60):

Louis: I want you to fuck me, hurt me, make me bleed.

Man: I want to.

Louis: Yeah?

Man: I want to hurt you.

Louis: Fuck me.

Man: Yeah?

Louis: Hard.

Man: Yeah? You been a bad boy?

Louis: Very bad. Very bad.

Man: You need to be punished, boy?

Louis: Yes. I do. (60-1)

Without thanatological context, these lines read as a not-atypical usage of sadomasochistic verbal cues between consenting adult partners who are about to engage in sex. The Man validates Louis' first assertion, subsequently escalates the exchange, and builds on Louis' responses in order to shift into verbal role playing of Man / "boy," all while seeking continued assurance of Louis' consent to their sexual trajectory. Within subculturally-validated means, the Man is adhering to the developed boundaries for anonymous, rough sexual interaction with another man. However, I suggest that Louis, through engaging this interchange, utilizes the sexual conventions accessible to him in order to grieve. Note that his first line – "I want you to fuck me, hurt me, make me bleed" – is the longest and most detailed in this exchange. Following it, his responses serve merely to give assurance to the Man that he is physically desirous of continued contact. His opening line and those that follow illustrate further that the Man is of little interest to Louis, either as a person or as a temporary sex partner. Louis may be a conduit to brief sexual diversion to the Man – a means to an end – and so too is the Man to Louis, but I argue that the endpoint he is seeking is neither orgasmic nor pleasurable. I further suggest that given Louis' incapacity to comfort or sympathize with Prior from the period of his diagnosis to this moment, this sex act is, in fact, an act of grieving through identification with Prior. Louis asks for the Man to "hurt" him and to "make [him] bleed" – just as Prior has been in pain and bleeding rectally. When the Man moves into role-playing comments, asking if Louis has been "a bad boy" and "need[s] to be punished," Louis is quick to affirm both questions, not because of the sexual implications of the encounter in which

he is engaged at the moment but due to the painful implications regarding his continued failures within the central relationship in his life.

In their collaborative text, Men Don't Cry... Women Do: Transcending Gender Stereotypes of Grief (2000), Terry Martin and Kenneth Doka note that in the research existent through the 1990's on grief involving losses due to AIDS, the studies "are problematic in that losses tend to be multiple, stigmatized and developmentally unexpected"; additionally, "surviving partners may themselves be HIV-infected. These studies did find high degrees of stress, including depression, anxiety, and guilt. They also did find increased use of sedatives as well as alcohol and recreational drugs" (104). While Martin and Doka validate the complexity of AIDS-related grieving, the review of research they conduct points to many expected adverse events for traumatic loss, including depression, anxiety, and guilt. Similarly, self-sedation through alcohol or drugs use is commonly associated with complicated grief. However, the attempted grieving act that I identify in Louis' exchange with the Man in Central Park is not treated in scholarly research on AIDS throughout the 1990's. Allowing for an interpretation of Louis' verbal exchange as one of self-punitive identification with Prior opens us to the possibility that normative grieving responses do not adequately address the particularities of same-sex partner grief regarding AIDS in the 1990's. Unable to grieve openly at his place of employment, where he is closeted, or within the gay community, where he fails its expectations for caretaking for his lover, Louis flees the hospital because he is unable to bear witness to Prior's pain. Here, he seeks instead to receive pain, literally and psychosocially re-

internalizing it through anal intercourse that he wants “to hurt” in order to allow the emotional ventilation often necessary to grieving processes.

Following the dialogue discussed above, Louis and the Man determine that neither can bring the other home with him; Louis references not living alone, and learns, in a brief comedic moment, that the Man lives with his parents. After they decide to have sex in the park, Louis asks the Man, “Do you have a rubber?” (62). When he responds, “I don’t use rubbers,” Louis hands him one, saying, “You should” (62). After the Man refuses again, Louis says, “Forget it, then” and begins to leave; immediately, the Man changes his mind and calls him back, where they begin having sex while using a condom (63). Shortly after, following several moments without dialogue, the Man tells Louis, “I think it broke. The rubber. You want me to keep going? Pull out?” and Louis responds, “Keep going. Infect me. I don’t care. I don’t care”; stage directions indicate that at this point, “the Man pulls out,” then says, “I . . . um, look, I’m sorry, but I think I want to go” (63).

What is first important to call attention to in this second half of Louis’ exchange with the Man is his initial insistence on prophylactic usage. Breaking from the assumed roles of their initial verbal foreplay, he asserts that the Man “should” use condoms generally and in walking away from him, Louis indicates a willingness to conform to the safety measures understood by 1985 to be important to his health as a gay man. Demonstrating the changing understanding of condom use at the time in which this drama is set, Louis nonetheless directs the Man to continue penetrating him after the Man has indicated that the condom may have broken. I am not claiming that in doing so, Louis demonstrates direct or indirect suicidal behavior; to argue as such

would be to reinforce the assumptions of dominant culture which this chapter seeks to expose. Rather, I suggest that Louis' directive implicates a state of ambivalence toward his life that is directly correlative to his simultaneous experience of anticipatory grief, ambiguous loss, and disenfranchisement – a complex experience that I assert furthers suicidal *possibility* if not actualization.

Anticipatory grief is a little-used term by contemporary postmodern thanatologists; developed as an extension of the work of Erich Lindemann, which I discussed in Chapter 1, it refers to grief processes in which one engages prior to the occurrence of an actual loss or death. The term itself is problematic, for as we can see through our examination of Louis, the grief felt or undertaken during the suffering or dying process of a loved one is not merely in relation to the eventual death of that individual; instead, losses throughout the spectrum of illness, both real and perceived, demand grieving. A consideration of anticipatory grief in relation to Louis is useful, as troubled as the term has become, insofar as it focuses attention to the particularity of his relationship with Prior as representative of an anticipatorily bereaved state of being in relation to AIDS that I suggest was prevalent to the gay and bisexual male experience in this decade. Due to the prevalence of HIV, the rapidity of its communication, and poor treatment outcomes, the first decade of AIDS was marked by staggeringly high death counts, not merely across the nation but within small, close-knit communities of men. In The Normal Heart, Larry Kramer's 1985 play on the early years of AIDS, one character, Tommy, gazing across a dwindling crowd of

male friends at a memorial service, notes, “We meet mostly at funerals now” (88).¹⁴ The inability to anticipate which friend, lover, or coworker would next be afflicted with HIV; which of those suffering would live longest; or whether oneself would contract the virus arguably forced every person even slightly personally affected by AIDS into a space of anticipatory grief. For individuals like Louis whose very communities were dying out around them, anticipation of death became, for decades, a permanent state of being.

Troubling this interpretation of anticipatory grief as I use it in this analysis is its interplay with ambiguity. To extend the work of Pauline Boss discussed in Chapter 2, I argue that the symptomatology and early institutional treatment of AIDS led to a necessary confrontation with ambiguous loss that complicated further subcultural attitudes toward life and death. Unlike commonly-accepted forms of ambiguous loss, in which the person for whom one is grieving either is physically present but psychically absent (as in Alzheimer’s disease) or is physically absent but psychically present (as in prisoners of war), AIDS at this time necessitated a grappling with both ambiguous presence and absence that complicated anticipatory grieving acts, as seen

¹⁴ While this scene of Kramer’s drama is memorable for its threnodic treatment of the staggering death count wrought by AIDS, writing of The Normal Heart was spurred by the author’s self-described anger at the lack of action within New York City gay communities and the lack of intervention offered by the city’s government. On March 14, 1983, New York Native published on its front page his now-famous article, “1,112 and Counting,” which eviscerated anyone not working actively to stop the spread of the syndrome. Already a polarizing figure, Kramer’s voice in its time is useful in recalling the anger born from both epidemic and stigma. In part, he writes, “If this article doesn't scare the shit out of you, we’re in real trouble. If this article doesn't rouse you to anger, fury, rage, and action, gay men may have no future on this earth. Our continued existence depends on just how angry you can get. . . I am sick of guys who think that all being gay means is sex in the first place. I am sick of guys who can only think with their cocks. . . I am angry and frustrated almost beyond the bound my skin and bones and body and brain can encompass. My sleep is tormented by nightmares and visions of lost friends, and my days are flooded by the tears of funerals and memorial services and seeing my sick friends. How many of us must die before all of us living fight back? I know that unless I fight with every ounce of my energy I will hate myself. I hope, I pray, I implore you to feel the same” (Kramer, “1,112 and Counting”).

in Louis' interactions with Prior throughout the scenes described. When first learning of Prior's diagnosis, Louis is unable to *be* in his presence, yet throughout the play, he expresses guilt and shame in being absent from him; he insists to Prior that he is "handling" the illness (though Prior knows otherwise), yet he asks Prior if he will "hate" him if he leaves him. When Emily comments on Prior being "a nice guy" and "cute," Louis is so imbued with ambiguity that he is unable to determine linguistically whether to speak of him in the past or present tense. The uncertainty he clearly experiences regarding Prior's state of health, their future, and potentially his own AIDS status furthers the already-complex forces of anticipatory grief at work in this drama.

No discussion of grief in any analyses of this play should fail to treat social disenfranchisement; as Louis personifies in the scene in Central Park, spaces of complicated grief as delineated above are all the more constrained when they must be hidden. Writing specifically on the dual disenfranchisement in AIDS-related grief, Doka notes that survivors, "may experience disenfranchisement because their relationships are negated by others," but additionally, "all survivors will experience the stigma of AIDS that inhibits disclosure and social support" (329). In attempting to come to terms with the unique interplay of anticipatory grief, accompanying guilt, and pervasive ambiguous loss for persons affected most by AIDS at this time, it is important to address the cultural perceptions of AIDS as resultant of self-destructive behavior. Here, I incorporate merely one example from Doka that suggests that public coverage of AIDS in the 1990's directly furthered disenfranchisement. He writes, "This perception is evident in the common stigmatizing, judgmental, and

discriminatory ways that some refer to ‘innocent victims’ of AIDS (e.g. those who contracted the disease at birth or by tainted blood products). The unfortunate connotation of such language is that others deserved their fate” (329).¹⁵

For a character such as Louis, seemingly perceived by the audience and by himself as no more or less deserving of such fate as his suffering lover, the direct, consistent, and institutionalized forms of disenfranchisement he experiences as a gay man in a heterosexist society *already* make vulnerable his social support for validated grieving. That he is the lover of a man suffering from a virus marked publicly with connotations of self-deservedness, as well as the tentatively healthy half of a couple being torn apart by biological, social, and psychological forces, leave him incapable of grieving either publically or within his community. He is left to initiate an anonymous sex act, which I reinforce is an attempted grieving act, and when it proves expectedly futile in attaining validation of his grief, he demands of his temporary partner that he infect him with HIV. Louis should not be read as a suicidal character; this dialogue resists easy assumptions regarding a “death wish” or survivor guilt. However, the crisis of grief Louis experiences as resultant of his disenfranchised positions in American culture and in his gay subculture may be read as secondary to the very interplay of psychosocial forces that increase suicidality. Regardless of the absence or presence of suicidality in Louis as a character, as a representative figure for examining power, privilege, and suicidality in American culture, he broadens our understanding of the ways in which gay men living in the midst of AIDS may have struggled with

¹⁵ For another approach to understanding grief disenfranchisement based on sexual identity in the contemporary moment, see Bryan McNutt and Oksana Yakushko’s article “Disenfranchised Grief Among Lesbian and Gay Bereaved Individuals.”

their own relationships to their lives and deaths and enacted grieving acts that were unexpected or unnoticed within dominant cultural contexts.

Maintaining Membership: Power and Privilege

In treating the social disenfranchisement of gay and bisexual men living amidst the AIDS crisis through my examination of this literary work, it is imperative that we recall that for many men who had sex with men in the 1990's, access to the privileges of dominant American culture was maintainable only if they performed denial of membership in a subcultural group. That is, for many men, regardless of their varying-held institutionalized privileges based on gender, age, race, class, or appearance, their sexual desire for and expression with other men limited their options for attaining power, *either* to membership in the privileged institutional structures of dominant culture *or* in belonging to communities formed on the basis of oppression of sexual identity by dominant culture. To choose the latter, as characters in Angels in America such as Prior and Belize do, may reinforce the bonds of community that are most validating during a time of fear and epidemic but comes at a cost, in terms of access to the power structures that threaten daily these communities. In choosing the former, Roy Cohn reinforces his role within political power structures, his influence in legal and governmental institutions, and his privileged status as “a heterosexual man” (52), but he unknowingly, though uncaringly, also affirms the strictures of the dominant power structures themselves. Further, in rejecting homosexual identity and subcultural group membership during the AIDS epidemic while suffering from the disease, men such as Roy may have avoided social death but biologically risked dying

isolated and unknown by sacrificing the community bonds that may have assisted them in their dying processes.¹⁶

The scene of Roy's diagnosis, which I am discussing in relation to its portentous implications of the risks and rewards of sexual identity denial in the 1990's, complicates previously-held cultural assumptions regarding group privilege and power. Roy is an insipid character throughout Kushner's play; though razor-sharp and entertainingly conniving, his uncontained bigotry, arguably the projections of a middle-aged, closeted, homophobic gay man, is wholly unsympathetic. Unlike Joe Pitt, his protégé, who is similarly closeted and fearful of admitting to sexual desires that confuse him due to religiously-ingrained stigmas, Roy is self-knowing and chooses to manipulate his sexual identity denial for personal gain.

In Act One, Scene 9 of Millennium Approaches, it is November 1985; there is no action within the scene as it focuses exclusively on the dialogic interchange between Roy and his longtime physician, Henry, who is attempting to tell him that he has AIDS and to explain, seemingly without judgment, the signs, symptoms, and pathology of the syndrome to the best of medical knowledge available at the time. Following Henry's initial review of what physicians know at the moment regarding AIDS, Roy responds, "This is very interesting, Mr. Wizard, but why the fuck are you telling me this?" (49). Simply, Henry explains that he is biopsying one of three lesions

¹⁶ See Orlando Patterson's 1982 work, Slavery and Social Death: A Comparative Study, for useful background on social death in disenfranchised populations. For focused extension on cultural conceptions of social death that are complicated by Roy's placement in Angels in America, the work of Leo Bersani has been particularly useful. In his polarizing essay, "Is the Rectum a Grave?" (1987), Bersani notes that while, "tragically, AIDS has literalized" the potential for the rectum to serve as a site of burial, which has "reinforced the heterosexual association of anal sex with self-annihilation," if it is in the rectum that "the masculine ideal . . . of proud subjectivity is buried, then it should be celebrated for its very potential for death" (222).

suspicious as Kaposi's sarcoma and points out multiple additional physical indicators common to the syndrome. Roy interjects, noting that AIDS affects mostly "homosexuals and drug addicts" (49); to clarify, Henry adds, "hemophiliacs are also at risk," then Roy performatively insists, "I'm not a drug addict" (49). Henry responds to Roy's willful obtuseness by saying, "this is absurd," as he is familiar with Roy's STD history (50).

Angrily, Roy proceeds to threaten preemptively his physician, with whom readers may gauge he has had an amicable and trusting medical relationship to this point. "Say it," Roy demands; "I mean it. Say, 'Roy Cohn, you are a homosexual.' And I will proceed, systematically, to destroy your reputation and your practice and your career in New York State, Henry. Which you know I can do" (50). Not responding in kind tonally, and avoiding the term "homosexual," Henry points to "everything from syphilis to" rectal venereal warts for which he has treated Roy in the past, adding, "You have had sex with men, many many times, Roy, and one of them, or any number of them, has made you very sick. You have AIDS" (50-1). It is interesting to consider in this exchange how Kushner offers his audience a partial reversal of the roles we expect physicians and patients to fill in a homophobic society, one in which the institutionally-subject physician explicitly or implicitly betrays prejudice toward a gay male patient who presents with active HIV. If enacted perhaps for but one reason – to illustrate to the reader the depth of Roy's sexual identity denial – this scene serves also to show through counterpoint the differing ways in which physicians can problematically treat AIDS diagnoses. While being prevented by Roy from fully explaining his diagnosis, Henry neither reproduces the stigmatizing

language to which Doka refers earlier in this chapter nor does he label Roy a homosexual, whether out of respect for his patient's wishes or fear of his patient's power. It is Roy, the homosexual man in the exchange, and not Henry, who implicates and embraces the stigma attached with this sexual identity. I term this exchange only a partial role reversal, however; in referencing the men with whom Roy has had sex "many, many times," Henry does assign causality for the illness, though not deservedness, in indicating that "one of *them*" has "*made* [Roy] very sick" (51; my emphases).

Following the pithy conclusion of Henry's diagnostic assessment, Roy is incensed. He tells Henry that he is "hung up on labels" but that these labels "don't tell you" "who someone sleeps with" (51):

Like all labels they tell you one thing and one thing only: where does an individual so identified fit in the food chain, in the pecking order? Not ideology, or sexual taste, but something much simpler: clout. Not who I fuck or who fucks me, but who will pick up the phone when I call, who owes me favors. . . Now to someone who does not understand this, homosexual is what I am because I have sex with men. But really this is wrong. Homosexuals are men who in fifteen years of trying cannot get a pissant antidiscrimination bill through City Council. Homosexuals are men who know nobody and nobody knows. Who have zero clout. Does this sound like me, Henry? (51)

Through this passage, I would like to examine several important ways in which the figure of Roy reinforces and problematizes the strictures of dominant power structures on the homosexual subculture of the 1990's. Primarily, Roy's comments explicitly affirm historic American cultural conceptions of homosexual communities as politically motivated but ultimately unimportant. Referencing homosexuals' "fifteen years of trying" to attain passage of an anti-discrimination bill in New York City, what is important to Roy, as a power player, is not the perseverance of gay rights activists but that they are, in his view and in those of the government and political party organizations at the time, incapable of getting it done. He states it baldly: homosexuals "have zero clout." There is no room for them in the power structures in which Roy enjoys privileges. However, Roy also complicates these power structures rhetorically by demonstrating to Henry that he, Roy Cohn, cannot be a homosexual because, as Henry readily agrees immediately following this passage, he *has* clout, even though he has "sex with men." Thus, as Roy instructs Henry on the uselessness of "labels," he reinforces to the audience a problematic cultural insistence on them, implying that perhaps it is identity, and not behavior, that is of threat to dominant power structures. Perhaps it is due to self-identified labels of "homosexual" or "gay" that access to power becomes lost in the 1980's and 1990's to other men, regardless of the biological sex of their sexual partners.

Following the passage above, Roy concludes his diatribe to Henry by adding, "Roy Cohn is not a homosexual. Roy Cohn is a heterosexual man, Henry, who fucks around with guys" (52). Here in a third way, through his continued enactment of sexual identity denial to Henry, Roy models a calculated method of passing that is

invested in the maintenance of the dominant cultural systems that would – in his mind, rightly – eject him should he identify as homosexual. To the audience of 1993, when this play opened on Broadway, Roy may have embodied the self-promoting, gay-loathing homosexual most dangerous to the communities who were struggling more than ever for recognition and validation by government and political power structures. In this sense, Roy may also be posited as Kushner’s cautionary figure, offered to a mobilized subcultural community for which motivation for activism in opposition to systematic oppression was never unneeded.

In concluding the scene, Roy asks Henry for his diagnosis again; when Henry responds, simply, “You have AIDS, Roy,” Roy counters definitively with, “No, Henry, no. AIDS is what homosexuals have. I have liver cancer” (52). Defeated, Henry acquiesces to Roy’s insistence, then counsels him wearily to contact “the First Lady” or another political contact to help him get into the National Institute of Health trial of AZT, which has “a two-year waiting list that not even I can get you onto” (52). Later in the drama, Roy does obtain a huge private cache of AZT from his political connections, and upon his death under Belize’s watch less than four months later, Belize coerces Louis into smuggling the drugs out of his hospital room for Prior.

Even Roy’s death at the close of Act Four of Perestroika does not elicit a sympathetic response from a reader; rather, it serves as a tentative comeuppance for the self-righteous man who, through this reading, can be viewed as a threat to gay communities in the midst of the AIDS crisis. Alternately taunting an apparition of Ethel Rosenberg (in whose trial the historical and literary Roy Cohn served as chief counsel) and addressing to Belize, his nurse, racist comments, he dies while babbling

on morphine about wanting to “be an octopus” (247). In Scene 9 of Act Five, Roy reappears in “Heaven, or Hell or Purgatory – standing waist-deep in a smoldering pit” as he forges a contract with Satan (or God) to represent him as his attorney in “a paternity suit” involving “abandonment,” sealing the deal with his client and concluding that while he “ain’t got a case” and is “guilty as hell,” Roy will “make something up” (274). Thus, while Roy is assigned to an indeterminate hereafter, he maintains the smug conviction in his decisions that drove him while alive; dying without friend or lover, he nonetheless attains in his afterlife what he sought most to keep secure in his lifetime: access to clout, privilege, and power.

Considering the grieving attempt made by Louis as a self-identified member of a disenfranchised population alongside the identity and membership denial of Roy, I believe these figures allow us to recognize more fully the insufficiency of culturally-prescribed responses to AIDS amongst affected individuals. The scenes addressed in this chapter have pointed toward the queering of societal expectations of responses to disease and death that are particular to their cultural moment and position. These scenes also necessitate that we consider, if not yet answer, the question: Does death become an obligatory act for membership in a group of persons that is in the midst of both biological epidemic and sociological stigmatization and if so, is death enough to ensure membership?

Group Mattering and Subcultural Meaning Making

In “Mattering and Suicide Ideation: Establishing and Elaborating a Relationship,” social psychologist G.C. Elliott writes, “Not to matter is a devastating

realization that can have profound consequences for a person; perhaps the most serious consequence is to question the value of continued existence” (223). Within postmodern conceptions of suicide, the issue of “mattering” has become of increased importance in understanding the ways in which psychosocial psychache may be complicated by an individual’s perceived sense of not mattering in his or her society. In approaching the relative cultural silence in the 1990’s surrounding the relationship between AIDS, suicide, and stigmatized homosexuality, I suggest that lack of public response to suicide risk amongst populations vulnerable to AIDS was in part resultant of a preexistent and primary sociological crisis of mattering that rendered suicidological mattering overlooked and unimportant. Simply put, I claim that to dominant cultural institutions in the 1990’s, including the media, the government, the family, and the health care system, men who have sex with men already *do not matter* excepting as they are relegated to marginalized positions of cultural attention, such as in the arts. To those who have access to power and privilege within American culture, those who, as Roy Cohn states, have “clout,” homosexual and bisexual men living during the AIDS epidemic of the 1980’s and 1990’s are dead already, regardless of their health status. While attention to mattering may be of importance in cultural attitudes toward suicides like those of the Lisbon sisters examined in Chapter 2, it is of virtually no import in discussions of AIDS and suicidality in the 1990’s because the most affected population does not matter within systems of privilege.

Because mattering does not “matter” in cultural reception of men who have sex with men in this decade, meaning-making attempts regarding deaths of suicide are resisted, excepting insofar as they are mapped onto already-held public assumptions

regarding deservedness, as Doka discussed, and the implicative expendability of this population. Within the complex framework of AIDS as the intrusive presence already troubling a complicated psychosocial relationship between a gay individual and his society, Angels in America is an illuminating literary tool in understanding better the ways in which alternate sites for forging meaning were not only important but also necessary to mattering for men at risk for AIDS. As personified in the figure of Prior Walter, whose responses to this illness develop from those secondary to suffering and isolation, to those of promise and possibility for change, I conclude that “group mattering” supplanted American cultural responses to the deaths of gay and bisexual men and in doing so, offered perhaps the only meaning in the face of chaos and uncertainty: the importance of community and the mobilizing hope for a collective future.

For much of the drama, Prior expresses consistently a certainty of his imminent death through bodily self-loathing, anger, and initially, gallows humor. In Act One, Scene 4, in which he discloses to Louis his recent AIDS diagnosis, he shows him his first Kaposi’s sarcoma lesion, sardonically introducing it by saying, “K.S., baby. Lesion number one. Lookit. The wine-dark kiss of the angel of death,” then punning while Louis resists, “I’m a lesionnaire. The Foreign Lesion. The American Lesion. Lesionnaire’s disease. . . . My troubles are lesion” (27). Immediately following his performative unaffectedness, Prior concludes, “Don’t you think I’m handling this well? I’m going to die” (27). Following a dream scene shortly after his condition begins worsening, in which Harper Pitt appears to Prior and claims, “Deep inside you, there’s a part of you, the most inner part, entirely free of disease. I can see that,”

speaking to himself in the mirror, he says, “I don’t think there’s any uninfected part of me. My heart is pumping polluted blood. I feel dirty” (40). Prior is preoccupied by his bodily suffering through the entirety of Millennium Approaches and much of Perestroika; while repeatedly distracted from his isolation in suffering by the portentous signs and mystical visitations interwoven throughout his scenes and attributed by him to hallucinations, he is concerned throughout the text with counting his lesions as they present; adjudging the level of pain he is experiencing; listing new symptoms; such as diarrhea and fever, as they appear; and cataloguing bodily sites for his prevalent anger at having AIDS.

Most of his outward expressions of anger are directed toward Louis who, as Prior had expected, leaves him for Joe Pitt shortly after he flees Prior’s hospital room and encounters the Man in Central Park. In Act Four, Scene 1 of Perestroika, less than four months have passed since Prior’s initial diagnosis. At Louis’ insistence, Prior meets him on a bench in Central Park, where he ventilates anger that I read as secondary not only to his physical suffering and partner’s abandonment but also to his deprivation and keenly-felt isolation. When Louis arrives, Prior greets him by saying, “Fuck you you little shitbag” (215). Undeterred, Louis begins their conversation by apologizing for having left him, claiming that while he can’t return to Prior, he carries bruises about it on the “inside” (215), but Prior responds, “There are thousands of gay men in New York City with AIDS and nearly every one of them is being taken care of by . . . a friend or by . . . a lover who has stuck by them through things worse than my . . . So far. Everyone got that, except me. I got you. Why? What’s wrong with me?” (220). While these lines may be read as plaintive or angry, I suggest they speak to

Prior's perceived isolation secondary to deprivation in the midst of illness. In Bereavement: Studies of Grief in Adult Life, Colin Murray Parkes notes that "deprivation implies the absence of a necessary person or thing as opposed to loss of that person or thing"; whereas bereaved persons react both to loss and to deprivation, "grief is the reaction to loss, loneliness the reaction to deprivation" (9). Deprived of "those essential 'supplies' that were previously provided by the lost person," the "psychological equivalents of food and drink" (Parkes 9-10), Prior's deprivation secondary to isolation in the midst of his illness queers further expected grieving outcomes. Whereas Prior self-proclaims that he is dying, and certainly engages grieving acts directed toward his fear of death throughout the play, here he manifests the loneliness felt from abandonment while suffering from an isolating condition already ignored by so many member of society. Moreover, he is unable to find meaning in his condition – biologically or in terms of his relationship to himself or his community.

I locate the crux of Prior's movement from suffering to hope in Act Five, Scene 5 of Perestroika. Throughout Millennium Approaches, Prior receives multiple portents from a Voice who has deemed Prior a Prophet. In Act One, Scene 2 of Perestroika, the Voice – manifested as the Angel – crashes through his bedroom ceiling, instructing him to tear up the kitchen floor to find the prophetic "Book" she has hidden beneath it. Explaining that God has abandoned human beings because of their constant movements and migratory tendencies, the Angel demands Prior's help as the "chosen one" in halting what Prior identifies as "human progress"; when he refuses, explaining, "I'm not a prophet, I'm a sick lonely man," the Angel departs,

Antarctica: Let them. Unaccountable multitudes. Horrible. It is by
their own hands . . . I will rejoice to see it. (261)

The disturbing nature of this discussion is underscored by its chilling reflection of attitudes at work in the play's contemporaneous culture. In particular, the figure of Antarctica echoes societal attitudes that AIDS was deserved by the gay community and that the "unaccountable multitudes" are expendable because the epidemic was brought on "by their own hands." His closing comment – "I will rejoice to see it" – summons cultural references to blatant attitudes of hate displayed toward victims of the AIDS crisis in the 1980's and 1990's, but his first words – to "let them" (die) implies a possibility for intervention from "above" that is purposefully not taken up. In this way, we may read the Continental Principalities as manifestations of some of the very attitudes most prevalently circulated by persons in positions of power and privilege in the historic moment of the drama as well.

When Prior enters the scene with the Angel, who is called in the text for the first time the "Angel of America," he curses God to the Angels and returns the Book to the Council (263-4). Following his negotiations with the Angels, who believe Prior should wish to remain in Heaven, he states simply, "I want to be healthy again. And this plague, it should stop. In me and everywhere. Make it go away" (264). The Angel of Australia replies:

Australia: Oh we have tried.

We suffer with You but

We do not know. We

Do not know how. (265)

Here, the figure of Australia indicates that rather than wishing the plague to continue, the Principalities are simply incapable of arresting it. Complicating my reading of the opening of this scene, I interpret the implication of these lines as relating directly to cultural conceptions of group identity and change. Whereas the Principalities are either unwilling or unable to assist in stopping destruction on Earth, change, the text soon implies, may be possible only from those on Earth.

Frustrated with Australia's expressed impotence, Prior responds, "I still want . . . my blessing. Even sick. I want to be alive" (265). At this point, the Angel of America gives an extended monologue, indicating that "It is Not-to-Be Time" and that Prior only "thinks" he wants to be alive (265-6). He insists otherwise, saying, "But still. Still. Bless me anyway. I want more life. I can't help myself. I do" (266) and "I don't know if it's not braver to die. But I recognize the habit. The addiction to being alive. We live past hope. If I can find hope anywhere, that's the best I can do. It's so much not enough, so inadequate but. . . . Bless me anyway. I want more life" (267). What is important to stress in this scene is Prior's movement from a previously-static preoccupation with bodily suffering to engaging insistent demands that express his desire to live. Repeatedly, he is dialogically pressured by the Principalities to affirm life; to "live past hope," if need be.

As he exits Heaven, the Angels, "unseen by Prior, make a mystical sign" (267). Emboldened, Prior turns back to the Council, stating, "And if He returns, take Him to Court. He walked out on us. He ought to pay," before departing (267). I assert that it is

not the metaphysical blessing that allows Prior to walk out of Heaven, where he is welcome to remain and would be free from pain and suffering. Rather, it is in his assumption of action that he attains the capacity to transcend not only the physical realm but also the societal effects of AIDS. First in wrestling the Angel for entrance into Heaven, then in demanding not only for himself but “in everywhere” that the plague upon humanity stop, and finally in leaving Heaven to return to Earth, knowing that the Angels above are ultimately powerless, Prior becomes a prophet and pedagogue, though not as the Angels expected him to be.

In the Epilogue of Angels in America, Prior, Louis, Belize and Hannah are sitting on the edge of the Bethesda Fountain in Central Park. The characters converse regarding the various religious themes and connotations associated with the Angel of Bethesda, on whom the fountain is modeled. In concluding the play, Prior breaks from the scene to address the audience directly, noting, “It’s January 1990. I’ve been living with AIDS for five years” (278). In a closing monologue that is perhaps one of the most moving written in a modern drama, Prior reinforces the concept of mattering that remained unreachable for characters throughout the narrative arc of the play and places the primary site of mattering in group identity and collective action. Consequentially, his lines speak to the promise of meaning-making possibilities for a disenfranchised and stigmatized subcultural community; they bear witness to the grievous losses experienced by it; and they affirm life and hope in the midst of suffering:

This disease will be the end of many of us, but not nearly all, and the dead will be commemorated and will struggle on with the living, and

we are not going away. We won't die secret deaths anymore. The world only spins forward. We will be citizens. The time has come.

Bye now.

You are fabulous creatures, each and every one.

And I bless you: *More Life*.

The Great Work Begins. (280; emphasis in original)

I conclude that “The Great Work” to which Prior refers is not meant to be assigned to those in positions of power or privilege, whether heavenly or human; through the figure of Prior, Kushner charges his contemporaneous audience and his later readers to move forward with this work. In these lines, Prior invites the audience to join him in commemorating the dead, remaining visible and present, and *working* with him toward a citizenship that he asserts will come.¹⁷ I further posit that in confirming that meaning is achievable in the midst of epidemic by *enacting* meaning-making dialogue to the audience, Prior blesses his audience not only with a prayer to a literal extension of life but with the reinforcement of mattering. He affirms that the dead matter and will struggle alongside the living; that the “fabulous creatures,” who are bearing witness in the audience matter; and ultimately, that “not going away” but maintaining a sense of

¹⁷ Here, I am compelled to gesture toward Hannah Arendt's theories of natality in relation to labor, work, and particularly action, as I believe the conclusion of *Angels in America* promises (re)birth for a community if and only if its audience takes up Prior's implicit call to join in the “Great Work.” In *The Human Condition* (1958), she writes, “Labor and work, as well as action, are . . . rooted in natality in so far as they have the task to provide and preserve the world for, to foresee and reckon with, the constant influx of newcomers who are born into the world as strangers. However, of the three, action has the closest connection with the human condition of natality; the new beginning inherent in birth can make itself felt in the world only because the newcomer possesses the capacity of beginning something anew, that is, of acting” (8).

futurity while tirelessly engaging The Great Work of change *matters*. In this way, though troubled by systems of power and privilege, stigmatized responses to subcultural contagion, and manifestations of complicated grief, Kushner offers in Angels of America a message of hope, not for salvation from above but from within communities – that while the “Angel of America” may be powerless to stop destruction, each person has the opportunity to become one of the angels *in America* by working for a future of acceptance, equality and “*More Life.*”

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Chapter 4

“No One Should Have to Live Like That”: Historical, Ethical, and Literary Implications of Assisted Suicide in the 1990’s

Introduction

This chapter will explore the American culture of suicide in the 1990’s through the historical, ethical, and literary implications of the death with dignity movement, which was gaining unprecedented momentum on multiple fronts over the course of the decade. First, I will discuss the major medical and legal controversies surrounding physician-assisted suicide, called by proponents, “death with dignity.” Next, I will treat two canonical pro-assisted suicide texts, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying by Derek Humphry and Prescription Medicide: The Goodness of Planned Death by Jack Kevorkian, and their contemporary criticisms. Finally, I will undertake close readings of two major literary texts of this period – the novel One True Thing by Anna Quindlen (1994) and the drama Wit by Margaret Edson (1993) – and will situate them within the historical framework of the death with dignity movement in order to argue that as cultural artifacts and works of literature, both implicitly furthered the death with dignity movement in their own historical moment. Although neither female protagonist in these texts dies of the assisted suicide acts being debated by contemporaneous medical and legal representatives at the time of publication, the framing of their narratives and incorporation of monologues regarding suffering provoke in their readers a desire to affirm and bear witness to their deaths. In doing so, these texts contributed to the

meaning-making conclusions regarding assisted suicide attained by a growing populace in regard to terminally ill person. As the third and final branch of my theory of a trifurcated cultural response to suicide, I show that assisted suicide for the terminally ill prompted American attitudes in the 1990's that were vastly different than those secondary to suicide deaths from psychache or mental illness, or those resultant of collective suicide events. Whereas earlier chapters have explored the differing ways in which American attitudes complicated or prevented meaning-making attempts following suicides enacted by physically healthy individuals, by socially stigmatized persons, and by "cult" members dying collectively, this chapter and its conclusions will demonstrate that only in the case of normatively terminally ill individuals who hastened their deaths were suicide and the individuals affected validated and valued.

Perceptions of "Assisted Suicide" Versus "Death with Dignity" in the 1990's

In December 1993, the American Medical Association (AMA) passed and adopted Opinion 2.211, resolving that:

It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to

control, and would pose serious societal risks.” (Council on Ethical and Judicial Affairs)

This resolution, which is still intact and incorporated within the AMA’s Medical Code of Ethics, resolutely barred any physician from assisting in hastening the death of a terminally ill patient while foreshadowing many of the claims that would be raised by “pro-life” lobbyists in coming years. However, whereas this parent institution for the medical community definitively forbade physicians from participating in assisted suicide, medical texts and studies published in merely the five years following the resolution’s passage spoke to an increased support within the medical community for death with dignity; they also identified instances of physician-assisted suicide undertaken in violation of the AMA’s tenet and of national law.

In 1996, bioethics scholar David Wendell Moller observed that “there is a growing pattern in the American public, and even among health care professionals, of greater tolerance and acceptance of suicide, especially when related to serious chronic and terminal illness” (183). He added, “recent data indicate that the drift toward approval of terminal-illness suicide is so strong that even health care professionals, who have an explicit professional code of ethics regarding patient suicide, are more tolerant of suicide when a terminal, chronic illness is involved” (184). In 1998, physician and palliative care specialist Diane Meier and her colleagues released the results of a nationwide survey conducted of 1,902 physicians, finding that 11% of those surveyed “reported that under current legal constraints, there are circumstances in which they would prescribe a medication for a competent patient to use with the primary intention of ending his or her life” and 36% of those surveyed “said they

would prescribe a medication if it were legal to do so” (1197). Interestingly, of the 320 physician respondents who reported having received a request from a patient for a prescription for a lethal dose of medication, 16% indicated that they provided at least one patient with such a prescription, in direct violation of the AMA Code of Ethics and U.S. legal code (1199).

While physician attitudes toward assisted suicide became more clearly divided during the 1990’s, concurrently, cultural controversy over the practice was heightened by the adoption of assisted suicide as an agenda item for non-profit political organizations devoted to public and governmental lobbying. Principally, the Death with Dignity National Center, the National Right to Life Committee, and the Hemlock Society (which splintered in the early 1990’s into Compassion & Choices and the Final Exit Society) provided leading voices in the cultural debates surrounding questions concerning the right to die. With emphases on agency, choice, and language, each of these organizations fueled public and legal dialogue on assisted suicide. These groups further contributed to the enactment of legalized assisted suicide in Oregon in 1994 via state ballot referendum; the injunction that delayed the implementation of the Oregon Death With Dignity Act until it was lifted on October 27, 1997; the attempted repeal of the Act by the Oregon state legislature in November 1997 via ballot referendum; and the immediate rejection of said referendum by 60% of Oregon voters.¹⁸ Here, I will outline the historical arguments of the primary national

¹⁸ For further background on the timeline of legal measures surrounding the initiation of physician-assisted suicide practices in Oregon, resources available under the heading “Death with Dignity Act” published by the Oregon Public Health Authority are particularly assistive. Additionally, in extending our examination of this unprecedented legal enactment into the following decade, it is useful to consult the U.S. Supreme Court decision made in 2006 to uphold the Oregon Death with Dignity law after it was challenged by the administration of President George W. Bush, “Gonzales, Alberto, Attorney

organizations that initiated and maintained societal discussions regarding death with dignity in the 1990's.

The Death with Dignity National Center, founded in 1993, clearly delineates crucial differences between practices of euthanasia and death with dignity; the medical and terminological differences are important to stress in terms of understanding their effect on public debate. As defined by the Death with Dignity National Center and in accordance with the medical definition from the AMA, euthanasia refers “to the act of painlessly but deliberately causing the death of another who is suffering from an incurable, painful disease or condition” (Death with Dignity National Center). Such acts are explicitly outlawed in the Oregon Death with Dignity Act, as well as in the nearly-replicable acts that have been passed since in Washington in 2008 via ballot referendum and in Vermont in 2013 through legislative action. Alternatively, death with dignity requires, above all else, self-administration of lethal medication by the patient. Lethal injections by physicians are disallowed; individuals die from the ingestion of high doses of barbiturates, generally Seconal (which is provided as capsules to be broken open, with their powder dissolved in water) or Nembutol (which is available in liquid form), either of which they must ingest without assistance.

From its inception, the Death with Dignity National Center has resisted not only the erroneous application of the term “euthanasia” to the practices it seeks to make legal and accessible but also the usage of the phrase “assisted suicide” in discussing such acts. Identifying “assisted suicide” as “inaccurate terminology,” it argues that this is “a biased phrase which opponents often use to scare people about

General, et al. v. Oregon, et al.”

Death with Dignity laws” ([Death with Dignity National Center](#)). Here, it is valuable to consider that the very reason the phrase “assisted suicide” is avoided by proponents of death with dignity and used nearly exclusively in cultural debates by opponents of death with dignity legalization originates in the broader, embedded stigmas of suicide and suicidality that have been discussed throughout this project. The Death with Dignity National Center states:

Because the person is in the process of dying and seeking the option to hasten an already inevitable and imminent death, the request to hasten a death isn’t equated with suicide. None of the moral, existential, or religious connotations of suicide apply when the patient’s primary objective is not to end an otherwise open-ended span of life, but to find dignity in an already impending exit from this world. They’re participating in an act to shorten the agony of their final hours, not killing themselves. ([Death with Dignity National Center](#))

The central values of the Death with Dignity National Center – choice and agency, physical palliation, patient dignity and professional compassion – are illustrated well in the above statement. However, it should be noted that its reification of criminalizing and stigmatizing language toward *others* who die of suicide, while successfully contributing to a clear distinction between end-of-life suicide deaths and those of non-terminally ill persons, nonetheless serves also to perpetuate cultural attitudes that demean and devalue persons suffering from psychache-related suicidality.

As perhaps the most aggressive opponent of death with dignity laws, both throughout the 1990's and today, the National Right to Life Committee rests its argument against such acts largely on three key points, which it distills clearly in its article, "Why We Shouldn't Legalize Assisted Suicide." The committee claims that "treatable depression, rather than the terminal illness itself" is the origin of "a patient's expression of a wish to die"; second, it draws upon outdated classical grief theory tenets in stating that "after a diagnosis of terminal illness, a person normally goes through a series of stages of coming to terms with impending death and resolving unfinished business in his or her life, a valuable process that is cut short by acceding to a depression-induced request for assistance in suicide" (National Right to Life Committee). Third and finally, it argues that "given growing pressures to contain medical costs and prevailing social attitudes, if assisting suicide is legalized, many terminally ill patients will be led to feel they are burdens and have a duty to die" (National Right to Life Committee).

In approaching these claims, we can turn first to the continuing empirical data of scholars such as Meier, from whose article "Characteristics of Patients Requesting and Receiving Physician-Assisted Death" we may be able to understand better the complexity of the simplified scare tactics historically employed by the National Right to Life Committee in regard to assisted suicide. Depression in terminal patients is a long-standing topic of inquiry in American medicine, and while this project cannot treat extensively the relationship between depression and terminal illness, it bears noting that situational or fluctuating depressive feelings at the end of life are non-pathological and, to some degree, expected. In speculating on the many ways in which

signs and symptoms of depression may be interpreted in terminal patients requesting assistance with their deaths, Meier notes, “physicians may reason that it is normal to be depressed or may be unable to distinguish depression from sadness under circumstances of terminal illness, may believe that depression in this clinical context is untreatable, or may have tried and failed to treat their patient’s depression” (2003, 1541). After the extensive surveying of nearly 2000 physicians, she observes, “While our respondents were less likely to honor a request for assistance in dying from a depressed patient, nonetheless physicians did assist some individuals whom they believed were depressed at the time of their request,” speculating that in addition to the above reasons, physicians may conclude that a patient’s depression is not interfering with his or her decision-making capacity” (2003, 1541). Above, all, Meier found, terminal patients of surveyed physicians who requested assistance in dying generally had extremely short life expectancy and experienced high levels of physical pain and deterioration, as well as decreased functioning:

Almost half (47%) had a primary diagnosis of cancer, and a large number were experiencing severe pain (38%) or severe discomfort other than pain (42%). Many were described by their physicians as dependent (53%), bedridden (42%), and expected to live less than 1 month (28%). The majority (90%) were lucid, but had experienced a recent deterioration in functional status (87%). (Meier 2003, 1540)

Supporters of death with dignity recognize the role of depression in many end-of-life experiences. Unlike the claims furthered by the Right to Life National Committee and

other historically-active opponents, however, they do not seek to collapse situational depression secondary to the dying process into loss of reason or cognitive functioning.

In responding to the second major argument of opponents to physician-assisted suicide – essentially, that these practices disallow patients from completing “unfinished business” – the Death with Dignity National Center and its affiliates often point to the structure of the law itself and qualifications for its usage, which bear noting. Under the Oregon Act (as well as those that have followed to date in Washington and Vermont), first drafted in 1993, an individual is eligible to receive a lethal prescription if and only if he or she is an adult, a state resident, diagnosed with a terminal illness with a life expectancy of six months or less in the opinion of two physicians, and evaluated as capable of making and communicating health care decisions. If these requirements are met, the patient must make two verbal requests to his or her physician separated by at least fifteen days; must attain confirmation of diagnosis, prognosis, and mental capacity from the prescribing physician and a consulting physician; must be advised of alternate options for palliative care; and must be encouraged by physicians to notify their next-of-kin regarding the prescription request (Oregon Public Health Authority). I delineate this process in detail to illustrate the impossibility of engaging this practice without sustained forethought and commitment. While the National Right to Life Committee and Catholic religious organizations have claimed that death with dignity arrests one’s preparation for death,¹⁹ we may alternately give credence to the likelihood that such purposeful, self-

¹⁹ Principally, the U.S. Conference of Catholic Bishops has consistently and publicly opposed Death with Dignity Acts; as one example, they released a 2011 statement titled, “To Live Each Day with Dignity: A Statement on Physician-Assisted Suicide,” indicating that instead of engaging in such

determined processes can allow one to approach death in a way that assists him or her in finishing the lingering business left in life while planning for death.

In examining the third major criticism invoked against death with dignity practices in the 1990's – that terminal patients will be made to feel financially and socially burdensome, thereby coerced to hasten their deaths – it is important to examine the early outcomes of the act as a legal precedent and testing ground. In “Oregon’s Death with Dignity Act: The First Year’s Experience,” a report compiled and released by the Oregon Public Health Authority, the panicked warnings by opponents that the terminal population would die in droves from assisted suicide is refuted through empirical data collection. In 1998, twenty-four state residents requested and received prescriptions for lethal medication to die; sixteen died after ingesting the medications; six died from their underlying illness, and two were alive as of January 1, 1999. The median time from medication ingestion to unconsciousness was five minutes, while the median time from ingestion to death was twenty-six minutes. In the majority of cases, the prescribing physician was at the patient’s bedside; no medical complications, such as vomiting or seizures, were reported by any physician (“Oregon’s Death with Dignity Act: The First Year’s Experience”).²⁰ In examining the empirical data across all seventeen years in which the practice has been legal in Oregon, I wish also to point out that while the number of lethal prescriptions

practices, individuals should utilize their final days during terminal illness to “devote their attention to the unfinished business of their lives, to arrive at a sense of peace with God, with loved ones, and with themselves” (5).

²⁰ In recently-available longitudinal data, Oregon reports that over the last seventeen years, a total of 1,327 people have received prescriptions for lethal medication under the Death with Dignity Act and 859 people have died from ingestion of the medication (Oregon Public Health Authority, “Death with Dignity Act – 2014”).

written per year has increased, approximately one-third of the number of persons receiving these prescriptions every year does not utilize them. In the documentary How to Die in Oregon, released in 2011 by director Peter Richardson, several terminal Oregon residents interviewed who attained these prescriptions suggested that owning the actual medication was as important – if not more so – than taking it. Some referenced having the drugs as “security” or “the backup plan.” Explaining to filmmakers the decision she has just made to take the medication, Cody Curtis, a soft-spoken woman in her mid-50’s who is dying from liver cancer, states, “I understand that there’s a certain dignity in suffering. But there’s a certain grace in accepting the inevitable” (How to Die in Oregon). While patients throughout the film do note a desire not to be a burden on their loved ones, we should remember that such sentiments are not uncommon to the dying population in general. To date, the Oregon Public Health Authority has not received one grievance alleging familial “coercion or undue influence” to die under the law, as physicians and end-of-life volunteers are bound by law to report if suspected (“Death with Dignity Act”). Additionally, qualitative data on patients’ self-reported reasons for enacting death with dignity in Oregon indicates that the primary reasons patients request lethal medication relate to desiring more control over their end-of-life experiences. It is crucial to note that “financial burden of treatment” is the least common reason reported (“Death with Dignity Act”).

In addition to the points above, the question of pain management was heavily debated in the 1990’s in relation to assisted dying practices. Often cited by opponents of the death with dignity movement as an alternative to assisted suicide in the 1990’s,

the typical practice of morphine dosing in terminal patients unexpectedly lent itself to the assisted suicide debate. Opponents to expanded end-of-life choices argued that such palliative treatment made assisted suicide unnecessary, while simultaneously, proponents of death with dignity insisted that that increasingly high dosing of morphine in the last stages of life often has been utilized as a “passive euthanasia.” Based on a secular variant of the Catholic principle of “double effect,” physicians commonly considered it permissible “to administer heavy doses of morphine to a terminally ill patient close to death, knowing that the morphine will depress respiration and make that death occur earlier, provided the physician’s intention is to relieve suffering, not to cause the death,” which is a practice explored by bioethics scholar Margaret Pabst Battin (18). This dosing norm has been absorbed into medical culture, which has “developed a prevailing mythology that giving high doses of morphine at the end is not killing (even though the patient dies as a result) and hence not subject to moral (or legal) censure” (Battin 18-19). Illustrating directly the historically-differentiated cultural treatment of terminal and non-terminal suicidal individuals, Battin, in her 1994 text The Least Worst Death: Essays in Bioethics on the End of Life, argued that “Some persons in some situations . . . have a fundamental right to suicide; others do not. Of course, the right to suicide, if it is one, is not alone among fundamental rights in being unequally distributed; it is merely more unequally distributed than most” (281). While Battin’s argument is sound insofar as her interpretation of pro-assisted suicide arguments from bioethical and legal standpoints as resting on “human dignity” and legal precedent (281), she does not address the ways in which her contemporaneous cultural critics identify morphine dosing and

other common pain management tools in end-of-life practices as inadequately successful in mitigating suffering. Indeed, even those most rigorously opposed to death with dignity practices in the early 1990's argued that pain could be successfully managed in as few as 90% of patients, leaving potentially one in ten individuals to suffer through his or her dying process. Writing on the need for legalized and regulated medical assistance in dying, Humphry also notes, "The leadership of the hospice movement constantly insists that it has complete answers to painful dying . . . but evidence has come forward from some experienced doctors and nurses that the situation is not as rosy as that"; he adds, "While hospices do relieve the majority of pain and give wonderful comfort care, there are still a number of distressing cases, about 10 percent of the total" in which pain management, he argues, is not managed successfully through morphine use (25).²¹

Medicide or Self-Deliverance?: Ethics and Praxes in Assisted Death

Clearly, an intense preoccupation with alleviating the pain and suffering of dying persons and affording them with choices in death was a shared hallmark of early pioneers of the right-to-die movement. While the complex history of the involvement and evolution of each regional and national organization in the assisted death movement is beyond the scope of this project, I do wish to trace the distinctions and criticisms of two individual figures who were arguably the most well-known

²¹ For another such representation of this frequently-circulated percentage in the 1990's and its usage in furthering opposition to death with dignity, see the 1997 article, "Why We Shouldn't Legalize Assisting Suicide," by Burke J. Balch and David Waters, who blame "uninformed medical personnel using outdated or inadequate methods" for cases in which pain is uncontrolled in terminal patients. They concurrently maintain their assertions that pain management is effective to the degree that assisted suicide is unneeded; for cases in which suffering is uncontrolled, they variously cite the availability of more invasive and costly procedures such as electrical nerve stimulation, over-the-counter medications such as non-steroidal anti-inflammatory drugs, and "non-pharmacological methods, which include distraction and relaxation."

proponents of the practice of death with dignity in the 1990's prior to its legalization, Dr. Jack Kevorkian and Derek Humphry. Alternatively calling assisted suicide practices "medicide," "obituary," "self-deliverance," and "euthanasia," Kevorkian and Humphry, while differing in theoretical and practical approaches to assisted death, shared a belief in the alleviation of suffering in terminal individuals, both in terms of physical pain and mental anguish. Their shared values and divergent approaches transgressed medical and legal precedents and directly offered correlative and contributory validation to the right-to-die movement and intensified cultural discourse surrounding it.

In September 1989, American pathologist Kevorkian, using "household tools," "scrap metal," and items purchased at "flea markets," completed his assemblage of a workable prototype for assisted suicide, a machine that would allow a person to self-administer lethal medication (Kevorkian 209). He called this device the Mercitron. In his text, Prescription Medicide: The Goodness of Planned Death, Kevorkian not only describes the process of assembling the Mercitron, quickly referenced in the media as a "Suicide Machine," but also extends arguments he had been developing for several years regarding his belief in the ethical right of a suffering person to die.²² While the attainment of lethal medications, insertion of an intravenous (I.V.) needle into a patient's arm, and detachment of the patient from the machine once death had occurred all necessitated Kevorkian's direct involvement and intervention in the use of

²² For a glimpse into Kevorkian's earlier writing on assisted death, see his 1988 article, "The Last Fearsome Taboo: Medical Aspects of Planned Death."

the machine, he stresses in this text that in developing it, he found it crucial that the patient be able to self-administer the medication by “flipping the switch” of the Mercitron (208). Once attached to the machine and receiving I.V. saline, Kevorkian notes, the patient, when ready, would press “a hair trigger switch” that would activate “a special mechanism” with several functions – first, “stopping the saline drip, starting a rapid infusion of a large dose of thiopental through tubing connected to the same I.V. needle, and finally triggering a timer. Sixty seconds later the timer would start a rapid infusion of concentrated potassium chloride solution to flow concurrently with the thiopental through the same I.V. needle” (208). Kevorkian argues that within “twenty to thirty seconds,” the patient would enter a coma state due to the thiopental solution, “and the potassium chloride will have paralyzed the heart muscle within several minutes.” He concludes, “In effect, then, the patient will have had a painless heart attack while in deep sleep. In all probability death will have occurred within three to six minutes after the device is activated, and cessation of heartbeat will be verified by ECG [electrocardiogram] tracing” (209).

Kevorkian’s Mercitron and related devices he later developed would be used in his assistance with approximately 130 deaths between 1990 and 1998. During that time, he would be tried in a court of law four times – unsuccessfully – for his assistance with suicides in the state of Michigan. While one court case ended in a mistrial and he was acquitted three times through the use of his attorney’s arguments on the “double effect” – that death was a side effect of Kevorkian’s palliative treatment of patients, not the intent, Kevorkian nonetheless already had his medical license revoked by the state of Michigan in 1991 based on the death of Janet Adkins

on June 4, 1990. Adkins, a 54-year-old woman who sought out Kevorkian's assistance after being diagnosed with early-onset Alzheimer's disease, was his first assisted suicide patient; her death took place in Kevorkian's Volkswagen van in a public park. Kevorkian describes her death as peaceful and appreciated:

With a nod from Janet I turned on the ECG and said, "Now." Janet hit the Mercitron's switch with the outer edge of her palm. In about ten seconds her eyelids began to flicker and droop. She looked up at me and said, "Thank you, thank you." I replied at once as her eyelids closed, "Have a nice trip." (230)

Kevorkian notified local police of Adkins' death, and by the end of the month, he had catapulted himself to celebrity status in popular media through numerous interviews and public statements. The extensive television and print media coverage on Kevorkian that was initiated with Adkins' assisted suicide reflected divided public opinion over "Dr. Death" and his Mercitron and ushered in a wave of public discourse regarding the right to die. Referencing the immediate response to Kevorkian's assistance in Adkins' death, Bonnie Johnson noted in a People magazine article published on June 25, 1990 that "a troubling debate about life's end had been born." She further observed, "Had Janet Adkins ended her life in one of the usual ways, she would be mourned now only by her family and friends. But by enlisting the aid of a doctor, she had created a maelstrom over the rights of the chronically ill to decide when and how they will die and whether a doctor should play a role in such an act."

The death of Janet Adkins provided Kevorkian with a platform from which to advocate for the legalization of assisted suicide and a subsequently growing, though divided, audience. His notoriety pushed the publication and sales of Prescription Medicide in 1991, though one representative review of the text by Kirkus Reviews concluded that it was “an angry doctor’s rambling and repetitious harangue, certain to arouse the ire of the medical establishment.” Indeed, much of the text appears hastily-written and disorganized, excepting the final chapters on assisted suicide, or medicide. Kevorkian concludes the text with a call for collective public and governmental support for assisted suicide. He references the need for “the strident advocacy of influential personalities who, unfortunately, choose to remain silent or disinterested – or simply antithetical,” claiming that “in having written this book and taken action through the practice of medicide as the first step in the right direction, I have done all that I can possibly do on behalf of a just cause for our species”; he concludes by writing, “But who knows – there’s always the chance that some unexpected quirk of human nature will compel a generally misguided society to add a new twist to the lessons of history by doing the right thing (for a change) at the right time and instituting obituary [another Kevorkian synonym for assisted suicide] without qualms and without delay” (244).

This excerpt reflects the then-developing perception of Kevorkian in the public eye: as a champion for legal change to afford to those suffering a safe and painless means of death. While in 1991, he notes in this conclusion that he has “done all that [he] can possibly do” to further the cause of death with dignity, ironically, his actions near the decade’s close would negatively impact both the legal push for assisted

suicide and cultural understandings of it. Stripped of his medical license in 1991, Kevorkian continued to assist in patient suicides throughout the decade. Exasperated by his ongoing activities, in 1998, the Michigan legislature initiated a law making assisted suicide a felony punishable by a maximum five-year prison sentence or a \$10,000 fine.²³ This law, while clearly and openly written in response to Kevorkian, represented to the death with dignity movement a major setback in its legal struggles. The Michigan law criminalizing assisted suicide, enacted merely a year after the long battle to legalize assisted suicide in Oregon finally took effect, sparked a growing divide between proponents of death with dignity.

On September 17, 1998, Kevorkian assisted in the death of Thomas Youk, his last known patient. Suffering from progressed amyotrophic lateral sclerosis (ALS), Youk was not attached to the Mercitron because Kevorkian had deemed him physically incapable of flipping the switch; instead, as Humphry notes in the 2010 edition of his own pro-assisted suicide text, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying, Kevorkian “departed from his normal method of linking the patient to his ‘suicide machine’ with its bottles of lethal drugs and allowing the patient to throw the last switch to launch the deadly infusion into his arm. This time, with his video camera rolling, Kevorkian used a three-pointed butterfly syringe to inject Youk” (167). Because Kevorkian’s direct fatal injection of Seconal, succinylcholine, and potassium chloride into Youk was videotaped and released by him to CBS News’ 60 Minutes three months later, general consensus was

²³ As per the Michigan Penal Code’s Section 750.329a, which criminalizes suicide assistance, acts eligible for prosecution include providing the means for another’s death of suicide, participating in a suicide, and otherwise assisting in any way during a suicide attempt.

that Kevorkian wished for imprisonment as a means of furthering his cause. Humphry writes, “Kevorkian was deliberately asking for trouble – as part of his campaign to make mercy killing acceptable – by having the Youk video shown on national television and defying the prosecutors to come for him. They had already known about the manner of Youk’s death but were ignoring it – until he defied their authority publicly” (Final Exit 168). Kevorkian was charged with second-degree murder in March 1999, four months following the video broadcast of Youk’s death; he represented himself at the two-day trial, was convicted, and received a sentence of seven to ten years, eight of which he served before his parole in June 2007.

Unwilling to associate themselves at all with the practices or ideas of the now-incarcerated “Dr. Death,” criticism against Kevorkian from assisted suicide advocates grew steadily. Humphry and the Hemlock Society, as well as the Death with Dignity National Center, sought to repair public perception of assistance in dying for the terminally ill in the wake of Kevorkian’s public spectacle and decreased credibility. In Final Exit, Humphry observes that “whether or not Kevorkian moved forward the debate on hastened deaths is debatable,” though he adds, “I for one wish this old man were not incarcerated. He is not a murderer in the normal sense of the word” (169). Importantly, he shows the distinction between Kevorkian’s actions and those furthered by advocates perceived to be more legally and publicly relevant to the death with dignity movement when he concludes, “What Kevorkian failed to see was that the crux of the debate (excluding the Netherlands) has moved from ‘euthanasia’ to ‘assisted suicide.’ Two trends have shifted matters in this direction: lawful physician-assisted suicide in Oregon, and non-physician-assisted suicide elsewhere” (Final Exit

169). Kevorkian's method of injection, whether direct or indirect; the brief amount of time spent in patient assessment prior to assisting in deaths; his assistance of non-terminally ill persons to die; and the lack of regulation or oversight in his eight-year practice of medicide were all praxes from which mainstream death with dignity advocates worked to distinguish their understanding of ethical assisted death.

Humphry, unlike Kevorkian, was neither a medical doctor nor was he, like many scholars lending their voices to assisted suicide debates, a formally-trained bioethicist. A British-born journalist whose 1978 memoir, Jean's Way: A Love Story, detailed the death of his wife three years earlier, Humphry's first-hand experience in assisting in the death of Jean, who had been suffering from terminal metastatic breast cancer, positioned him differently than Kevorkian as a leader in the right to die movement. His oft-repeated epitaph, "Freedom to die in a manner of our own choosing is the ultimate personal and civil liberty," with which he opens Final Exit, can be read as born from personal experience as much as from political conviction (vi). Shortly after the memoir became a bestseller in the United Kingdom, where authorities had chosen not to prosecute him for assisted suicide, which was illegal there as well, Humphry relocated to the United States, where in 1980 he became a principal founder of the Hemlock Society. Known throughout the 1980's within "pro-euthanasia" circles, as they were then called, Humphry became publically-known on a national level following the publication of Final Exit, his 1991 text outlining the purposes, ethics, and practices of "self-deliverance" that Humphry and Hemlock Society members espoused. An unexpected bestseller by a small publisher, Carol Publishing of Secaucus, New Jersey, Final Exit topped the New York Times bestseller

list of August 18, 1991 in the “Advice, How-to and Miscellaneous” category. Demand for the text was itself newsworthy; in a New York Times article on August 9, 1991, reporter Lawrence Altman observes, “In an age of big promotion and large first printings, it is not unusual for a book by an established author or on a highly topical issue to go straight to the No. 1 position in its first week on the best-seller list. But it is rare for a book by a small publisher to obtain broad enough sales to make any of the best-seller lists”; in the article, he refers also to the “controversy” that had “swirled around publication of the suicide manual because many experts fear that it will be misused by people who are depressed or who might even commit murder. Others believe that it is a loud protest against the medical profession for allowing terminally ill patients to suffer” (“How-To Book on Suicide is Atop Best-Seller List”). One week later, another New York Times piece was written on the text by then-columnist Anna Quindlen, whose 1994 novel One True Thing and its interplay with her reading of Final Exit will be treated later in this chapter.

Humphry, who had been working below the radar of public scrutiny on issues pertaining to patient rights and assisted death for over a decade, was already well-versed in the criticisms and controversies surrounding these topics by the time of Final Exit's publication. Anticipating the “expert” fears of the book’s misuse or abuse, the introduction of every edition of the book, from 1991 to the most recent edition released in 2010, is prefaced with the following text, titled “Caution”:

If you are thinking of ending your life because you are depressed, or cannot cope with the pressures of this difficult world, do not use this book. It is for dying individuals who need such information and will

find it a great solace. I ask people with suicidal thoughts to share them with family or friends and if this does not help to call one of the hot lines or help lines listed in their local telephone book. Please respect the true intentions of Final Exit: the right of a terminally ill person with unbearable suffering to know how to choose to die. (xxix)

Here, Humphry not only explicitly bases his arguments for assisted suicide as pertaining only to the physically ill – which was important in preemptively foreclosing his need to defend his intent to further a suicide free-for-all – but also clearly grounds his stance exclusively for terminally ill suffering persons. In doing so, Humphry distances himself, and thereby his Hemlock Society members and, later, the Death with Dignity National Center with which he played an integral historical role, from the less-restrictive stance of Kevorkian, who publicly assisted individuals with non-terminal illnesses. Whereas prior to his arrest, Kevorkian’s supporters defended his actions as merciful interventions for persons in the dying process, following his incarceration and fall from favor even within assisted suicide communities, I note that it was necessary for these communities to assure the public that the type of death with dignity for which Humphry, the Hemlock Society, and the Death with Dignity National Center called was *not* the assisted suicide practiced by Kevorkian.

Chief amongst their distinctions, the legalized assisted suicide argued for by Humphry and these groups would be officially limited in the 1990’s only to terminally ill patients; such stress on terminality served to mitigate some of the accusations posed toward those who argued that legalization of death with dignity would breed a “slippery slope” in which disabled and non-terminal persons could be coerced into

suicide. The questionability of the practices of Kevorkian supported such fears, even as Humphry and others attempted to make distinctions from his praxes. As Humphry later lists on the website of another of his current organizations, the Euthanasia Research & Guidance Organization (ERGO),²⁴ Kevorkian's patients were not all suffering from terminal cancer or progressed ALS. Of the 93 cases that Kevorkian made public or acceded to in the media during his active practice, many were not clinically terminal; some had only suspected or disputed diagnoses (ERGO). The stark list of names, dates, ages, and diagnoses provided by Humphry, which I have corroborated in my research into accessible patient histories and obituaries and, in some cases, the public investigations covered by the media following their deaths, gives a competing historical picture of Kevorkian. While a number of patients who died with his assistance suffered from terminal cancers, congestive heart failure, or ALS, at least 42 of his known cases involved the death of someone who was not terminally ill – or, in some cases, not ill at all, as is the case for four disabled patients who suffered from quadriplegia with no underlying illnesses or terminal diagnoses. Two other patients were assisted in death following strokes. Two were diagnosed only with chronic fatigue. A number of patients were identified by Kevorkian as having various physical pain disorders but, importantly, no definitively degenerative disease course, including fibromyalgia chronic pain syndrome, pelvic pain, syringomyelia [fluid-filled spinal cysts], chronic arthritis, Crohn's disease, sciatica, and severe arthritis pain. Alternately, other patients lived with diseases that are typically

²⁴ To clarify, Humphry's use of the term "euthanasia" is not clinical – that is, he is not referring to the direct injection of a patient to hasten his or her death, as Kevorkian practiced on Youk. Rather, he references the term in keeping etymologically with its Greek roots. As he notes in his "Author's Notes" prefacing Final Exit, "my use of the word 'euthanasia' simply means 'good death' which – as you will read – comes in many ways" (vii).

progressive and degenerative but are not terminal, such as osteoporosis, osteoarthritis, rheumatoid arthritis, Parkinson's disease, and multiple sclerosis (MS). As a woman who has lived with MS for ten years to date, it has been particularly poignant to me to determine that, to best knowledge, the largest non-terminal diagnostic population assisted in death by Kevorkian was made up of multiple sclerosis patients, at least nineteen of whom died with his assistance. Even Janet Adkins, Kevorkian's first patient, had only received her diagnosis of Alzheimer's disease one year before her death at 54 in June 1990; she had not yet experienced progression in cognitive or motor disability.

In Final Exit, Humphry not only outlined his ethics in support of assisted suicide specifically for the terminally ill but also provided to readers a detailed account of ways in which to proceed in such practices, then in violation of the law. In the absence of any state laws allowing death with dignity, Humphry's text gave readers a fascinating, practical blueprint for planning their deaths or assisting in the deaths of loved ones. From advice on making the decision to die and attending to legal documents and advance directives, to legal protection measures for the assisting person, Humphry walks his reader through the process with the spare, journalistic style for which he is known. Though much attention was given in the press to the extensive and detailed discussion of effective means of death – for example, the benefits of barbiturate poisoning versus helium asphyxiation – in considering Humphry's impact on public opinion regarding the right-to-die movement in the 1990's, his "basic rules" for assisting in a person's death are perhaps the most noteworthy. As they are integral to understanding Humphry's legacy in validating and

supporting individuals' desires to end their terminal suffering, as well as the wishes of their loved ones to be able to act in order to help them end their pain, I quote the rules here in entirety:

1. Don't persuade the dying person; up to a point try to dissuade with reason.
2. Don't touch. It must be self-deliverance. Don't physically assist.
3. If you must touch because the patient is physically helpless – amyotrophic lateral sclerosis (ALS) – absolute silence both before and after the death is paramount. You must not tell anyone about this.
4. Give comfort and love, and provide privacy and security.
5. Do not dial 911 for the emergency services. That immediately activates paramedics who will try to revive the person, and policemen who are looking for something to do, especially if it is out of the ordinary. Call only the doctor and ask for a death certificate.
6. Make sure that the person being helped has left a note in their handwriting giving their reasons for self-deliverance and accepting personal responsibility.
7. Before and after, say nothing to anybody. If the police want to ask lots of questions, answer only in the presence of a lawyer. Do not assume you are in the clear; that has trapped many people. (Final Exit 20-1)

In examining these tenets, we may see the focus placed on protection from legal ramifications for the assisting person; the stress placed on autonomy and agency for the assisted person; and the sense of contract or covenant implied between the two. Rather than a clinical experience in which a “patient” is attached to a “suicide machine” by a decertified “doctor,” Final Exit offers an option for assisted death as mutually enacted by loved ones in the privacy of a home. In the rules outlined by Humphry, the suffering person is invested with authority; he or she is in charge of the death, and the caregiver or assistant is there to “give comfort and love” and to serve. In addition to the validation provided to a terminal population potentially desiring assisted suicide, the text also places responsibility in the hands of the suffering person, arguably easing the apprehensions or fears of potential assistants. Not only does he give advice regarding documentation and interactions with authorities following death but also and importantly, Humphry begins his list of rules by advising against persuasion while simultaneously encouraging dissuasion “up to a point.” I posit that the utility of this written measure is to initiate patient self-determination from the beginning of the assisted death process; by instructing caregivers to try to dissuade the terminally ill from self-deliverance, Humphry paradoxically supports patient decision-making while potentially easing some of the potential qualms or guilt of his or her assistant. Finally, it is essential to note that while Humphry, like Kevorkian, shows little use for the laws that, at the time, were uniformly opposed to assisted suicide, of paramount difference in his approach is the trust he places in the patient-caretaker relationship. Unbound by the same set of professional ethics to which Kevorkian was initially tethered, and not, to our knowledge, having assisted in any death other than

that of his terminal, suffering wife, Humphry re-humanizes the experience of assisted death by prioritizing the patient, to whom he speaks directly in his text, and imbues it with renewed compassion as he stresses the centrality of the relationships that are most meaningful to him or her.

I conclude that no single text had a greater impact on public perceptions of assisted suicide in the 1990's – or beyond – than Final Exit. In the midst of national debates between lobbyists, state and federal governments, and non-profit groups, Final Exit provided an accessible, relatable, and practical alternative to the jargon being spouted by attorneys and medical professionals involved in the controversy. It garnered particular criticism from opponents to death with dignity from within the medical community; bioethicist Sherwin Nuland, whose seminal text, How We Die: Reflections on Life's Final Chapter, first published in 1994, was itself a New York Times bestseller before being awarded the National Book Award for Nonfiction, and it originally included a passionately negative response to Humphry, the Hemlock Society, and Final Exit. Noting that debates regarding assisted suicide “certainly belong in the public arena,” whereas “decisions themselves will always properly be made in the tiny, impenetrable sphere of personal conscience . . . exactly as it should be,” Nuland added, “into all of this, an organization called the Hemlock Society has intruded itself” (156). He continued:

These pages are not the forum in which to critique the problematic way in which this well-meaning self-help group of generally intelligent people has publicly validated the suicide decisions of those who may suffer from impaired judgment. Nor is it my intention to ventilate more

than just a bit of my disdain for the misguided way in which the Hemlock Society's founder, Derek Humphry, has represented himself in the limelight of the media during promotion of his ill-advised cookbook of death, Final Exit. (156)

Nuland's comments, included in a text that overall makes little mention of assisted suicide but rather focuses on dying processes, the bioethical interventions available to the medical community, and the patient-physician relationship, speak to the degree to which Humphry's text sparked controversy and debate upon its initial publication. Yet Final Exit clearly resonated with the public. Since 1991, readers have purchased nearly one million copies of Humphry's "ill-advised cookbook" (ERGO); currently in its revised third edition, the text has been continuously in print for nearly a quarter-century; has been translated into twelve languages; has been adapted by Humphry into an informational film, Final Exit on DVD; and has remained arguably the only non-medical reference on the practicalities of assisted suicide to fuel consistently both private and public debate.

Literary Voices in the Right to Die Movement

In this tripartite exploration of the ways in which the historical and ethical implications of assisted suicide impacted greatly American attitudes toward this practice in the 1990's, it is essential to consider the ways in which literature provided fictional but palpable examples of terminal suffering and, in doing so, contributed indirectly to the death with dignity movement. Here, I will explore two major works of literature produced in this period and unpack specific ways in which the texts bred

compassion and empathy for a patient's right to die with dignity and a minimum of pain. While neither of the white, middle-aged female protagonists in these texts dies of assisted suicide, I argue that both works further the ethics and claims of the death with dignity movement through three major literary interventions: first, through the attitudes and points of view of caretakers within both the institution of the family and that of the health care system; second, through the difficulty each protagonist experiences in forcing speech regarding her suffering from a space of being silenced; and third, through the rendering of each of their deaths as vastly differing in means yet equally horrific in process.

In One True Thing, narrator Ellen Gulden traces in hindsight the months she spent caring for her terminally ill mother, Kate, whose death by morphine overdose leads to Ellen being accused of killing her mother out of mercy, of which she is acquitted. Much of the text concerns itself with the development and maturation of Ellen, who leaves her journalism career begrudgingly to move home to an affluent college town and assist Kate, a traditional homemaker with whom she never had felt close and whose company she shunned in favor of that of her erudite father, George, an English professor. As Quindlen's novel progresses, Ellen forges a bond with Kate that culminates in Kate's death, while her relationship with her father is progressively shaped by frustration at his frequent absence in caretaking duties, his extra-marital affairs, and his seeming incapacity to grasp the reality that his wife is dying. Kate is largely incapacitated at home for the end stages of her dying process; Quindlen frequently demonstrates to the reader that Kate is exasperated with her physical deterioration and pain and is readying herself to die but is unable to communicate as

such for much of the novel because she is unable to speak about her suffering to her family. Finally, toward the end of her life she begs both Ellen and George to assist her in dying. Because the novel is narrated from Ellen's memory and point of view, the reader is led to believe that George administers lethal amounts of morphine to his wife and allows Ellen to take the blame. At the novel's conclusion, the reader learns that Kate self-administered the morphine; George and Ellen, who do not speak for years following Kate's death, each thought the other had assisted her in suicide.

Wit does not focus on the familial relationships often existent for a terminally ill patient in its characterization of Vivian Bearing, a professor of 17th century poetry at a major research university. Indeed, while One True Thing is set principally in the Gulden home, Edson's drama takes place nearly exclusively in a room of the University Hospital Comprehensive Cancer Center. Throughout the play, Vivian directly addresses the audience with the wit and pithiness of commentary likened to that she most admires in her lifelong subject of scholarly inquiry, the metaphysical poet John Donne. Frequently, she breaks from the action of the scene in which she is participating to speak to the audience, even as the nurse and physicians who make up the rest of the principal cast proceed in the action of the scene without her response. Diagnosed with advanced metastatic ovarian cancer, Vivian is recruited for an aggressive clinical trial in the hope of extending her life, though she is shown to be more valuable to her physicians – the chief of medical oncology, Dr. Harvey Kelekian, and his clinical fellow, Dr. Jason Posner – as a research subject in terms of the information she can provide to science through her participation in the study. Whereas Vivian is an imperious, highly educated, and self-contained female protagonist who

seemingly has no need for familial ties, by the concluding scenes of the play she is self-mockingly grateful for the attention of her nurse, Susie Monahan, who proves to be the only medical professional who treats her as a human agent rather than a subject of study. Regardless, Vivian dies brutally in the hospital following months of pain and suffering as Susie, Jason, and the code team fight literally over her body due to a miscommunication regarding her code status.

In analyzing first the ways in which caretaker's point of view and the cultural institutions of the family and the health care system contribute to the literary interventions in the death with dignity movement that these texts created in the 1990's, it is important to consider what I believe to be the contingent nature of readers' sympathy. That is, while neither female protagonist commands as much attention or sympathy as those surrounding her at the beginning of each text, as the institutional failures in each of their narratives compile, both women become figures more deserving of care and dignity in the reader's reception of their dying processes. Whereas Kate is loved but largely disrespected by her family due to her choices to fulfill traditional caretaking roles in the home as opposed to pursuing a professional career, and Vivian is highly respected in scholarly circles but personally disregarded due to her self-reliance, self-regard, and sense of superiority, the nature of their deaths renders the compassionate Kate and the elitist Vivian similarly disenfranchised, either by her family system or her health care system.

Early in One True Thing, Ellen notes, "All my life I had known one thing for sure about myself, and that was that my life would never be her life. I had moved as far and as fast as I could; now I was back at the beginning" (31). While the right to die

and assisted suicide advocates play minor explicit roles in the novel's narrative, it is Kate's suffering, as narrated by Ellen, that compels early sympathetic response from Quindlen's audience. In memory, Ellen recounts:

At the end I always did what she asked, even though I hated it. I was tired to death of the sour smell of her body and the straw of her hair in the brush and the bedpan and the basin and the pills that kept her from crying out . . . I tried to do it all without screaming, without shouting, "I am dying with you." But she knew it; she felt it. It was one of many reasons why she would lie on the living-room couch and weep without making a sound, the tears giving her gray-yellow skin, tight across her bones, the sheen of the polished cotton she used for slipcovers or the old lampshades she painted with flowers for my bedroom. I tried to make her comfortable, to do what she wanted. All but that one last time. (12-13)

In this passage, Quindlen communicates effectively the unspeakable suffering of an individual in the last stages of metastatic cancer – unspeakable in this case because the nature of the relationship between mother and daughter prevents Kate from speaking of her suffering. Even in this passage from the prologue of the novel, while providing the context with which the reader will engage the narrative of the text, the focus is really on Ellen's suffering, not Kate's. Ellen pleads with her reader to believe that she repeatedly "tried to do it all" for Kate, yet the only action in this remembered passage is of Kate weeping on the couch "without making a sound." Ellen shows that she is aware of how she was unable to ease her mother's suffering in her dying process; as

insistent as she is that she “tried,” the reader’s sympathy is instantly attuned to Kate, with her sour-smelling body and straw-like hair, who knows that her daughter – her caretaker – hates being the witness to her bodily deterioration and encroaching death. While Ellen claims in this passage to have done everything her mother asked of her, “all but that one last time,” the reader is pressed to question whether a suffering, terminal patient deserves more than mere acquiescence to her requests but may, in fact, deserve the dignity and respect of not having those requests resented by her caretaker.

Much of Ellen’s growing bond with her mother during the novel’s narrative is secondary to her increasingly distant relationship with her previously-adored father, who appears to Ellen to be largely oblivious to the needs of Kate and, specifically, to the degree to which Ellen is working alone to meet them. When she attempts to confront him about his emotional absence in the household, their interchange is telling. George cuts off her concerns brusquely, stating, “I think this time should be about your mother. It calls for a little empathy”; she replies, “You never taught me empathy,” and he responds, “Learn it now,” leaving her to ask, “And you? Where is your empathy?” – a question to which he does not respond (142). Indeed, neither Ellen nor George displays empathy or understanding toward one another as they become silent adversaries circling Kate’s progressively-wasted body in their household. They frequently communicate through Kate; George spends increasingly long hours in his office at the college or in a local bar, unable to face his wife’s decline, and Ellen grows stoic in her slavish attention to her mother even as she feels acutely put-upon by her father. Lost to each of them in this dynamic is a capacity to understand, validate,

or hear the very person over whom they fight and from whom they compete for affection. The caretaker in Quindlen's text, then, as seen chiefly in the figure of Ellen, is entrapped and doomed to failure. Such failure is not secondary to a lack of love or devotion but, as identified both by Ellen and George, to an inability to empathize.

When discussing empathy in my work, I refer to a non-patriarchal conception of the term that resists projection onto another and instead engages in the work of reception from and feeling with another. This definition of empathy is best articulated by ethicist and philosopher Nel Noddings, who writes:

I do not project; I receive the other into myself, and I see and feel with the other. I become a duality. I am not thus caused to see or to feel – that is, to exhibit certain behavioral signs interpreted as seeing and feeling – for I am committed to the receptivity that permits me to see and to feel in this way. The seeing and feeling are mine, but only partly and temporarily mine, as on loan to me. (30)

As neither Kate Gulden nor Vivian Bearing is afforded empathy within the institution upon which she depends, the dying processes of both women are solitary temporalities marked by separation from those physically closest to them as well as silence. As Vivian bemusedly remarks near the beginning of *Wit*, “I have been asked ‘How are you feeling today?’ while I was throwing up into a plastic washbasin. I have been asked as I was emerging from a four-hour operation with a tube in every orifice, ‘How are you feeling today?’ I am waiting for the moment when someone asks me this question and I am dead” (7). Referring to hospital physicians and staff, she is at first

baffled, then increasingly exasperated, as this query is repeated throughout the course of the play, with its final refrain tossed at her after she has slipped into a coma. The sardonic nature of Vivian's asides to the audience and privately witty remarks that go unnoticed by health care professionals throughout the drama remain strong throughout much of the arc of the text, though as her physical health deteriorates secondary to aggressive research therapies, she appears to be less assured by her own wit and more aware of her isolation from the hospital staff who neither values nor empathizes with her.

In the beginning, Vivian's relationship with Dr. Kelekian is framed as one of contemporaries; as an academic as well as a clinician, Kelekian jovially trades jibes about students with Vivian and bemoans the unnoticed labors of university professors. Yet this congeniality quickly becomes transparent as the reader realizes rapidly that under these ploys, Kelekian's interest in Vivian is primarily as a research subject and only secondarily as a patient – and even less as a person. Still, early in the drama, he plays upon her professional vocation while enrolling her in the clinical trial, stating, “This treatment is the strongest thing we have to offer you. And, as research, it will make a significant contribution to our knowledge” (12). Framing her participation as pedagogical allows Vivian to acquiesce to the trial and maintain, for a time, her professorial imperiousness. Kelekian warns her of the treatment's rigor, adding, “You must be very tough. Do you think you can be very tough?” and in doing so, knowingly assures himself of a compliant, uncomplaining patient (12). When Kelekian brings his medical students into Vivian's room after several weeks of treatment during Grand Rounds, she says to the audience as the students compete to answer rapidly-fired

questions from Kelekian, “It is just like a graduate seminar. With one important difference: in Grand Rounds, *they read me* like a book. Once I did the teaching, now I am taught. This is much easier. I just hold still and look cancerous. It requires less acting every time” (32; emphases in original).

Vivian’s observations of Kelekian and of Jason, who handles most of Kelekian’s daily work with patients, speak to the detachment she experiences in the health care institution, yet until she is thoroughly weakened from chemotherapy, sepsis, and metastatic cancer progression, she does not appear largely to mind her position vis à vis her physicians. While she expresses discomfort during a pelvic exam, in which Jason leaves her uncovered on an examining table for an extended period time while looking for a nurse to assist, and embarrassment when, during the same exam, he mentions, while internally palpating her ovarian tumor, that he had taken one of her courses as an undergraduate, she comforts herself with reciting the poetry of Donne while left alone and noting to the audience regarding Jason, “I wish I had given him an A” (25). Through these scenes, and many others, Edson illustrates to her reader the ways in which the dying woman is less a person and more an object of study within the parameters of health care as a cultural institution. As seen in the oblivious question, “How are you feeling today?” being asked of Vivian as she vomits or writhes in pain; the lack of attunement to physical care or comfort during her pelvic exam; and the way in which expectations placed upon her to be “tough” arrest her ability to demand more attention, the reader’s empathy toward Vivian increases concurrent with his or her realization that within the context of the drama, the audience is Vivian’s *only* source of empathy nearly until her death. Susie, the nurse

who cares for Vivian, similarly loses respect for the physicians with whom she works as her patient's health and dignity rapidly decline in the final scenes of the drama.

When Vivian is admitted to the hospital through the emergency room for sepsis and is confined to an isolation room, Susie suggests to Jason that the dosage of her experimental treatment should be lowered until she can combat the systemic infection, to which he responds, "Lower the dose? No way. Full dose. She's tough. She can take it" (38). Powerless within the health care field, Susie attempts to minimize Vivian's suffering even as she is unable to make decisions that would improve the quality of her dying process.

To complicate my reading of the ways in which the health care system fails Vivian, and to implicate her as Edson's representative model for the experience shared by many end-of-life patients who are reliant upon health care systems for support that is not given, I find it essential to discuss the ways in which gendered expectations and sexism in the American health care institution have contributed in multiple ways to the lack of dignity afforded to female patients. Sociologists Judith Lorber and Lisa Jean Moore have explored this issue extensively in their text Gender and the Social Construction of Illness, first published in 1997. They argue that while nursing has been a female-dominated profession since its inception, since the mid-twentieth century when "tender loving care" was added to nursing practice, the nurse has inhabited the gendered role of "mother" to the physician as "father" (41). This model posits the patient as the "child," often with devastating results to his or her comprehensive health care. For a terminally ill female patient, such as Vivian, this dynamic is uncovered when we read the positionality – literal and figurative – of Susie

and Jason arguing over Vivian's prone body, or Kelekian quizzing his students on Vivian's prognosis while never addressing her directly. In her 1979 article, "Sexism in Women's Medical Care," psychologist Mary A. Halas observed that traditionally, women have been socialized "to be passive recipients of medical care – especially from men" (5). She added, "The attitude with which women seek medical care within the male-dominated system is one of subservient dependence on all-knowing authority. This dependence on all-powerful doctors and women's relinquishing of responsibility for their health to male doctors is the result of physician behavior that reduces the patient's sense of autonomy" (5). Penned fifteen years prior to Wit and over thirty-five years prior to this writing, Halas' observations still ring disturbingly true.

Today, some studies suggest that the ways in which women have been socialized as patients may be transcended if their physician is a woman. As Lorber and Moore reify, data indicates that female physicians generally spend more time with their patients than their male counterparts and patients are more likely to be honest and disclosive about their health with a female physician (40). However, they assert that "these gender differences do not come from women doctors' motherliness or greater nurturance, but from the interactive and situational effects of the practice setting" (41-42). Suggesting that women are often more invested in long-term patient care opportunities than male physicians, they observe that female practitioners thus have a greater opportunity to develop rapport, trust, and greater understanding of their patients' lives.

Unlike Vivian, Kate in One True Thing is being treated by a female physician, Dr. Cohn, as well as a female home-care nurse, Theresa. Mirroring the compassion that Lorber and Moore have observed in their research on female physicians, Cohn makes house calls to the Gulden residence when Kate is in too much pain to be moved to the hospital, cheerfully but firmly refuses Ellen's requests to discuss her mother's disease without her patient being present, and suggests counseling for both Kate and Ellen during the progression of Kate's disease course. Similarly, Theresa, unshackled by the institutional setting of the hospital, is a self-directed and receptive nurse, resisting a maternal role in favor of a professional, empathic approach to Kate. Ironically, in this novel, it is Cohn who points out to Ellen that intellect, so valued by Kelekian in Wit, is of little import in the dying process. She counsels an exasperated Ellen, saying, "As you may have realized by now, intelligence is not what's needed here. Empathy is. Your mother seems to be in a great deal of pain. It's hard to tell how much because, as you well know, she is an uncomplaining patient. Perhaps to a fault" (102-3).

Here, I wish to bridge the complicating factors begat from the attitudes of caretakers in the familial and health care institutions and the ways in which both Kate and Vivian, in their respective texts, struggle to find their voices in order to force speech regarding their suffering from culturally-encouraged silence. Both these factors enhance readers' empathy for the characters while they illuminate the degradation of the dying process as caused perhaps not primarily by the wasting of the body but by the lack of attention to the person who is not yet dead but is often treated as if she were. For Vivian, as we shall see, societal expectations regarding intellect, gender, and

suffering prevent her from discussing openly her pain and fear with her primary caretakers – her health care team. For Kate, while her health care practitioners provide her with empathy, her primary caretakers – members of her family system – do not. In this way, each woman is silenced in her suffering, and each finds her voice only when she is in the final stages of the dying process.

Throughout the novel, Kate is frequently prevented from talking about her disease, pain, and impending death by George and Ellen. While Ellen is increasingly angered by her father's silence regarding Kate's dying process, confronting him by demanding, "Do you grieve? Do you care? Do you ever cry?" (64), Ellen similarly avoids discussing end-of-life issues with her mother, focusing instead on daily caretaking and housekeeping tasks. Two of the most compelling scenes in the novel occur when Kate, seemingly pushed beyond all boundaries of gender expectation or convention, is so overwhelmed by her decreased sense of dignity and correlative silencing that she produces monologues on her condition that are arresting to the reader. In the first such scene, Kate has been laying in the bathtub for an extended period of time, only having recognized upon finishing bathing that she cannot physically get herself out of it. After struggling for a time and exhausting herself, she is forced to call Ellen into the bathroom to help her, at which time she bursts into tears and cries, "I would have died before I would have let you see me like this. Just . . . rotten. That's what I look like now, like a peach when it's all rotten. Like bad fruit. Why can't I just die and be done with it? It's a crime for a human being to have to live like this. Rotten like this" (216). Unable to respond helpfully or verbally, Ellen silently helps her mother out of the bathtub, wrapping a towel around her and leading her to

bed. In memory, Ellen notes, “I never try to remember how she looked that morning. I remember that I never touched her, and I never looked her in the eye” (217). The loss of dignity being palpably felt by Kate in this scene is not mitigated or shared in Ellen’s response. Kate’s attempts at speech – including using the word “dying” for the first time aloud since her diagnosis – go dialogically unrecognized by her daughter and contribute to the pathos of the scene. Even her assertion that “it’s a crime for a human being to have to live like this” – a sentiment that would be wholly endorsed by proponents of death with dignity – doesn’t receive so much as a nod from Ellen.

In the second scene, which occurs shortly prior to Kate being wholly confined to a hospital bed in her home, she finally explodes verbally, directly addressing the ways in which her suffering has been furthered by her inability to speak of it. When Kate begins to reflect on her life and its impending close, Ellen attempts to stop her from talking; Kate responds, “Yes, yes, yes somebody let me speak the truth, somebody let me”; she adds, “Saying it is the only thing that makes me feel better, even the drugs aren’t as good as that. All the things we don’t say, all the words we swallow, and it makes nothing but trouble” and concludes by saying, “I want to talk before I die. I want to be the one who gets to say things, who gets to think the deep thoughts . . . Let me talk now without *shushing* me because it hurts you to hear what I want to say. I’m tired of being *shushed*” (226; emphases in original). This monologue constitutes an emotional breakthrough for Ellen and Kate, but it comes far too late in the novel’s narrative to provide Kate with any seeming solace; instead, she appears defeated, concluding their exchange by saying, “If I knew you could be happy, I would just close my eyes and rest . . . it’s so much easier,” to which Ellen responds, “I

know it is. I wish you could” (226). What is important to note here is the emotional response culled in a reader of this passage; the portrayal of a woman who is close to death and begging merely to be *heard* is both tragic and arguably, to many readers, achingly familiar.

In Wit, while Vivian initially frames ironically her position as a subject as opposed to an agent through her asides to the audience, as her disease progresses, she begins to address it more plaintively. In one such scene, in which she is bedridden on an otherwise-bare stage, she tells the audience, “I don’t mean to complain, but I am becoming very sick. Very, very sick. Ultimately sick, as it were. In everything I have done, I have been steadfast, resolute – some would say in the extreme. Now, as you can see, I am distinguishing myself in illness” (43). It is only near the end of her dying process that she feels able to speak to anyone about her fears. During a scene she later describes to the audience as “a *maudlin* display” (55; emphasis in original), Vivian weeps for the first time in an exchange with Susie. To Susie’s pithy validation of Vivian’s suffering – “What you’re doing is very hard” – Vivian responds, “Hard things are what I like best,” but when Susie adds, “It’s not the same. It’s like it’s out of control, isn’t it?” Vivian begins “crying in spite of herself,” then whispers, “I’m scared” (52). Following this breakthrough of speech, Susie initiates a conversation about code status, suggesting that Vivian might wish to make a decision regarding her end-of-life wishes. Referencing the doctors with whom she works, Susie adds, “They like to save lives. So anything’s okay, as long as life continues. It doesn’t matter if you’re hooked up to a million machines” (54); Vivian then ultimately chooses a Do Not Resuscitate (DNR) code.

In a second scene, Vivian, like Kate, appears pushed beyond all expectations of “toughness” and cries out to the audience upon realizing that she is truly dying. Here, we may read the cutting fear, disorientation, and unpreparedness for death that I argue have been directly exacerbated by the space of uncomplaining silence in which she has been culturally coerced to inhabit throughout her dying process. She is described here as “tense, agitated, fearful,” and she “slowly” addresses the audience while “trying extremely hard” (56):

I want to tell you how it feels. I want to explain it, to use *my* words. It’s as if... I can’t... There aren’t... I’m like a student and this is the final exam and I don’t know what to put down because I don’t understand the question and I’m *running out of time*. I am in terrible pain. Susie says that I need to begin aggressive pain management if I am going to stand it. “It”: such a little word. In this case, I think “it” signifies “being alive.” (56; emphases in original)

Vivian’s self-identified inability to speak up during months of treatments within a paternalistic health care institution has rendered her incapable of locating the words to describe her thoughts and feelings regarding her dying process. While she directly and plainly addresses the physical pain from which she suffers, the helplessness and frustration born from being unable to identify and own *words* to describe her holistic pain undeniably further complicates the degree to which she suffers. And whereas she can rely upon Susie to begin palliative care for her physical agony, we may read this monologue as a plea to her audience to bear witness to her totalistic suffering, which is psychosocial, not merely biological, in nature.

Both Kate and Vivian grapple with imposed silences surrounding their dying processes that are complicated by the responses and points of view of the persons who are entrusted with their care within differing cultural institutions. The reader, or witness, to each female character's suffering is encouraged through the authors' renderings of them to consider the ways in which their suffering not only is protracted and undeserved but also is silenced and underserved. In this way, these fictional texts contribute to an American public understanding that realistic end-of-life possibilities include the cultural devaluation of suffering, gendered expectations regarding strength versus weakness, and complicated pathways toward locating speech in the midst of coerced silence. The inability of characters throughout both the novel and drama to bear witness to the testimonies of Kate and Vivian regarding suffering and death serves as a cultural reminder of the ways in which living and dying individuals need to be valued and heard. Psychiatrist Dori Laub has noted that in bearing witness to traumatic testimony during the crisis of another, the listener "partakes of the struggle of the victim with the memories and residues of his or her traumatic past. The listener has to feel the victim's victories, defeats, and silences, know them from within, so that they can assume the form of testimony" (Felman and Laub 58). Additionally, the listener "has to be at the same time a witness to the trauma witness and a witness to himself" in order to be an "enabler of the testimony" (Felman and Laub 58). Edson and Quindlen, through their female protagonists, powerfully enable their reader to fulfill the role of witness to the suffering of these characters in the absence of any other; perhaps in no way is this literary witnessing more palpably felt than in the characterization of each terminal character's death.

In these texts, neither Kate nor Vivian is afforded what we may visualize when we consider a dignified death, regardless of our individual beliefs and stances regarding physician-assisted suicide. Whereas cultural conceptions of what is commonly termed “a good death” often include having some self-determination throughout the dying process; being afforded palliative care to ease pain and suffering; and being at peace with oneself and others, we see in the works of Edson and Quindlen that neither character is encouraged to exercise agency; neither is given aid in her psychosocial suffering or adequate pain relief for physical agony; and ultimately, both die alone. Though neither Kate nor Vivian dies of assisted suicide, I posit that the ways in which their deaths are described in the text and the actions of other characters that precede or follow them unquestionably demonstrate implicit sympathy with proponents of death with dignity and arguably furthered support for the legal movement at the time of their publications. These texts together imply that without a radical shift in the ways in which dying persons are treated in their end-of-life processes, the only options for many terminally ill patients are unassisted self-deliverance or brutal, protracted death.

In One True Thing, as the reader is assured from the prologue onward, Ellen does not assist her mother in her death. Her inability or unwillingness to do so becomes progressively unsettling to the reader when juxtaposed against the descriptive passages in the novel of Kate’s suffering as well as her clear wish for that suffering to end. Further, as the text follows not only Kate’s decline in health but also the strengthening bond she develops with Ellen during her dying process, the reader arguably begins to *expect* an intervention from Ellen to aid her mother in dying.

However, in spite or perhaps because of the nature of the newly-found relationship Ellen shares with Kate, she is incapable of fulfilling her mother's direct requests for assistance in dying. Repeatedly, Kate begs Ellen, saying, "Help me, Ellen . . . I don't want to live like this anymore," and, "Please. You must know what to do. Please. Help me. No more," to which Ellen can only reply, "It'll be better in the morning" (229). The reader can sympathize, finally, with Ellen, if only in her expressed narrative guilt at not being able to assist Kate, as when Ellen states, "When people wonder how I survived being accused of killing my mother, none of them realizes that watching her die was many, many times worse. And knowing I could have killed her was nothing compared to knowing I could not save her" (370).

Similarly, on the final night of her life, Kate begs George to assist her as well; upset and overwhelmed, he refuses. While he tells Ellen that "no one should have to live like that," he shows direct anger and emotion at his wife's impending death for the first time in the novel but then retreats upstairs to the bedroom, claiming that he is incapable of spending the night by Kate's hospital bed as she has requested (244). While readers may sympathize with the impotence of a spouse who feels that he cannot help his suffering partner, or a child who is unable to end the life of her mother, following the narrative arc of the novel, such sympathy may be greatly overshadowed by readers' empathy for Kate, who is left to overdose alone and in pain. As I argue that this novel calls upon readers to bear witness to suffering in dying processes, so too does it provoke questions regarding how to alleviate it, as well as conclusions that in One True Thing, Kate's solitary, fatal overdose amidst familial detachment should not have been her only recourse from suffering.

An alternative type of death is portrayed in Wit, where deliverance from suffering is not directly self-attained but is similarly delayed by others. After months of participation in her grueling clinical trial, Vivian is afforded palliative care only in the last days of her life. After Susie suggests the use of a patient-controlled morphine pump to allow Vivian some control over her dosage and heightened alertness, Kelekian rejects her proposal, ordering a morphine drip instead and noting only, “She’s earned a rest” (57). No longer of use to the research study, Vivian is afforded a “rest” seemingly as a reward for the months in which she successfully, in her own words, “distinguish[ed]” herself “in illness” – that is, by fulfilling the silenced, patient / child role to Kelekian’s physician / father position (43). It is also important to stress that even in prescribing long-overdue palliative measures, Kelekian is unwilling to accede to Vivian any agency over the strength of her medication or the frequency with which she receives it, preferring instead to deliver a high, steady dose into her bloodstream, thereby ensuring increasing periods of unconsciousness.

Vivian is conscious only briefly following the introduction of the morphine pump, her death occurring while she is unconscious. Discovered nearly immediately following her cardiac arrest by Jason, Vivian is treated in the concluding scene of the drama in a way that is both disturbing and indelible in the mind of a reader. A melee erupts in her hospital room as Jason “begins CPR, kneeling over Vivian, alternately pounding frantically and giving mouth-to-mouth resuscitation” while he calls repeatedly for the code team and ignoring Susie’s desperate attempts to stop him as she repeated yells, “She’s DNR!” and “She’s NO CODE,” to which he uncomprehendingly responds, “She’s Research!” (64). While Jason and Susie are

arguing literally over and on Vivian's body, the code team rushes into the room; stage directions indicate that "they throw Vivian's body up at the waist and stick a board underneath for CPR. In a whirlwind of sterile packaging and barked commands, one team member attaches a respirator, one begins CPR, and one prepares the defibrillator" (64). Susie – and Jason, who too late, realizes his mistake – try to stop them but are pushed away, and as the code team "administers electric shock, Vivian's body arches and bounces back down" until Jason convinces them that he "made a mistake" (65). The final words uttered in the drama, as a radiant Vivian slips from bed unseen by the other characters and walks offstage toward a shining light, are those of Jason, who, surveying the scene around him, collapses on the floor and utters only, "Oh God" (66).

While Jason's regret or perceived sense of responsibility comes far too late in the drama for Vivian's comfort, his final line echoes the horror of witnessing this scene on stage, or even reading it in the drama. For while Vivian's final walk offstage may signify release from pain and suffering, undeniably her final moments of life and first moments in death are characterized by a bodily manipulation and intrusion that not only was expressly undesired by her but also serve to strip away her last vestiges of dignity in the dying process. Considering Vivian's death vis à vis that of Kate in One True Thing, the reader is left unsettled by the lack of care afforded to these dying women and frustrated by the dearth of options offered to them other than unassisted self-deliverance or brutal death. Moreover, I argue that for many readers, engagement of these texts may further their receptivity to alternative possibilities to alleviate such death scenes being repeated in their own lives and in the lives of their loved ones.

In concluding my analyses of these texts while reiterating my claim that they served implicitly to further the death with dignity movement at the time of their publication, I point briefly to the ethos of their authors and reception of these texts at the time of their circulation. In her 1991 article, “Final Exit: Why is a Cookbook for Suicide So Popular?” written while working as a columnist for the New York Times, Quindlen speculates on reasons for the sizable audience eager to read Humphry’s text, noting that some readers may be people “who know that when you become a patient, often you cease to be an actor and become an acted upon,” people who have “seen people who are husks, tied upright in wheelchairs, staring at the ceiling from hospital beds, saved from death by any means possible, saved for something that is as much like life as a stone is like an egg, a twig like a finger.” Describing her personal stake in reading and considering Humphry’s claims, she adds, “I’ve read Final Exit out of curiosity but I’ll keep it for another reason – because I can imagine, having once nursed a cancer patient, the day when I might want to use it,” concluding, “if that day comes, whose business is it, really, but my own and that of those I love?” Written by an author who previously had expressed support for self-deliverance options, One True Thing did not coerce its readers into supporting assisted suicide; rather, the widely-read novel, and its acclaimed 1998 film adaptation of the same title, asked its audience to consider, in the midst of public and legal debates over death with dignity, whether dying persons deserved better than the options they had been afforded.

Concurrently, Edson, herself a former employee in an AIDS and cancer treatment wing of a major research hospital, succeeded through Wit in provoking not only a textual readership but also an extensive theatre audience; her only play to date,

Wit was awarded the Pulitzer Prize in Drama in 1999 following four years of mounted productions off-Broadway and in regional theatres around the country, where it continues to be revived (The Pulitzer Prizes). In 2001, Mike Nichols directed an award-winning television film adaptation that reached an audience in a new decade. While assisted suicide is never mentioned in the drama, Edson's text nonetheless allowed its audience to bear witness in a unique way to the suffering and institutional mistreatment of a character with whose dying process some readers could identify and others could empathize. In doing so, regardless of the particularities or means of a reader's personal encounter with Wit in the 1990's and beyond, he or she was challenged, like readers of One True Thing, to consider the voices in the public realm that were already arguing for assisted suicide as a legal option for terminally ill individuals.

Assisted Suicide and its Cultural Consequences

In examining the implications of public exposure and reception to debates and enactments of end-of-life suffering in the 1990's through ethical, historical, and literary lenses, I close by asserting that the attention paid to issues surrounding the right to die marked a significant shift in public understanding of the positionality of the terminally ill in American culture. By the decade's close, Oregon had enacted its Death with Dignity Act, paving legal precedent for laws that have followed in Washington (2008) and Vermont (2013). As we have seen, the work of Kevorkian and Humphry, though highly controversial, attracted a spotlight on patient advocacy, and organizations such as the Death with Dignity National Center and the National Right to Life Committee assured the role of public debate on patient issues throughout the

decade. Finally, literary works such as the representative texts examined in this chapter simultaneously fictionalized and humanized end-of-life suffering and, in doing so, furthered support for assistance in dying processes. By the close of the decade, assisted suicide for the terminally ill had achieved an unprecedented degree of approbation in American culture, but how did growing approval of death with dignity impact greater cultural understandings of suicide as a phenomenon?

In short, I argue that the responses to assisted death for the terminally ill, while themselves markers of important progress in the treatment of physically-suffering persons in the 1990's, complicated responses to other suicide deaths. As death with dignity became accepted as a means of dying that both *is* and *is not* considered "suicide," its cultural framing contributed the final branch of the trifurcated cultural response to suicide that I have identified in my study of this decade. Whereas self-delivered deaths to ease terminal suffering received increased support, concurrently and arguably consequentially, the treatment of physically healthy individuals suffering from psychache did not. Subsequently, the understanding of persons who are chronically or acutely suicidal has not kept pace with radical changes in cultural reception of death with dignity practices. Following the exposure of suffering experienced by dying persons growing out of the legal, ethical, and literary movements of the 1990's, an increasingly-growing public audience began echoing George Gulden's assertion that "no one should have to live like that," yet the solitary, non-terminal suicidal person received no such validation. In this way, while the terminally ill population has achieved some measure of re-enfranchisement as a result of the remarkable shift in cultural attitudes toward assisted death occurring in the

1990's, the continued societal stigmatization and disenfranchisement of physically healthy suicidal persons has only worsened.

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Conclusion

Cultural Inheritances and Contemporary Implications

And if one wave breaking says
You're dying, then the rhythm and shift of the whole
says nothing about endings, and half the shawling head
of each wave's spume pours into the trough
of the one before,
and half blows away in spray, backward, toward the open sea.

- Mark Doty, "Becoming a Meadow" (1993)

In titling this dissertation project, I wished to mark the need for continued literary scholarly interventions in the field of suicide studies, while initiating thanatological interventions into the field of literary studies. Through this work, I have sought to unpack the unique culture of suicide existent in America in the 1990's through the analysis of literary texts and cultural moments that gave rise to the trifurcated suicide response that I have theorized in that decade. However, much work remains to be done if we are to realize fully a psychosocial understanding of suicide in all its manifestations; this project seeks to work *toward* such an understanding, and in concluding this work, I will explore some of the cultural implications of suicide in the 1990's specifically as they are inherited in our contemporary moment of American culture. While the above excerpt from Mark Doty's poem, "Becoming a Meadow," lyrically penned at the height of the AIDS crisis, may have spoken initially to death from physical disease, it may also be read as a fitting epigraph through which to consider the experiential reality of suicidal persons in our present moment. Although

we rarely conceptualize the suicidal individual as living within a dying process, he or she is indeed on an unstable trajectory toward death, where the tidal pull of psychosocial pain may bear greater weight than that which is afforded by personal or cultural attention to alleviating such pressure. If the suicidal person is, then, dying, I argue that while part of our cultural response to him or her “pours into the trough” of our inherited conceptions of suicide that were crystallized in the 1990’s, the rest “blows away in spray, backward, toward the open sea,” which is inhabited by persons who are yet to die of suicide. That is, in meditating on our present moment, I argue that the ways in which we respond to suicidal ideation, acts, and deaths are historically inscribed by the unique culture of suicide of the 1990’s, yet these responses remain largely divisive, disparate, and disenfranchising for the suicidal population.

In Chapter 1, I examined American cultural responses to mass deaths of suicide in the 1990’s, namely those of the Branch Davidians in Waco, Texas in 1993 and Heaven’s Gate members in San Diego, California in 1997, and I identified attitudes toward both events as grounded historically in the Jonestown massacre of 1978. Today, however, little cultural attention is paid to domestic “cult” groups; indeed, the history of Jonestown is largely unfamiliar to younger adults who have grown up in the wake of the only American mass death event to surpass Jonestown in its body toll: the murder-suicide terrorist attacks of September 11, 2001, in which nearly 3,000 people were killed (The National Commission on Terrorist Attacks Upon the United States 552). I argue that the events of September 11th altered – but did not eradicate – the type of American cultural response to collective death events driven by suicidal acts that was enacted following Jonestown and Waco. Once a nationwide

collective grief process began over lives lost in a debris-filled New York City, a gaping pit in Stonycreek Township, Pennsylvania, and the smoking Pentagon in Arlington, Virginia, shadowy figures of Jim Jones and David Koresh were replaced in cultural consciousness by the countenance of Osama bin Laden and his often faceless, nameless lieutenants.

Both the mass death events of the 1990's and those of September 11th were contingent upon suicide; the media circus surrounding Waco, for example, and the terrorist attacks were frenzied and literally spectacular. At the root of both events was a male, messianic religious leader arming himself and his people for revolution; both were treated in the press as dangerous, mentally unstable, and evil. However, what distinguished the 9/11 attacks in terms of inherited cultural responses to suicidal mass death events was precisely the same element that begat the protracted War on Terror in a suddenly-xenophobic (again) culture: the messianic figure responsible for the event came from *outside* America, practiced Islamic religious ideology even more foreign to dominant American culture than the radical Christianity of Jones or Koresh, was still alive when the events were over, and commanded an army of persons seemingly willing to die so that Americans could die as well. Rather than doling out cyanide-laden punch to often-unwilling followers in the jungle of Guyana, like Jones, bin Laden could engineer and command the single greatest attack on U.S. land, all while remaining unreachable by authorities of the nation he was infiltrating.

Because of the events of 9/11, American culture is no longer preoccupied with cult suicides per se; the suicide spectacle is no longer found on a compound in Texas but can be located instead in suicide bombings. Media attention over suicide bombings

both domestically and abroad, initiated with the attacks of 9/11 and continuing throughout the War on Terror, have replaced historical responses to “cult” figures of the 1990’s in analogous yet shifting ways. Whereas attitudes toward figures such as Koresh and Applewhite were circulated both to caution and to entertain the American public, the current domestic insistence on terror awareness presents society with a post-bin Laden “any man” – who is faceless, nameless, threatening, outside the fabric of American society, and ready to die so that an ironically rapidly-desensitized American public may die, too. In focusing first on the face of bin Laden, then on those of any “radical,” Muslim, foreign-born male instead of previously-feared (though seemingly unique) religious leaders who enacted mass death events, the cultural response to mass death events driven by suicide has altered little with the change of players but experiences a shift in regard to victims. For whereas the men, women, and children who died in Jonestown, Waco, and San Francisco were blamed for their allegiance to megalomaniacal leaders, deemed deserving of their deaths, and are barely remembered, for those who died in the terrorist attacks of September 11th, we are reminded every year on the anniversary of their deaths of their innocence and deservedness of commemoration, as our country will “never forget” *those* dead.

Unlike responses to collective death events driven by suicidal acts, cultural attention to individual suicide deaths has appeared to have increased since the 1990’s, though without many positive results. The suicide rate in the United States is again climbing; according to the most recently-available data from the Centers for Disease Control and Prevention (CDC), suicide is now the third-leading cause of death for ten- to fourteen-year-old children and the second-leading cause of death for both fifteen- to

twenty-four-year-old adolescents and twenty-five- to thirty-four-year-old young adults (CDC 2015). Until recently, suicide was the third-leading cause of death for adolescents, second to accidents and homicides. While media attention and public response to adolescent suicide specifically would at first suggest a cultural mobilization to stop the suicidal crisis in younger populations, I argue that it is the continuation of stigma and disenfranchisement inherited from the divergent suicide responses of the 1990's that influences directly contemporary framings of suicidal persons as situated in one of two camps: as either "pushed" to die by outside pressures or as too mentally disturbed to continue living.

As an example, the continued treatment of suicidal youth as driven *either* by psychological distress *or* by social pressures fails to account for the dynamic, unique interplay of psychosocial forces that bear upon an individual at risk for suicide, which I explored in Chapters 2 and 3. According to the 2012 assessment of the National College Health Association, "More than 11 percent of college students have been diagnosed or treated for anxiety in the past year [2011] and more than 10 percent reported being diagnosed or treated for depression"; furthermore, "Almost 73 percent of students living with a mental health condition experienced a mental health crisis on campus. Yet, 34.2 percent reported that their college did not know about their crisis" (American College Health Association). At the same time that institutions of higher education are failing to provide adequate support for students in mental health crises,²⁵ the media frenzy surrounding direct and cyber bullying has undercut, rather than

²⁵ See also D. J. Drum and colleagues, "New Data on the Nature of Suicidal Crises in College Students: Shifting the Paradigm" (2009) for suicide-specific research on problematic contemporary responses in higher education.

enhanced, an integrated psychosocial understanding of psychache and suicidality. In the most recent case in the national spotlight, an 18-year-old Massachusetts woman, Brittany Carver, is currently awaiting trial on charges of manslaughter for “encouraging,” via text message, her former boyfriend, 18-year-old Conrad Roy, to die of suicide (Debuquoy-Dodley). Little attention in the media has been paid to pre-existent mental health conditions or social pressures that may have heightened Roy’s suicidality; rather, the focus of circulated narratives is on the idea that Carver’s alleged communications to him “urged” him to die. The consistent oversimplification in media accounts of adolescent suicide remains reflective of a larger, historically-inherited cultural problem in relation to the ways in which American responses to suicide essentialize and stigmatize the experience of suicidality, not merely for adolescents but perhaps most visibly for them.

The death of Edwin Shneidman in 2009 marked the conclusion to over a half-century of work by this pioneering suicidologist. Throughout his career, he urged clinicians and communities alike to recognize the role of psychache in suicidality and to practice anodyne approaches in assisting suicidal individuals to alleviate both the psychological and sociological forces that he recognized as dynamically putting them at risk. Toward the close of his career, he asserted that, “The rule for saving a life in balance can, amazingly enough, be rather simply put: Reduce the inner pain. When that is done, then the inner-felt necessity to commit suicide becomes redefined, the mental pressure is lowered, and the person can choose to live” (201), as opposed to being left with what I term the “choiceless choice” to die of suicide. Unfortunately, and with grave results, American responses to persons who are psychosocially

suffering have not greatly altered since the 1990's, as evidenced by quantitative data on completed suicides, estimates of suicide attempts, and perceptions of mental illness circulated by our cultural institutions. While legal and religious measures indicting suicide have eased in recent decades, a death of suicide still breeds shame, silence, and disenfranchisement in families, communities, and American society at large.

Shneidman counseled that the two basic questions in clinical suicidology should be, "Where do you hurt?" and "How many I help you?" (203). These are questions that do not require clinical experience to ask, but troublingly, they are rarely posed to the suicidal person, who remains isolated in his or her pain within our contemporary society.

Suicidality from psychache today is further complicated when it is experienced by an individual within an already-disenfranchised population. In Chapter 3, I focused on cultural attitudes of the 1990's toward men who have sex with men in the midst of the AIDS crisis, arguing that as this population was deemed "dead already," gay and bisexual men experiencing suicidality were virtually unseen by dominant culture. Although there have been hopeful movements toward identity equality in this country, through both legal measures and the galvanized activity of nonprofit organizations dedicated to sexual and gender identity equality, we are far from treating equitably lesbian, gay, bisexual, transgendered, and queer (LGBTQ) youth and adults under continuing American systems of privilege and inequality. Targeted attention to LGBTQ suicide has largely come from advocates and allies within the community, not from governmental or institutional measures. Yet this attention is clearly not enough, as the CDC estimates that lesbian, gay, and bisexual youth are four times more likely

to attempt suicide than their heterosexual peers, for whom suicide is *already* the second-leading cause of death (CDC 2011).

The effects of social disenfranchisement on suicidality and suicide responses are not, of course, resonant only in the LGBTQ community. Little attention has been paid to suicidality in Native American populations; in elderly persons; amongst the physically disabled; within impoverished and homeless populations; and amongst African-American men and women. Each of these sub-cultural groups has been extensively socially disenfranchised historically and to the present moment, presenting a particular dearth of attuned comprehension of and targeted intervention for suicidality within these populations. Native Americans, whose history of genocide originates with the earliest European settlers of this country, have the highest rate of suicide in the U.S. in terms of racial demographic (CDC 2013), but seemingly because of their now-dwindled population, their death toll from suicide does not warrant national attention. Elderly persons, who have a low rate of suicide generally, may be compromised in sharing psychache or suicidality when cultural insistence on silence in suffering, both mentally and physically, remains strong. The physically disabled, like elderly persons, are taught that to be respected, they must be uncomplaining, making their potential suicidality a taboo topic. Both they and homeless populations must additionally grapple with social attitudes of themselves as burdensome while striving to maintain dignity in the face of prejudice. African-American men and women die of suicide at a significantly lower rate than their white counterparts (CDC 2013), but I suggest that it is perhaps due to the same attitudinal systems of racial inequality that place them at higher risk instead both for incarceration and for homicide that their

individual instances of suicide are treated as unimportant to dominant culture. Simply put, the social disenfranchisement of all of these populations makes more possible crises of mattering for persons who will be as unseen in their suicidality as they are underserved by their society at large.

In examining American cultural responses to physician-assisted suicide today, I find that the momentum of the death with dignity movement in the 1990's, which I analyzed in Chapter 4, has only recently been resurrected on a nationwide platform. Whereas the enactment of the Death with Dignity Act in Oregon in 1997 represented the cumulative efforts of thousands of advocates for terminally ill persons' rights to die and promised to serve as a legal model for future states in offering a precedent for governmentally-sanctioned and regulated assisted death, following the legalization of assisted suicide in Oregon, twelve years passed before a second state, Washington, legalized death with dignity in 2009. In that same year, the Montana Supreme Court ruled that nothing in the state's statutes prohibited a physician from prescribing lethal medication to a terminally ill patient, although legislative action is still pending to ensure the legality of such practices. In 2013, Vermont legalized death with dignity, becoming the third state to do so and the only one to accomplish assisted suicide legalization through legislation as opposed to a ballot referendum.

Notably, in the current (2015) legislative session, twenty-two state legislatures, in addition to the District of Columbia, will have seen a bill proposed to legalize death with dignity by the end of the year. This unprecedentedly-widespread presence of pro-assisted suicide legislative action speaks not only to the continued efforts of the Death with Dignity National Center and other lobbying organizations but also to the recent

and unique attention on death with dignity in the public sphere in the last year. Specifically, the media frenzy surrounding Brittany Maynard, a 29-year-old woman with terminal brain cancer who moved from California to Oregon in 2014 to take advantage of the Death with Dignity Act, spurred public debate and rejuvenated interest in assisted suicide as a topic of ethical inquiry. Partnering with Compassion & Choices, a present-day iteration of the Hemlock Society, Maynard advocated for assisted suicide legalization while modeling her own dying process for the American public. In the weeks prior to her death, she commanded national attention, as news outlets from People and Time magazines to The New York Times and CNN tracked her final days, recounted her life story, and reported on her statements in favor of making death with dignity a choice for all Americans. Her own article, released by CNN on October 14, 2014, titled “My Right to Death with Dignity at 29,” further spurred media attention and public interest in her story and consequentially, in debating the merits of legal options to die for the terminally ill.

The day before Maynard’s death on November 1, 2014, Marcia Angell, the former editor-in-chief of The New England Journal of Medicine, wrote in the Washington Post that Maynard had become, in the span of mere weeks, the “new face” of the assisted death movement, one who had “greatly helped future patients who want the same choice” (Angell). Curiously, after only minimal legal progress in the national assisted suicide movement in the seventeen years following Oregon’s passage of the act, the life and death of one young, well-educated, Caucasian woman was paid more attention than the efforts of the volunteers, lobbyists, and persons dying of assisted suicide had been given for years. In this way, Maynard can be read as

replacing the fictional characters of Kate Gulden in One True Thing or Vivian Bearing in Wit – who were also relatively young, well-educated Caucasian women whose narratives served, as I have argued, to spur on the death with dignity movement in the 1990's. As opposed to encounters with Anna Quindlen's novel or Margaret Edson's drama two decades earlier, the American public bore witness to the dying process of Maynard in real time, in print and on live television, and in doing so, was introduced to a living, representative face for assisted suicide, the future legal outcomes of which remain to be seen.

I conclude this project by reinforcing that the interplay of social, political, ethical, and literary events created a historically-unique understanding of suicide in the 1990's, the effects of which remain with us in our contemporary American moment. Whether or not American society has retained all the figures or theories prevalent in the 1990's, it maintains a resultant trifurcated response toward suicide while evading the dynamic psychosocial understanding of suicide toward which this project works, even with the realization that it is not yet culturally achieved. I close, then, with a call for action in addressing collectively through multidisciplinary psychosocial means the varying ways in which the trifurcated cultural response to suicide requires radical adjustment. Suicide has been and continues to be an overlooked and stigmatized epidemic in our culture. In order to arrest the systematic and individual responses to suicidality that disenfranchise suicidal persons, the dead, and their survivors, we must break silences on suicide, not only in our homes and communities but also and importantly, within the academy. We must seek, through rigorous scholarship, meaningful ways in which to contribute positively to our environments in order to

mitigate the mental and physical suffering of others. Most importantly, it is imperative that we recognize that suicide is a cause of death, not a personal failure, and that each of us has an opportunity – and a responsibility – in ending the epidemic of suicide in our contemporary culture.

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