



ASSEMBLING CRIP ARCHIVES: DISABILITY AND ILLNESS IN NORTH AMERICAN
GRAPHIC NARRATIVES

Coral Anaid Díaz Cano

Tesis doctoral

San Cristóbal de La Laguna, septiembre de 2021

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Escuela de Doctorado y Estudios de Posgrado

ASSEMBLING CRIP ARCHIVES: DISABILITY AND ILLNESS IN NORTH AMERICAN
GRAPHIC NARRATIVES

Coral Anaid Díaz Cano

Tesis doctoral presentada para aspirar al grado de Doctora con Mención Internacional por la
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Programa de doctorado en Arte y Humanidades por la Universidad de La Laguna

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To my parents and brother.

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from their friendship, their passion, and their reading recommendations—and I must say
it is always incredibly rewarding to share our love for the graphic form as fellow fans.

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Resumen

Esta Tesis Doctoral estudia las representaciones de discapacidad y enfermedad en tres narrativas gráficas publicadas en Estados Unidos y Canadá: *Stitches: A Memoir* de David Small (2009), *Marbles: Mania, Depression, Michelangelo & Me* (2012) de Ellen Forney, y *Tangles: A Story about Alzheimer's, My Mother, and Me* de Sarah Leavitt (2010). Se desarrolla un enfoque interdisciplinar que une la teoría crítica de la discapacidad, la teoría *crip*, y los estudios del cómic para examinar cómo los autores de estos textos construyen archivos *crip* donde interpretan sus realidades corporales lejos de discursos normalizadores. La teoría de la discapacidad rechaza la patologización de aquellas personas que no se ajustan a las normas capacitistas. Dentro de este marco, el modelo político/relacional abarca las diversas concepciones de enfermedad y discapacidad, reconociendo que la realidad de esta última puede conllevar trauma, dolor, y, en algunos casos, la necesidad de intervenciones médicas. Asimismo, las prácticas subversivas y contestatarias que nacen dentro de la teoría *crip* tienen el objetivo de crear espacios fuera de los discursos patologizantes para valorar el conocimiento subjetivo de las personas que conviven con la discapacidad en alguna de sus formas. De este modo, tanto las conceptualizaciones del tiempo *crip* como la idea de futuro resultan cruciales para investigar las extrañas temporalidades que emanan de las experiencias expuestas en estas narrativas gráficas. Además, este proyecto emplea la teoría del cómic para vertebrar un estudio de las estrategias que usan los autores para plasmarse a sí mismos en el espacio de la página. Específicamente, el análisis visual se centra en los principales aspectos formales del medio y en la red de conexiones artrológicas que se forman tanto en una única secuencia como a través del mismo texto. El capítulo de *Stitches* ofrece una discusión crítica sobre las complejidades de la discapacidad y su relación con la enfermedad y el dolor. Articulando las representaciones que Small crea de sus propios interiores corporales como potencialidad *crip*, se sugiere que este texto constituye una cripistemología de su vivencia del cáncer y de la pérdida de voz. El análisis de *Marbles* investiga los ricos recursos textuales y gráficos empleados por la autora para visualizar su trastorno bipolar a través de sus distintivas prácticas archivísticas. Compuesto por fuentes internas y externas, el archivo de Forney también exhibe sus exhaustivos procesos de autovigilancia y su turbulenta relación con la medicación. En *Tangles*, Leavitt explota la fragmentación de la forma gráfica para compilar un proyecto *crip* que desestabiliza las concepciones capacitistas del tiempo, mostrando así tanto el cruel, irrefrenable progreso

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del Alzheimer como los preciados momentos que compartió con su madre. En última instancia, esta investigación sugiere que estos archivos *crip* rechazan el posicionamiento negativo de la discapacidad y la opresión médica. En su lugar, idean y ensamblan testimonios gráficos que se resisten a doblarse ante la coherencia capacitista.

Palabras clave

Narrativas gráficas; Discapacidad; Enfermedad; Teoría crítica de la discapacidad; Teoría *crip*; Estudios del cómic; David Small; Ellen Forney; Sarah Leavitt

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Abstract

This dissertation studies three graphic narratives published in the United States and Canada that engage with representations of disability and illness: David Small's *Stitches: A Memoir* (2009), Ellen Forney's *Marbles: Mania, Depression, Michelangelo, & Me* (2012), and Sarah Leavitt's *Tangles: A Story about Alzheimer's, My Mother, and Me* (2010). It develops an interdisciplinary approach that draws on disability studies, crip theory, and comics theory to explore how the authors of these texts construct crip archives to interpret their embodied experiences away from normalizing discourses. Disability studies contests the pathologization of bodyminds that do not conform to ableist norms. Within this framework, the political/relational model encompasses the manifold understandings of disability and illness, acknowledging that the reality of impairment sometimes entails trauma and medical intervention. Similarly, the subversive and contestatory practices produced by crip theorists engage with the most negative, painful aspects of the lived experiences of disabled bodyminds while affirming the knowledges that derive from them. The conceptualizations of crip time and futurity are thus crucial to investigate the uncanny temporalities of disability and illness portrayed in these graphic narratives. In addition, this project builds on comics theory to vertebrate a study of the representational strategies used by these autobiographical cartoonists to capture their drawn selves. Specifically, the visual analysis focuses on the major formal properties of the medium and the network of relationships formed on the page. My reading of *Stitches* offers a critical discussion of the complexities of disability and its linkage to illness and pain. Articulating Small's depictions of his own bodily interiors as crip potentiality, the analysis suggests that this text composes a cripistemology of his situated experience of cancer and voicelessness. My chapter on *Marbles* examines the textual and graphic devices employed by the author to visualize bipolar disorder through her archival practices. Composed of internal and external sources, Forney's archive also exhibits her exhaustive self-surveillance procedures and her refusal to be a passive recipient of healthcare. In *Tangles*, Leavitt exploits the fragmentation of the graphic form to compile a crip project that destabilizes ableist understandings of time, showing both the cruel progress of Alzheimer's disease and the precious moments that she shared with her mother. Ultimately, this research finds that these crip archives reject the portrayal of disabled bodyminds as sources of individual tragedies and medical oppression. Instead,

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they devise and assemble graphic testimonies that resist ableist coherence and compulsory able-bodiedness.

Keywords

Graphic Narratives; Disability; Illness; Disability Studies; Crip Theory; Comics Theory;
David Small; Ellen Forney; Sarah Leavitt

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*The body as home, but only if it is understood that bodies are never singular,
but rather haunted, strengthened, underscored
by countless other bodies.*

— Eli Clare, *Exile and Pride: Disability, Queerness, and Liberation*.

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1. Introduction

“April 28, 2020: Dizziness and fevers start,” reads the first caption of “The Thing,” a comic strip published on the website *The Nib* in May 2021. Written by Colleen AF Venable and drawn by Ellen T. Crenshaw, this autobiographical piece visualizes Venable’s exhausting process of recovering from a mild COVID-19 case during the ongoing pandemic that has altered the lives of millions across the globe. It covers the troubling diagnosis through medical videocalls, the pervading, debilitating symptoms of the illness, and the boredom of a quarantine spent “in a Brooklyn apartment where the windows are all obscured or face brick walls, except one.” At the beginning, the protagonist tackles the situation with a dose of humor: the very first panel depicts her dressed as a cowboy, handling a flamethrower directed at the comically overgrown virus particles that surround her. Similarly, her wittiness appears when she manifests one of the most common symptoms of the illness: “Between being unable to crawl into the shower and fostering a litter of baby rabbits, losing my sense of smell was probably a blessing.” Nevertheless, the last panels embrace a more somber tone, as her extenuating symptoms still appear six months after her diagnosis and leave a lifelong impact on her health: “My lungs still haven’t recovered. I carry inhalers like weapons, one in every pocket. I lost an octave of my singing voice” (Venable and Crenshaw). The story ends with Venable’s cartoonish self sitting alone in a park, mask on, questioning the certainty of a return to “normal” and missing the friends that she has lost to the pandemic in the last year.

This strip is an example of the many stories about COVID-19 told in the hybrid medium¹ of comics, which combines words and images to generate sequential narratives. As comics scholar Hillary L. Chute (2008) observes, this graphic form “doesn’t blend the visual and the verbal—or use one simply to illustrate the other—but is rather prone to present the two nonsynchronously” (“Comics as Literature” 452). The enthralling interaction between these two distinct modes creates a space for meaning that cannot be conveyed in images or words alone—a characteristic exploited by creators who want to capture the manifold experiences derived from this uncanny illness. Certainly, this is the case of public accounts: according to Sathyaraj Venkatesan and Ishani Joshi (2021), the

¹ Hillary Chute emphasizes the importance of understanding that comics is not a genre (which she defines as “a style, a category that comes with a set of approaches and expectations,” such as fantasy, humor, or romance), but a medium “in its own right.” As she asserts, this medium usually “gets mistaken for its most popular genre: superheroes” (*Why Comics* 1-2), but, as I attempt to show in this dissertation, the possibilities offered are much broader.

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production of comics about COVID-19 responds mainly to the necessity to convey complex scientific and medical information about the pandemic to the wider public. Drawn by medical workers, patients themselves, and even caregivers, the accounts employ a wide range of art styles and take advantage of the “visual economy and sequentiality” (Venkatesan and Joshi) of the medium to deliver critical messages during troubling times in which epidemiological data changes almost daily. Even governments in countries like India or South Africa have employed the immediacy and the accessibility of comics to deliver critical evidence about the risk of infection, the importance of wearing masks, or social distancing measures (Venkatesan and Joshi). Unlike infographics or charts, comics² is capable of presenting health data through visual storytelling, which helps the reader to contextualize the impact of contagion (Callender et al. 1062). Thus, this hybrid form can be employed to educate the population on hygienic measures and epidemic spread at a time where quick communication is crucial.

While the prolific linkage between comics and the communication of scientific and medical information merits critical examination, I am particularly interested in the work of autobiographical cartoonists who, like Venable and Crenshaw, experience the workings of medical knowledge in their own skins and turn inwards to explore their own disrupted bodies and minds. Among these works, graphic narratives that engage with disability and illness³ are a productive source to map and inspect. As Chute observes, they have multiplied in the last twenty years, mainly due to the immediacy and the “diagrammatic ability” of the medium to “make visible both external features of a condition, and internal, cognitive and emotional features that are hard to communicate accurately” (*Why Comics* 241-243). In doing so, personal narratives that account for medical symptoms, diagnoses, impairments, and treatments are capable of challenging stereotypes and medical discourses about bodies and minds that fail to meet the standards of what is considered to be “normal.” In both the United States and Canada, there is a

² Following Chute, I will be using the plural noun “comics” followed by a singular verb when referring to comics as a medium (*Why Comics* 1-2).

³ Several terms have been employed to describe memoirs about anomalous bodies: for instance, Anne Hunsaker Hawkins (1999) uses the term “pathography,” which is “a form of autobiography or biography that describes personal experiences of illness, treatment, and sometimes death” (1). According to Sidonie Smith and Julia Watson (2010), “autopathography” refers to “personal narratives about illness or disability that contest cultural discourses stigmatizing the writer as abnormal, aberrant, or in some sense pathological” (*Reading* 261). Another term is “autosomatography,” which defines a memoir “about what it’s like to have or to be, to live in or as, a particular body—indeed, a body that is usually odd or anomalous” (Couser, *Signifying* 2). On the other hand, somatography entails “living *with*, loving, or knowing intimately someone with” an anomalous body (2).

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rich body of graphic narratives about disability and illness where cancer is one of the most common themes, as observed in the popularity of works like Brian Fies' *Mom's Cancer* (2009), which portrays the lung cancer that affects the author's mother, and the breast cancer narratives *Cancer Made Me a Shallower Person* (2006) by Miriam Engelberg and *Cancer Vixen: A True Story* (2009) by Marisa Acocella Marchetto. Other texts depict conditions as diverse as anorexia in Lesley Fairfield's *Tyranny* (2009) or Parkinson's disease in Peter Dunlap-Shohl's *My Degeneration: A Journey Through Parkinson's* (2015). Visual impairment is explored in the recent collaborative graphic memoir *Dancing after TEN* (2020) by Vivian Chong and Georgia Webber, and several other works deal with mental illnesses, like *Hyperbole and a Half: Unfortunate Situations, Flawed Coping Mechanisms, Mayhem, and Other Things That Happened* (2013) by the internet sensation Allie Brosh, who uses humor and strident colors to chronicle her depression. Without a doubt, the richness of the medium and the wide variety of personal stories that illustrate bodily and mental matters make it worth exploring.

As one of the discourses that studies and measures human beings, medicine categorizes bodies and minds into universalized definitions and descriptions. According to physician and cartoonist Ian Williams (2015), the "official" language of medicine and healthcare is constituted through "[t]extbooks, guidelines, and verbal discussion among healthcare professionals," and it is "sanctioned by authority, peer reviewed, and packed with 'objective' and 'evidence-based' propositions" (129). But it is the medical engagement with images and visualization techniques that renders this discipline all-encompassing:

The visual aspects of the discourse are mediated through an analogous official iconography that shows how sick people should look and helps distinguish the "normal" from the "abnormal." The marks of disease on the body are appropriated by medical photographers or illustrators; positioned in "neutral," anatomically "correct" positions and in the "correct" light; and captured in photographs or drawings. Any sense of the individual is removed by cropping off the head, isolating the body part, or blacking out the eyes. (129)

There is almost no surface or part of the body that medicine has not conquered and categorized, removing all the traces and the identities of the individuals categorized as "abnormal." Against this technical language in which illness and disability are inscribed and recorded, autobiographical cartoonists that connect with their situated experiences produce counter-discourses born "from the need to express oneself and, possibly, to challenge the 'medical' authority from which the author feels excluded" (Williams 129). As illustrated by the brief analysis of the strip that opens this introduction, the medium of

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comics proves to be apt for the subjective representation of disability and illness against the objectivity of medical and scientific discourses. A description of the shortness of breath that never seems to disappear, or a picture of the sweaty, fatigued body lying on the bed, unable to move, or even a pictorial brawl with the obnoxious green, round virus—everything is possible in the hybrid space of this form.

The act of drawing and redrawing the self multiple times in a single page reveals the close connection between comics and the physicality of the body, which is especially productive when it comes to the portrayal of these bodies and minds that do not meet normative standards of appearance, health, or ability. In her inquiry of the linkage between comics and disability, Susan Squier (2008) observes that “as a medium combining verbal and gestural expression, comics can convey the complex social impact of a physical or mental impairment, as well as the way the body registers social and institutional constraints” (74). Since the visualization processes of this sequential art bring the body to the page, cartoonists obtain creative freedom to design the appearances, shapes, and gestures that convey their depictions of embodiment, and also the systems, institutions, and discourses through which these bodies—and minds—are restrained.

This PhD Thesis studies three graphic narratives published in the United States and Canada that engage with representations of disability and illness: *Stitches: A Memoir* (2009) by American cartoonist and illustrator David Small, *Marbles: Mania, Depression, Michelangelo, & Me* (2012) by American cartoonist Ellen Forney, and *Tangles: A Story about Alzheimer’s, My Mother, and Me* (2010) by Canadian cartoonist and writer Sarah Leavitt. Each of these works is concerned with visualizing the different embodied realities of living with illness and/or disability in their own unique ways: while Small’s *Stitches* narrates the author’s acquired disability after a surgery to treat cancer removed one of his vocal cords, *Marbles* explores Forney’s struggles after being diagnosed with bipolar disorder at thirty years old, and *Tangles* shows the disruption that Alzheimer’s disease brings to Leavitt’s mother. Most importantly, these three graphic narratives create archival spaces that manifest and enact the plurality of bodies and minds.

These works are but a limited account of the manifold experiences of disability and illness. In fact, there are several North American graphic narratives that could have been included as primary sources, such as *Raised on Ritalin: A Personal Story of ADHD, Medication, and Modern Psychiatry* (2016) by Tyler Page, which chronicles the author’s ADHD, or *Chlorine Gardens* (2018) by Keiler Roberts, which covers Roberts’ struggles

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with pregnancy on top of multiple sclerosis diagnosis. Other examples include *Rx* (2018) by Rachel Lindsay, who, like Forney, grapples with bipolar disorder while producing a critique of medication culture, and *Mis(h)adra* (2017) where Iasmin Omar Ata narrates the life of an Arab-American college student who lives with epilepsy. Even though these are all excellent texts that deserve critical examination, they do not offer the same level of archival engagement as the works that will be studied here. When creating my selection of primary sources, I was actively interested in selecting graphic texts that articulate embodied subjectivity through archiving practices—be it through the inclusion of redrawn photographs, sketches, and indexes, or through an enthralling visualization of bodily interiors. I am thus drawn to the graphic narratives that display the very own traces and inscriptions left by their characters—and authors—on the page.

This project develops an interdisciplinary approach that draws on disability studies, crip theory, and comics theory to explore how the authors of my selected texts construct crip archives to interpret their lived realities away from normalizing discourses. Central to this framework are the prolific understandings of disability studies, which contest the pathologization of bodies and minds that do not conform to ableist norms. The critiques and relationships born within this field produce a dynamic body of theoretical work that enriches the analysis undertaken. Conceptualizations such as the political/relational model of disability offer a vantage point to account for the differences—and the coalitions—between the categories of illness and disability, and to explore the lived reality of impairment, which sometimes entails trauma and the need for medical intervention. Relevant to this study are the subversive ideas developed by crip theorists, which aim to disrupt preconceived binaries such as abled/disabled and body/mind. Furthermore, I build on comics theory to vertebrate my study of the representational strategies used by these autobiographical cartoonists to uniquely capture their drawn selves. Specifically, the visual analysis focuses on the major formal properties of the medium and the network of relationships and connections formed between the different elements on the page. For this purpose, I include pictures of selected panels and pages from these graphic narratives as the textual analysis unfolds and, with the intention of making this dissertation as accessible as possible to blind/visually impaired readers, each image attached here is preceded by a thorough description of its contents and form.

My work articulates a crip reading of three graphic narratives about disability and illness by constructing, revisiting, and repurposing archives, which become a

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fundamental part of this Thesis. A connection between the medium of comics and the archive is found in their peculiar relationship with time, as observed by comics scholar Jared Gardner (2006):

The comics form is forever troubled by that which cannot be reconciled, synthesized, unified, contained within the frame; but it is in being so troubled that the form defines itself. The excess data—the remains of the everyday—is always left behind (even as the narrative progresses forward in time), a visual archive for the reader’s necessary work of rereading, resorting, and reframing. (“Archives, Collectors” 801)

Thus, the very own visual form of comics—where time moves forward through the space of the page through its panels, grids, and rows—mimics the “excess data” of the archive. Either in print or online, comics readers can access the previous data with a turn of the page or a click of the mouse, going back and forth between grids, reworking sequences, and reframing the details of the story. This archival aspect of comics is distinctly enthralling when cartoonists interpret their own bodies and minds before and after they have been affected by illness and disability. I read the making of archives as the act of reworking and repurposing textual and graphic objects that both affect and destabilize the graphic narrative. Therefore, the archival reading deployed here looks at the traces that these authors leave behind and probes records of photographs, sketchbooks, diaries, and scattered notes to analyze how they confirm—or sometimes even contradict—the main body of the narrative. As lived-in archival artifacts, the three graphic narratives studied in this project construct archives that allow their respective authors to understand and interpret their embodied experiences away from the normalizing discourses of science and medicine. Additionally, my reading of illness and disability also accounts for the adversities, the suffering, and the pain that is sometimes embedded in these lived experiences, and the boundless spaces of the crip archive serve to account for that negativity.

This dissertation is divided into seven chapters. After this introduction, chapter 2 engages with comics theory and the study of graphic narratives by examining the formal properties of the medium and its historical roots in North America. Special attention is paid to autobiographical comics, which showcase the power of the graphic form to represent embodiment and subjective temporalities. Then, chapter 3 articulates the critical framework of disability studies and crip theory, beginning with an outline of the contested eugenics and medical models. Their individualized, pathologizing vision of disability is heavily criticized by the social and rights models, which serve as a starting point to delve

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into the notions of ability and normalcy. Understanding disability as a set of assemblages rather than a fixed, delimited definition, I consider the inclusion of mental disability and chronic illnesses within the category of disability. Following this, my reading of crip theory considers the subversive and contestatory notions developed in this field, which challenge pre-conceived binaries and normative, ableist understandings of time and futurity. Building on crip conceptualizations of time and futurity to investigate the uncanny temporalities of illness and disability, I delve into their most negative, painful aspects while acknowledging their value as part of embodied experience.

Chapter 4 examines Small's *Stitches* and offers a critical discussion of the complexities of the lived experience of disability and its linkage to illness and pain. By inspecting the visualizing technology of x-rays, I explore the role of the medical gaze and how David challenges it by scrutinizing his surgical scar in front of the mirror. Close attention is paid to the graphic ways in which Small connects the medical abuse that David suffers in his young body to the disabling neglect that he endures at the hands of his parents. Reading Small's depictions of his own bodily interiors as crip potentiality, the analysis suggests that this graphic narrative composes a cripistemology of voicelessness that deals with his subjective experience away from prying medical eyes. In addition, I draw connections between the queer and crip elements hidden in the text by exploring the character of Betty, David's cold, detached mother.

My analysis of *Marbles* in chapter 5 examines how Forney constructs a crip archive of Bipolar I Disorder in opposition to the medical portrayal of her symptoms. Her rich, enthralling archive is composed of different levels, such as notebooks, autobiographies of famous artists, sketches, photographs, or the many reading materials that the protagonist consults. Forney inscribes bipolar disorder as an embodied experience by employing different formal devices to depict the distinct moods of mania and depression and the disconcerting stages in between. Crucial to the archive and to the management of her disorder is Ellen's self-surveillance notebook, which accounts for the material and emotional costs of monitoring herself and exhibits her active role in her own care. By analyzing Ellen's turbulent relationship with her medication, I delve into *Marbles'* exploration of capitalist ideas of work and productivity. Moreover, the analysis provides a thorough examination of the other archival levels present in the text, such as autobiographies, Ellen's preparatory sketches, retraced photographs, and medical texts. Composed of internal and external sources, Forney's crip archive details her process of

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learning about her disorder while manifesting the complexities of living with a mental disability that requires close management.

Chapter 6 delves into *Tangles*, where Leavitt employs the visual and textual properties of comics to represent the disintegration that Alzheimer's provokes on her mother's body and mind. I study the different temporalities laid out by the author to visualize her mother's pre-disabled and disabled selves. Born in the desperate need to remember and preserve every aspect of her mother, Leavitt's archive is composed of three different levels—Midge's handwritten notes, Sarah's journal, and the interludes between episodes—that allow her to understand her family's crisis and to document her mother's presence, both before and after the disruption that illness brought to her life. In this way, Leavitt assembles a crip project that destabilizes ableist understandings of time, showing both the cruel, relentless progress of Alzheimer's disease and the precious moments she shared with her mother. Lastly, chapter 7 articulates and evaluates a series of conclusions drawn from the critical analysis of my corpus.

This research investigates how these crip archives reject the portrayal of disabled bodies and minds as sources of individual tragedies and medical oppression, assembling and composing visual and verbal testimonies that challenge objective, constricting definitions. In doing so, this dissertation intends to open new paths for the research of graphic narratives that engage with illness and disability. By combining the potential of a crip analysis and the openness of a hybrid medium, it accounts for the creativity embedded in the process of narrating from—and to—the disabled self.

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2. Comics Theory and Graphic Narratives

Real and fictional worlds dwell in the open space of the page, born in the dynamic interactions between words and images. In his famous study *Understanding Comics: The Invisible Art* (1993), cartoonist Scott McCloud states the complex nature of the medium of comics by providing his often-quoted definition: “juxtaposed pictorial and other images in deliberate sequence, intended to convey information and/or produce an aesthetic response in the viewer” (9). Emphasizing its capacity for sequential narration and storytelling, McCloud delivers an insightful study on the medium, focusing on its formal elements, processes, and idiosyncrasies while exploring the versatility of this art form to depict endless possibilities. Comics favors the incorporation of the verbal and the visual, the present and the absent, and everything that happens in between. Precisely, these exceptional characteristics make the medium of comics worth examining.

In the first section of this chapter, I will explore the fruitful vocabulary of comics—panels, frames, pages, layouts, balloons—by drawing on the work of comics scholars such as McCloud (1993), Hillary Chute (2008, 2017), and Randy Duncan and Matthew J. Smith (2009, 2017). Special attention will be paid to the processes of encapsulation, closure, and blending, which provide comics with their unique fragmented texture. Besides, I will rely on Thierry Groensteen’s notion of arthrology (2007) to write about the assembled connections and the network of relationships that unfurl in—and between—sequences and pages. My second section will engage with the rich history and production of this medium in North America. Among the many scholars who have researched this topic, I have chosen the works of Chute (2017), who studies the origins of comics in the United States from their beginnings in the nineteenth century to the popularity of the graphic novel nowadays, and Brenna Clarke Gray (2017) and Candida Rifkind and Linda Warley (2016), who articulate the development of the graphic form in Canada. Drawing on Chute’s discussion on graphic narratives and their extensive potential to represent private stories (2010), the last section will deal with autobiographical comics, applying Elisabeth El Refaie’s (2012) concept of pictorial embodiment to explore the cartoonist’s engagement with their own identity through multiple self-portraits. This chapter will demonstrate that the medium’s capacity for the (re)creation of subjectivity and memory makes it apt for the representation of private stories about disability and illness.

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2.1. The Art of Fragmenting and Assembling

As any other medium, comics has its own language, which has been explored and analyzed by cartoonists and scholars alike. A key element in this context is the panel, defined “as an area on the page (or screen, if one were to view webcomics, for instance) that captures a distinct moment in time” (Duncan and Smith, “How” 10). The strength of this element lies in its ability to act as a “general indicator that time or space is being divided” (McCloud, *Understanding* 99), that is, the contents drawn inside a panel define the durations of the time and the dimensions of the space where the narrative is taking place. This idea can also be explained with the fact that the size, shape, and the content of a panel are employed “to indicate the passage of time in a comic book narrative,” and usually, “the larger the panel, the longer the time span depicted in it” (Duncan and Smith, *Power* 138). Cartoonists have plenty of freedom when choosing and creating the appropriate panels that convey the rhythm of their narratives: for example, a long sequence of events can be depicted within a small panel, but a big panel, occupying one or two pages, can be used to portray “a single instant of time” (138). The frames, or the borders that surround panels, usually appear as a rectangular shape represented by black lines, although they may present variations in size, shape, or color (Duncan and Smith, “How” 11).

The space of the physical page contains the different panels and their surrounding frames, arranged “into strips of panels, or tiers” (“How” 20). The design of the layout, or the specific and deliberate arrangement of the panels on the page, responds to the artistic and communicative vision of the author. For cartoonists, the creation of the layout design is often a challenge, “as they attempt to vary layout from page to page in order to maintain enough visual variety to engage an audience” (Duncan and Smith, “How” 21). While clear page layouts allow the reader to read quickly, an unusual layout “is a means of attracting attention to the images and the comic’s construction, as well as slowing the pace of reading” (Ahmeed 153). In addition, the distribution of the panels affects the reading pattern, which can vary depending on the place where the work is created, among other factors. In the West, for instance, the reading pattern follows a Z, “starting at the top left of the page, proceeding left to right, then down and left to the next tier, and so forth” (Duncan and Smith, “How” 21). However, even though reading patterns are taken into consideration by cartoonists when creating the pages of their works, the very act of reading in comics does not necessarily follow a linear, straightforward arrangement.

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Readers may approach the page with the intention of following the pattern they are most accustomed to, but, as Chute remarks, “[c]ognitively, one’s eye usually first takes in the whole page, even when one decides to start in the upper left corner and move left to right.” In this manner, reading in comics can happen in all directions, which is called “comics’s ‘all-at-onceness,’ or its ‘symphonic effect’” (*Why Comics* 25). Accordingly, comics does not only entail an act of reading and following a narrative, but also an act of “seeing” what the author has created on the page—which is crucial to the three texts that I will be examining in this Thesis. As stated in the introduction, the engagement with the visual is essential in medical settings. Jared Gardner (2015) notes the “drive of late 20th-century medicine to replace patient narratives with data derived from ever more sophisticated diagnostic technologies.” New imaging and diagnostic technologies like x-rays or MRIs “were designed to provide objective insights” at the cost of patients’ subjective narratives (Gardner). As the analysis will show, the pictorial capacity of comics becomes a powerful tool at the hands of cartoonists who aim to depict their own altered bodily and mental realities, thus confronting the constraining objectiveness imposed by the visual cultures of medicine and science.

Another significant aspect of comics is found in the process of encapsulation, which is “the selection of key moments of action” (Duncan and Smith, *Power* 5). In other words, encapsulation is the art of selecting the specific “bits” of the story that will become panels. Since cartoonists cannot depict every single moment in the narrative, they have to decide which scenes—or the “imprecise units of the story that usually, but not necessarily, have unity of time and space and portray a continuous action”—are going to constitute sequences—“[t]he major building blocks of the story” (Duncan and Smith, *Power* 131). Given the creative freedom of the medium, the amount of time encapsulated into a panel may vary from “an instant, a moment, or even a sequence of events” (*Power* 137).

The process of encapsulation and the placement of panels on the page reveal the unique relationship that the medium of comics shares with time and space. In his seminal treaty *Comics and Sequential Art* (1985), Will Eisner already recognized that the “ability to convey time” is “critical to the success of a visual narrative” (26). However, a great deal of this success does not take place in the encapsulated time and the packed space of the panels scattered through the page, but in the timeless emptiness that surrounds them. In this sense, the gutter, or the empty space between panels that appears when two panels are situated next to one another, becomes a crucial narrative element. Although it may

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present variations, most cartoonists employ a bordered gutter, as it is “the clearest indication that there’s a distinction between where the panel’s image goes and where it doesn’t” (Wolk 131). Owing to the open nature of this device, the reader can perform a process that McCloud names “closure,” which is a “phenomenon of observing the parts but perceiving the whole” (*Understanding* 63). While panels are able to “fracture both time and space, offering a jagged, staccato rhythm of unconnected moments,” the readers connect these fragmented, encapsulated moments through the process of closure “and mentally construct a continuous, unified reality” (McCloud, *Understanding* 67). Thus, readers are capable of turning sequences into a narrative that unfolds before their eyes. As his definition of comics “hinges on the arrangement of elements,” McCloud goes as far as to argue that “comics is closure” (67). The magic that happens in the blank, missing spaces of the page is also praised by Chute, who contends that comics “is as much about what is *outside* the frame as what is *inside* it—what can be pictured, and what cannot be or won’t be pictured, and is left to the reader’s imagination” (*Why Comics* 23). This fruitful interaction between panels and gutter allows comics to move “forward in time through the space of the page, through its progressive counter point of presence and absence: packed panels (also called frames) alternating with gutters (empty space)” (Chute, “Comics” 452). Reading comics becomes a task of filling the gaps between panels, reading what is present and what is missing.

The incorporation of verbal content in comics also takes part in the interplay between presence and absence, albeit in a different manner. According to Duncan and Smith, words are present in comics in four different ways: as “dialogue, thoughts, sound effects, and captions” (“How” 15). The dialogues between the characters in the story are depicted inside word balloons usually located next to them and subjected to a great deal of variation in size, shape, and function: they can, for instance, offer access to the thoughts of a character, “usually depicted by scalloped balloons with a trail of cloud-like puffs connecting the speaker to the balloon” (15). While sound effects are expressed by onomatopoeia, usually floating in panels, captions “are typically the words of a narrator or a character off panel superimposed over the panel for explanation or effect” (“How” 16). Additionally, when words are absent from a comic page, readers are demanded to stop and consider what is happening in the narrative. As Douglas Wolk (2007) points out, “[w]ithout language acting as a ‘timer’ or contextual cue for understanding the image, every visual change causes the reader to stop and assess what exactly is happening, and

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how long it's supposed to take" (129). In this way, the absence of verbal content affects the narrative as much as the gutter affects visual narration. Even so, scholars such as Robert C. Harvey (2009) acknowledge the importance of the incorporation of verbal elements in comics, which distinguishes the medium from other pictorial narratives: "in the best examples of the art form," he argues, "words and pictures blend to achieve a meaning that neither conveys alone without the other" (25). Consequently, this blending of the verbal and the visual to reach new meanings is what makes the medium unique.

In view of all that has been mentioned so far, comics is a hybrid form able to produce coherence from fragments and empty spaces, and from the blending of pictorial and textual qualities. But this art does not only draw its strength from fractured spaces and invisibility. As Thierry Groensteen argues, the medium is also capable of connecting and assembling seemingly discordant features: comics "is not only an art of fragments, of scattering, of distribution; it is also an art of conjunction, of repetition, of linking together" (22). Drawing on the field of semiotics and the Franco-Belgian school of comics, Groensteen employs his analysis of the language of comics to coin the notion of "arthrology" (2007). Broadly, arthrology (from the Greek *arthron*, meaning "articulation")⁴ is broadly defined as the connections and relationships produced between panels in a single comics work. He further distinguishes between two main types of relations between panels: the linear type, also called "restricted arthrology," which has to do with the elementary relationship between the panels that compose a single sequence; and the distant or translinear type, named "general arthrology." General arthrology considers that the connections between separate, distinct panels within the same work comprise a network of relations (22). More elaborate and fluid than the previous one, this second type encompasses a network that involves connections between different graphic motifs and images within panels that are repeated throughout the narrative: "Once a graphic motif spreads across the entirety of the network that composes a comic, it can arouse several thematically or plastically differentiated series" (Groensteen 155). Ultimately, these special relationships signal the dynamic capacity of comics for interconnectedness as well as its ability to produce and rework multiple meanings.

⁴ Arthrology also makes reference to the "science concerned with the study of joints," as stated in the Merriam-Webster Dictionary ("Arthrology").

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2.2. Comics in North America

Comics has an extensive and prolific history in North America, having occupied its place in the publishing industry, the markets, and the cultural movements of the United States and Canada. In the introduction to *Why Comics? From Underground to Everywhere* (2017), Chute provides a compelling examination of the development of this art form in the United States. She begins by distinguishing three different categories encompassed within the word “comics” as cultural landmarks that helped shape the historical growth of the medium: first the newspaper comic strip from the 1890s, then the comic book, dated from the 1930s, and finally the graphic novel, “which began as such in the 1970s” (*Why Comics* 6).

As can be seen from Chute’s categorization, the United States has a particularly colorful and productive relationship with the medium. The late nineteenth century saw the appearance of weekly humor magazines that were called “comic weeklies” or simply “comics.” They were mostly focused on comical artwork and eventually developed comic strips, or “narrative series of pictures with words, which began to appear in the mid-1890s” (Chute, *Why Comics* 7-8). These comic strips were often called the “funnies,” a short term for “for the funny papers or funny pages of a newspaper.” In the 1920s, the popularity of the funnies gave rise to “the format of a stand-alone comic book,” which allowed publishers to compile and reprint comic strips previously published in newspapers (*Why Comics* 8). Besides, the funnies associated the medium with youth culture and favored the publication of comic books as they are known today (Chute, *Why Comics* 11). But it was not until 1938 that the publication of *Superman* inaugurated the famous Golden Age of comic books, “making comic books wildly commercially successful” and inaugurating the boom of superhero comics, followed by Batman in *Detective Comics* #27 in the following year (Chute, *Why Comics* 12). Despite its commercial and cultural success, the Golden Age came to a halt with the release of *Seduction of the Innocent* (1954) by psychiatrist Fredic Wertham, which affected the publication and distribution of comic books. Wertham’s study “aimed to establish a link between comic-book readership and juvenile delinquency” and culminated in the creation of the Comics Code by the Comics Magazine Association of America (12). Nonetheless, the censorship practices applied by the Comics Code were not able to stop a Silver Age of comic books in the 1960s, characterized by the rise of a second superhero boom. With Stan Lee working in Marvel Comics, superhero comics began to explore a different path:

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one that did not represent superheroes as archetypes of moral perfection to emulate, as they were during the Golden Age, but “as flawed and neurotic” (Chute, *Why Comics* 13).

American comics continued to grow successfully during and after this Silver Age, establishing a mainstream comics culture that was represented in publishing companies such as Marvel Comics and DC Comics. However, while the second superhero boom was taking place, many cartoonists experienced the need “to work outside of mainstream systems of publication and distribution if they were going to take comics seriously as a form of expression and develop its capacities” (Chute, *Why Comics* 13). This new drive marked the start of the underground comics revolution of the 1960s and 1970s, a key movement “with literary, artistic, and popular force that profoundly shaped contemporary comics.” Taking place mainly in New York and San Francisco, this movement promoted the creation of self-published works produced by independent artists who had no ties to big publishing companies. These works were often renamed as “comix,” the X pointing out their adult nature (13). In this manner, cartoonists “shifted away from the notion that comics had to be action-packed, silly, formulaic, or even slightly inclined toward children” (Chute, *Why Comics* 15). The comics born under this movement were committed to their freedom of expression, and many creators took this opportunity to explore radical and political themes, break taboos, and experiment formally (15). Many groundbreaking feminist and gay titles were created under this movement, such as *Wimmen Comix* (1972) and *Come Out Comix* (1973) (Chute, *Graphic Women* 24).

Challenging the idea that comics were light-hearted products for children and teenagers, underground works contributed to establish this art form for an adult readership. But, according to Chute, it was not until 1986 that comics for adults were fully consolidated with the publication of three key works that shaped the industry at large: *Maus I: A Survivor’s Tale: My Father Bleeds History* by Art Spiegelman; *Watchmen* by writer Alan Moore and artist Dave Gibbons; and *Batman: The Dark Knight Returns* by writer Frank Miller, with art by Miller and Klaus Johnson (*Why Comics* 21). These works were published—and critically acclaimed—under the label “graphic novel,” which had already been employed by Will Eisner in 1978 to promote his seminal work *A Contract with God*. Eisner intended his work to be marketed as a graphic novel “to emphasize its literary qualities,” and in the 1980s the label was used “to identify the auteuristic, individually driven artistic work” (*Why Comics* 16). Nowadays, graphic novel is the term

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used to indicate “book-length comics for a sophisticated adult audience” (*Why Comics* 19-20).

Within the field of comics for adults, American comics have been separated into two broad schools, very different from each other: on the one hand, “mainstream” or “commercial” comics owned by big companies such as Marvel or DC Comics and created “by at least two people, one writing, one drawing—and typically by many more, for instance, people inking and lettering the comics;” and, on the other hand, “independent” or “literary comics,” created by a single person who writes and draws the story (Chute, *Why Comics* 20). Duncan and Smith observe that many alternative and independent comics are autobiographical “and put more emphasis on the author than on characters,” thus recreating the personal vision of the cartoonist (*Power* 66). As will be noted in the last section of this chapter, the ever-growing field of autobiographical comics accounts for many successes in the industry.

The situation of Canadian comics shifts from a development in parallel to the American comics industry to a search for its own market and voice. As Gray points out, the history of Canadian comics in English⁵ is “the story of Canadian culture more generally: starting with a reliance on and expression of British cultural connections, later giving away to the impact of American cultural hegemony, and finally becoming an expression of a unique cultural identity” (62). Before World War II, Canadian comics fans read comics produced in the United States due to the lack of an industry in their own country (Gray 63). However, this situation changed in 1940 with the War Exchange Conservation Act, which restricted the importation of non-essential items from the United States and led to the development of a Canadian comic books industry. The comics published during this period were called “Canadian Whites, a reference to the black-and-white interiors found within brightly colored covers” (63). Canadian Whites featured characters such as Nelvana of the North and Johnny Cannuck, who were “committed to the war effort and had strongly nationalist tendencies” (63). As Gray notes, this Golden Age fell apart with the repeal of the War Exchange Conservation Act in 1951, which brought a collapse for the Canadian comic book industry. Consequently, the period from 1950 to 1970 “was one of complete absence of any Canadian voices in comics, whether

⁵ For a detailed account of Canadian comics that delves into the Québécois tradition, see *The Canadian Alternative: Cartoonists, Comics, and Graphic Novels* (2017), edited by Dominick Grace and Eric Hoffman, and Jean Paul Gabilliet’s “Comic Art and Bande Dessinée: From the Funnies to Graphic Novels” in *The Cambridge History of Canadian Literature* (2009).

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mainstream or alternative” (Gray 64). This silence did not come to an end until “another burst of patriotic identity-building emerged in 1967: Canada’s centennial and the year Canada hosted the World’s Fair with Expo 67 in Montreal,” when the need to define a clear notion of Canadianness brought the creation of Canadian superheroes in the 1970s (64). Captain Canuck, created by Robert Comely and Ron Leishman in 1975, was the most significant superhero of this period, symbolizing “Canadian empowerment” and “a smug anti-Americanism that often shapes the way Canadians define themselves” (Beaty 434; qtd. in Gray 65).

While the 1970s brought success for Canadian superhero comics, it also provided an acclaimed venue for independent and alternative Canadian comics, which reached “domestic and international success” with works such as the acclaimed *Cerebus the Aardvark* (1977) by Dave Sim and Chester Brown’s *Yummy Fur* (1979) (Gray 66). In the introduction to *Canadian Graphic: Picturing Life Narratives* (2016), Candida Rifkind and Linda Warley trace the origins of alternative comics in Toronto in the late 1970s and early 1980s (2). 1986 was also a productive year for Canadian comics due to the growing number of comic book stores and the fact that comics became “increasingly fetishized as collectibles” (Bell 131; qtd. in Rifkind and Warley 2). After a series of ups and downs in the market of alternative Canadian comics, the scene of the 1980s fostered the self-published works of cartoonists Julie Doucet and Chester Brown, “pioneers of contemporary graphic life narratives” (Rifkind and Warley 2). The founding of the publishing house Drawn & Quarterly in Montreal in 1989 contributed to the publication of “complex, sophisticated English-language graphic narratives by both Canadian and international cartoonists” (Rifkind and Warley 2-3). Then, in the 1990s, Montreal was established as the “home” for many North American alternative cartoonists. In fact, Montreal “has long been a hotbed of countercultural and underground literary and cultural activity; it is also a city where North American and European comics traditions co-mingle” (Rifkind and Warley 3). This tradition gave rise to a first generation of alternative Canadian cartoonists, with acclaimed artists such as Julie Doucet, Chester Brown, Guy Delisle, or Seth. And these artists have been followed by a second generation of artists that work in printed and digital formats, such as Ho Che Anderson, Kate Beaton, Emily Carroll, Jeff Lemire, or Jillian Tamaki (3). Gray highlights the production of Native Canadian comics creators such as Michael Nicoll Yahgulanaas, who acknowledges and readdresses the stereotypical, culturally appropriative representation of the First Peoples

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in many Canadian Whites and in Canadian comics in later decades (68). Today, the multiplicity of voices and backgrounds in Canadian comics has enriched the success of the medium, as demonstrated by the number of comics by Canadian authors “earning places on best-of and bestseller lists” (Gray 69).

The appearance of the graphic novel format shaped the industry of comics in North America and the way comics are read and consumed today. But, despite its marketable popularity, the term has been met with resistance by some comic creators and comic scholars. Charles Hatfield (2005) considers that the term “threatens confusion as the graphic novel bids for acceptance within the wider field of literature and criticism” (5). Similarly, Chute points out that graphic novel “can seem pretentious, like a bid for prestige that attaches to the term ‘novel,’” and because “‘novel’ implies fiction, and much of today’s important book length comics work is nonfiction” (*Why Comics* 19). In her own words, “the most riveting comics texts coming out right now—from men and women alike—are not novels at all,” but texts “deeply invested in their own accuracy and history,” which even “reject the categories of nonfiction and fiction altogether in their self-representational storylines” (*Graphic Women* 3). Since it includes both fiction and nonfiction, Chute prefers the term “graphic narrative” over graphic novel, and the success of the groundbreaking autobiographical works *Maus*, *Persepolis* (2000) by Marjane Satrapi, and *Fun Home* (2006) by Alison Bechdel support her argument (*Why Comics* 19). As will be noted in the next section, graphic narratives that deal with personal stories hold special significance in this medium.

2.3. Framing Selves into Panels: Autobiography and Graphic Narratives

Chute’s articulation of graphic narratives and the presence of successful nonfiction work in comics gestures to the close relationship that this medium shares with autobiographical accounts. In fact, the rich interplay between the verbal and the visual offers a unique opportunity to narrate personal, traumatic issues, since

[i]mages in comics appear in fragments, just as they do in actual recollection; this fragmentation, in particular, is a prominent feature of traumatic memory. The art of crafting words and pictures together into a narrative punctuated by pause or absence, as in comics, also mimics the procedure of memory. (Chute, *Graphic Women* 4)

The medium of comic allows for the reproduction of the memories of a lifetime and the cartoonist’s own reflections on these memories, as it is able to give voice to the child protagonist and the adult narrator simultaneously, “even within the space of a single

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panel, layering temporalities and narrative positions.” The page displays “the process of an author interpreting her memory, her recollections, as a visual procedure,” which motivates the representation of hybrid subjectivities in the hybrid and spatial form of comics (Chute, *Graphic Women* 5). This is one of the medium’s most significant tools: granting creators the power to engage with their drawn selves amidst panels, balloons, and frames, alongside their most intimate experiences.

It is precisely this engagement that has fostered the creation of autobiographical accounts in the form of graphic narratives and a subsequent critical production that articulates the representation of the self on the page. In *Autobiographical Comics: Life Writing in Pictures* (2012), Elisabeth El Refaie notes that autobiography⁶ “has become the genre that most defines the alternative, small-press comics production in North America and Western Europe today” (36). Finding its origins in the tradition of the underground comics movement, autobiographical work done in the medium of comics has grown at large in the last decades (El Refaie 38). Being “a deliberate and self-conscious act of *communication*,” autobiography affects the manner in which creators “attend to their memories in the first place, as well as affecting how they select, interpret, and combine their memories into stories” (El Refaie 100). But it is not only about recollecting memories: autobiographical comics also engage with the physicality of the body, which has been one of the key issues in many famous graphic memoirs (El Refaie 95). Through the process of creating their work, cartoonists are required to produce multiple drawn versions of their selves, a practice that El Refaie calls “pictorial embodiment” and that entails a close connection with bodily image and identity: thus, graphic memoir provides artists with the means “to represent their physical identity in ways that reflect their own innermost sense of self” (51). In this way, these cartoonists are repeatedly portraying themselves, many times at different ages and periods of their lives (El Refaie 62). Chute also makes a compelling connection between comics and embodiment, stating that comics is “about locating [bodies] in space and time.” In this

⁶ El Refaie provides a distinction between the terms autobiography and memoir: “[a]n autobiography is often defined as the story *of* a life, whereas a memoir is used to designate a story *from* life” (4). Graphic memoir, then, designates a story from life done in the medium of comics. Another term that refers to graphic memoir is Gillian Whitlock’s “autographics” (2006), which draws attention “to the specific conjunctions of visual and verbal text in this genre of autobiography” (966). Throughout this Thesis, the term “graphic narrative” will be employed in the sense intended by Chute to refer to both fiction and nonfiction work produced in the medium of comics. To refer specifically to autobiographical work in the comics form, the terms “autobiographical comics” and “graphic memoir” will be used interchangeably.

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medium, embodiment “may be read as a kind of compensation for lost bodies, for lost histories. Comics resurrects and materializes” (“Comics Form” 112). The openness and plasticity of comics provide creators with a means of working, recreating, and reframing their own memories and reclaiming their bodily identities; they are therefore able to create their own temporalities within the spatial conventions of the comics form.

The creation of temporalities in graphic narratives sheds light on the underlying subjectivity implicit in the process of devising an autobiographical account. Silke Horstkotte and Nancy Pedri (2016) argue that autobiographical writing maintains a tension “between a *narrating I* (the self who tells) and an *experiencing I* (the self told about),” thus presenting a double temporality that makes autobiography “inherently self-reflexive with regard to both its form (as the narrating I has to make choices regarding the telling of its story) and its concept of subjectivity (as the narrating I reflects on its own earlier self)” (77). This engagement is further convoluted when the autobiographical work is created in the medium of comics, as subjectivity is “(subjectively) represented not only on two temporal layers, but also on two modal tracks, a verbal and a visual one” (77).

The presence of these two tracks contributes to the overall meaning of the autobiographical work and favors the inclusion of markers of subjectivity, visual clues, and knowledge missing from traditional autobiography. Two of the most significant markers are the very act of drawing on the page—which “is much more closely connected with the artist’s hand and body than (type)writing”—and the inclusion of images of the artist sitting at their drawing board (Horstkotte and Pedri 82). Another riveting engagement with subjectivity lies in the fact that many cartoonists write the text of their graphic narratives by hand, using tools such as pens or ink. As Chute remarks, “[c]omics is largely a hand-drawn form that registers the subjective bodily mark on the page; its marks are an index of the body, and its form lends its pages the intimacy of a diary.” In this manner, “[c]omics works are literally manuscripts: they are written by hand” (“Comics Form” 112). The intimacy produced by the handwritten marks on the page, done by the same hand that both writes and draws the story, works hand in hand “with the sometimes visceral effects of presenting ‘private’ images” (Chute, *Graphic Women* 10). The combination of pictorial and textual elements produced by the physical work of the cartoonist’s hand on the page provides information for a reader that actively interacts with the contents of the narrative.

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The tradition of autobiographical comics has produced a varied, rich body of work that started with the publication of Justin Green’s *Binky Brown Meets the Holy Virgin Mary* in 1972, considered by Gardner (2008) to be the first autobiography done in the medium of comics (“Autography’s Biography” 7-8). In *Binky Brown*, Green explored his life with obsessive-compulsive disorder, exhibiting “the process of mental illness from the perspective of the ill” (Chute, *Graphic Women* 17-18). The importance of this work gestures to the importance of bodily and mental matters in this medium: as Chute notes, “[i]t is fitting that Green would choose comics, a medium that is centrally occupied with experiments in spatiotemporal representation, for a narrative marked by an obsession with space and time” (*Graphic Women* 17). Comics’ capacity “to be diagrammatic—representing objects in space and in time, showing and telling” leads cartoonists to engage with the particularities of their encounters with illness and disability, from shedding “light on institutional spaces like hospitals” to illustrating “details like the measurements of a core biopsy needle” (Chute, *Why Comics* 241). As a result, the close involvement with the drawn, embodied self on the page allows for the representation of the most intimate, disorienting—and even painful—experiences of the body and mind.

Cartoonists working in graphic narratives that deal with disability and illness employ the prolific elements of comics to negotiate and rationalize their new, shifting identities and bodies—as well as the losses that their conditions may entail. My own analysis builds on the strengths of this art form: for instance, the notion of arthrology will be especially useful in my fourth chapter, as it grants me the ability to examine the enthralling network of connections that appear in David Small’s *Stitches* (2009), where the author repeats crucial panels and layouts to recreate the pervasive medical gaze on his younger self’s body. And while Ellen Forney disrupts traditional layouts and reading patterns in *Marbles* (2012) to reproduce the distinct embodied moods of mania and depression, the gutter, the blank spaces, and the overall “gappiness” of comics play an important role in Sarah Leavitt’s *Tangles* (2010), as they mimic the symptoms of dementia in Leavitt’s mother. As has been shown in this chapter, comics proves to be fit to represent embodied subjectivity. Its alluring power grants the opportunity to visualize the intricacies and complexities in the lived experiences of cancer, bipolar disorder, and Alzheimer’s disease, therefore building narratives of “lost bodies,” to recall Chute’s words (“Comics Form” 112)—of bodies that will be materialized in the boundless space of the page.

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3. Critical Theories of Disability and Illness

Through history, many social and scientific discourses have attempted to define and classify disability and illness, which has proven to be a difficult endeavor. What counts as “disabled” has varied greatly according to different disciplines and socio-historical contexts: for instance, sociologist Carol Thomas (2007) observes that the “commonsense perspective” assumes that disability is caused by “an injury to the body” through illness, an accident, or a disruption in the development of the fetus during gestation (12). A different view is provided by disability scholar A. J. Withers (2012), who argues that disability is not a fixed category but “a fluid definition that depends not only on the context in which it is defined, but also who defines it” (3). Illness has been described as “the social lived experience of symptoms,” while disease is a term used to denote “a technical malfunction or deviation from the biological norm” (Lupton 93-94; qtd. in James and Hockey 4). Other scholars such as Hester Parr and Ruth Butler (1999) distinguish between transitory illnesses such as the flu, which affect all people’s lives, and chronic illnesses, which involve “a permanent and ongoing bio-physical or psychological condition which normally involves therapeutic interventions” (8). Central to these definitions is the notion of health, as illness “represents an altered state of physical/mental being” that is only able to signify “through contrast with our experience of a different condition, the somatic state called ‘health’” (James and Hockey 12).

But, what is the relation between disability and illness? Thomas Couser (1997) points out that even though the two categories are related, they are different conceptual entities: “The common sense of the difference is that illness is temporary and can be moderated by treatment, if not cured, whereas disability is permanent and can be only moderated by rehabilitation” (*Recovering Bodies* 117). However, this distinction is not completely transparent, because the lived realities of bodies and minds complicate their categorization: while some people that are ill can become disabled, those individuals that live with a physical or sensory impairment are not ill by default. These tensions are worth exploring, as they account for the connection between the two seemingly separated classifications: as Parr and Butler point out, “different mind and body characteristics have perhaps been artificially separated by fixed understandings of what constitutes illness, physical impairment and mental healthiness” (7-8). Individuals that are disabled and/or ill share similar experiences “of frustrating mind/body characteristics, similar disabling structures, social responses and embodied acts of resistance in wider social life” (Parr and

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Butler 8). Besides, these similarities do not stop at the flesh, since the mind can also be affected by disability and illness. In fact, the study of the body/mind division has contributed greatly to the understandings that we have today, as many disability scholars have attempted to disrupt the Cartesian dualism of body and mind—which understands them as separate essences, the first animal, and the latter, human (Cameron, “Bodies” 17). Thus, in this work, mental illnesses will be understood as disorders of the mind that are diagnosed as pathological by medicine and psychiatric practitioners (Packer xx).

The trouble of defining and articulating disability and its relation to illness has given rise to much literature on and various approaches to the topic. Crucial to this project are the models through which scholars have addressed, studied, and delimited disability. In this regard, a model is “a framework of ideas used to make sense of phenomena and experience in the social worlds we inhabit,” and it is employed to represent “a particular way of ordering and structuring knowledge” (Cameron, “Medical Model” 98). Withers makes an extensive distinction between six models “of inventing, understanding and managing the concept of disability within Western societies” (3): the eugenic model, the medical model, the charity model, the rights model, the social model and, finally, the radical model. Precisely because disability is not a fixed category, these models have been inventing and (re)interpreting it, according to different socioeconomic ideals and historical and cultural contexts. They are not fixed, either, but rather are “porous, bleeding into each other or reinforcing one another” (Withers 3). It is my intention to employ some of these models that Withers examines to construct the thread of discussion of this chapter, which allows me to articulate some of the most prominent debates around disability and illness. My aim is to explore the constructions of these two categories under the frameworks of disability studies and the subversive analyses produced within crip theory.

Beginning with the eugenics and medical models, the first section of this chapter will study the controversial construction of disability as an individual’s fault—a painful tragedy that must be eliminated or cured with medical intervention and technology. Michel Foucault’s notions of biopower and surveillance (1963, 1975, 1976) will be useful to examine the medical gaze and the notion of health and its relation to disability. The second section will turn to the social and rights models, which focus their theorization of disability on the inaccessibility of the social and built environment. Tobin Siebers’ notion of ability (2008) and Lennard Davis’ work on normalcy (1995, 1997, 2002) are key terms

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for this analysis. Following this, the third section will investigate the tensions generated within and between disability and illness, especially in relation to the issue of invisibility and the inclusion of chronic illnesses and mental illnesses in the definition of disability. Then, building on Robert McRuer’s notion of crip de-composition (2006), the fourth section will explore the ways in which crip theory and its contestatory understandings of disability and illness disrupt pre-conceived binaries such as abled/disabled and body/mind. Much has been written on the alliances between crip and queer identities, but I will be mainly following the works of McRuer and Carrie Sandahl (2003). Additionally, this section will investigate how crip bodyminds fail at reproducing normativity by drawing on Sara Ahmed’s figure of the killjoy (2010) and queer theorist Jack Halberstam’s concept of failure (2011). Mapping these crip experiences of failure will allow me to introduce the formulations of cripistemology as epistemic knowledges that depart from disabled bodies and minds. Finally, the last section will address crip formulations of time as studied by Alison Kafer (2013) and Ellen Samuels (2017). The arguments developed by Kafer will also serve to position the discourses that have constructed disability as a threat to the future of abled people.

3.1. The Medical Gaze: From Eugenics to Healthcare

Science and medicine have repeatedly attempted to provide a definition of disability suitable for their practices. Scholars often situate the modern medical conceptions of disability in eugenics, which in turn was inspired by the evolutionary theory developed in the nineteenth century. The main idea operating within eugenics is that human evolution can be shaped “in positive ways by engaging in selective breeding” (Withers 13). In this eugenic model, disability is articulated as an inheritable and undesirable trait located in the individual body, and through the process of establishing a dominant group identity, eugenics stigmatizes and marks certain people as unfit to exist in society (Withers 14). In doing so, scientific and evolutionary discourses legitimize the operation of othering those anomalous individuals perceived as a hindrance to the progress of the human species. Eugenics, hence, offers a “solution” to the “problem” that disability creates: by selectively breeding and eliminating the most devalued, deviant members, eugenicists would achieve “a more productive and far less troubled society” (Withers 15-16).

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As modern medicine advanced, the popularity of eugenics declined.⁷ However, eugenics laid the foundations for the modern medical understanding of disability, a clinical approach “which focuses on the use of diagnostic tools to identify pathology and make interventions in that pathology in order to cure or minimize it” (Withers 31). While eugenics intends to completely eradicate disability, the medical model attempts to eliminate and reduce it while also paying close attention to its source (31). Here disability is also seen as an individual fault, located in a body that can be cured and/or improved with the help of medicine and technology. Under this consideration, disabled people are perceived as highly dependent—on both technology and on non-disabled people—and ultimately weak. This belief is developed by experts from the medical-industrial complex, such as “doctors, medical researchers, pharmaceutical corporations, insurance corporations, hospitals and others involved in the medical industry” (Withers 31), who express their views in rigorous scientific and medical terms. Nonetheless, despite the usage of scientific data and facts, the medical model is unable to provide a concrete definition of disability, conceptualizing it instead as “a lack of health and/or functioning” (Withers 33). Health, according to the World Health Organization (WHO), is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (James and Hockey 64). This insistence on “well-being” serves to explore the process of medicalization, which plays an important role in the medical model.

Medicalization takes place when new categories of disability are created according to the changes produced in the social definition of health (Withers 33). That is, when science and medicine decide that an alteration on what they consider the normal state of bodies and minds risks the health of the individual, new classifications of illnesses and/or disabilities conceptualizing that alteration are created, studied, and treated. Besides, the medicalization of the body can occur on several levels, such as “conceptually, when a medical vocabulary is used to define a problem; institutionally, when physicians legitimate a programme or a problem; or on the level of doctor-patient interaction, when actual diagnosis of a problem occurs” (Withers 33). Once the process of medicalization takes place, the medical gaze becomes “the filter that is applied to

⁷ Although the problematics of eugenics are not the focus of the discussion of this chapter, it must be observed that its controversies and practices have not disappeared completely nowadays, as some disability scholars warn (see Campbell 2000). For instance, Margrit Shildrick (2005) remarks the ongoing bioethical debate of “sterilizing ‘at risk’ individuals who are deemed incapable of making informed choices about sex by reason of their mental disabilities” (“Disabled Body” 765).

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medicalized people’s experiences,” and this gaze is “a non-disabled gaze looking at the disabled body” (Withers 39). As a result, the medical gaze sees certain bodily and mental processes as problems meant to be corrected and fixed, instead of accepting them as human variations (Richie 376). Establishing that an individual or group needs to be placed within the medical domain is “an expression of the values and needs of those with power” (Withers 34). In this manner, the process of medicalization is problematic precisely because it is never neutral: it exerts its authority to decide what is considered normal and what is rejected as deviant.

The ideas developed by Michel Foucault (1963, 1975, 1976) contribute to the examinations of the notion of health and its relation to surveillance. It should be noted that, even though Foucault’s arguments do not explicitly refer to disability, they are helpful to explore the medical model’s understandings of both disability and illness. Biopower, one of his key notions, designates the set of mechanisms and techniques “for achieving the subjugation of bodies and the control of populations” (Foucault, *History of Sexuality* 140). It is thus a subtle power over life used to govern populations and discipline individuals, subjecting every aspect of human life to social and political control, and it is exerted with the consent of those who participate in its system. Within discipline, biopower “was embodied in institutions such as the army and the schools, and in reflections on tactics, apprenticeship, education, and the nature of societies” (140). In *Discipline and Punish: The Birth of the Prison* (1975), Foucault delves into the regulation of bodies within systems that employed disciplinary surveillance, such as carceral institutions. Disciplinary power is “exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility” (187). He then employs Jeremy Bentham’s Panopticon to conceptualize “the gaze” which regulates the production of the subject, implying that we are being looked at all the time, by others as well as by ourselves. As he observes, “the major effect of the Panopticon” is “to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power” (*Discipline* 201). Due to its particular arrangement, the Panopticon strips its subjects of their individuality and subjectivity: “The crowd, a compact mass, a locus of multiple exchanges, individualities merging together, a collective effect, is abolished and replaced by a collection of separated individualities” (201).

MachLachlan applies Foucault’s notion of the gaze to the disciplines of healthcare and medicine: as the scientific gaze penetrates the skin and regulates all the inner and

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outer functionings of the individual, it forces them to conform to their own expectations of the shapes and forms that their body must adopt (7). This regulation is observable in many areas of life: for instance, in their analysis of disability welfare in Great Britain, Margrit Shildrick and Janet Price (1999) remark that the external examination of the doctor is complemented by the self-surveillance techniques of the patient, who needs to survey themselves and complete countless forms and paperwork in order to be eligible for benefit. Disabled individuals seeking social welfare willingly internalize the practices of healthcare procedures and become instruments of their own surveying gaze, thus exerting their own self-regulation through disciplinary control (“Breaking Boundaries” 434). In this sense, medicine functions as a disciplinary regime, as health and physical capacity become norms and practices of regulation “that produce the bodies they govern” (Shildrick and Price, “Breaking Boundaries” 433).

In *The Birth of the Clinic: An Archaeology of Medical Perception* (1963), Foucault asserts that the discourse of medicine produces and recreates a concept of normalcy through the observation of both sick and healthy people:

Medicine . . . will also embrace a knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the *model man*. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives. (34)

Consequently, medical knowledge prescribes the proper ways, habits, and procedures that an individual must follow in order to fit into the model of “healthy man.” The alleged objectivity of medical evidence is what grants this discourse the power to create the standard of health: as Couser remarks, modern Western medicine wields its authority based on its presumed expertise and the supposed truth of data. Physicians and doctors exercise their power through the usage “of specialised languages (‘expert-ese’),” which employ terms such as “diagnosis (the identification and description of illness), prognosis (the prediction, or pre-scription, of its course), and therapy (the course of treatment)” (*Recovering Bodies* 19). These terms regulate, universalize, and give meaning to the lived experiences of individual bodies and minds. The power balance favors the medical professional, since doctors can exercise their authority within a discourse that grants them the privilege of ruling over individual bodies (19). Moreover, this power is exercised through institutions that discipline the individual body, “such as the doctor’s surgery, the hospital, the clinic, and through the actions of community health workers” (James and

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Hockey 33). The aim is always to delineate, shape, and correct that which deviates from medical and scientific norms.

Because of its demands of healthy, high-performance bodies and minds, the medical model is complicit with neoliberal and capitalist systems. While physical and mental debility is rejected, health is regarded as the ultimate objective and the aspiration of every individual—a quality to be maintained at all costs in order to keep a productive place within society. The medical model pathologizes the disabled body and mind and conflates illness and disability, problematizing the different experiences of the people that live with them and deciding who is healthy and who is in need of medical intervention. As Cristina Richie (2019) observes, conditions and diseases “which are not harmful to the body become medicalized when they are seen as socially problematic” (383). Under these beliefs, people with disabilities that are otherwise healthy are perceived as in need of medical intervention. Richie provides the example of a blind person, who may face disadvantages due to the lack of sight, but who does not face any illness and is otherwise healthy. In their case, the largest obstacle they must overcome is a society constructed for visually unimpaired people (384). Furthermore, certain incapacities or conditions are medicalized and rejected, whereas others are mainstreamed and accepted because they do not threaten productive labor: the medical model hence “denies and minimizes, through a variety of remedial accommodations, the manifold disabilities that are ‘acceptable’ in polite society, such as aging, hearing loss, and loss of visual acuity” (Iozzio 863; qtd. in Richie 384). It is this power over disability that social activists and scholars question and target by offering an alternative approach entirely focused on people with disabilities.

3.2. Out of the Hospital Aisle: The Social Model

Contrary to the medical and scientific approaches described in the previous section, other understandings have strived to conceptualize disability in a different light, aiming at removing its pathologization and achieving political representation and social rights for disabled people. In the decades of 1960 and 1970, these ideas converged in the two models that will be explored in this section: the rights model, adopted in the United States and Canada, and the social model of disability, developed in the United Kingdom. Since the latter became the “predominant discourse in disability organizing on both continents” (Withers 81), it is the one that I will be paying close attention to. The analyses executed by these models gave rise to new conceptualizations that intended to detach disability from the hospital rooms and from the penetrating medical gaze.

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During the 1960s, disabled people in the United States began to challenge the medical model and its “hegemonic dominance over the definition of disability” through disability organizations inspired by the civil rights and feminist movements (Withers 82). These critiques converged in the rights model, which sought to ensure that people with disabilities had access to equal citizenship rights by eliminating physical, linguistic, and social barriers. This model defined disability as “a characteristic, or a perceived characteristic, for which an individual is treated unequally in society” (Withers 82). For that reason, at the time of its conception, the rights model was perceived to be more useful to disabled individuals than the medical model, because it recognized disabled people as a minority group lacking rights and freedoms in a social context dominated by a non-disabled majority (Davis, “End of Identity” 264). Aiming to remove people with disabilities from the individual tragedy story, the ideas of this model ultimately allowed for a repositioning of disabled individuals within mainstream society.

The social model, which was first named by disability rights activist Michael Oliver in 1973 (Shakespeare), considered that disability is a constructed category and created a distinction between disability and the controversial notion of impairment, which was fundamental for its development. For the first time, a difference was made between those who have disabilities and those who live with impairments. Following the ideas of scholar and activist Lennard Davis (2013), impairment can be defined as “the physical fact of lacking an arm or a leg,” while disability is “the social process that turns an impairment into a negative by creating barriers to access” (“End of Identity” 265). MacLachlan provides a similar definition of disability: “the societal consequences of such an impairment, including cultural and economic disadvantage, oppression of rights, exclusion from society and so on” (71-72). To illustrate the difference between the two terms, Davis proposes the example of wheelchair users: while they have an impairment that limits mobility, they are not disabled if they can carry out their lives in environments equipped with lifts, ramps, or automatic doors (“End of Identity” 265). In this fashion, the social model claimed that disabled people face a disablement promoted by a physical environment and a society that excludes and stigmatizes them, and that said society determines the extent to which a person is disabled by their impairment.

The understanding of disability proposed by the social model allows me to introduce and conceptualize the key notions of normalcy and ability, which are central to the field of disability studies. As a concept, normalcy did not exist in Western society

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before the early-to-mid nineteenth century, since the paradigm was organized around an unattainable bodily ideal that rendered all human beings imperfect in one way or another (Davis, “Bodies of Difference” 100). However, at the beginning of the nineteenth century in Europe, the foundations of what Davis calls “the bell curve”—the idea of the norm that came with the development of statistics—appeared for the first time (100). Under this paradigm, most bodies were considered to be normative and fell under the two extremes of the curve of normalcy, whereas those with abnormal bodies fell beyond its extremes (Davis, “Bodies of Difference” 101). Choosing not to fixate on the disabled individual as an object of study—as the medical model does—Davis explores instead the concept of the norm and the hegemony of the “normal” body (“Constructing Normalcy” 3). A norm is different from “an ideal” in the sense that it “implies that the majority of the population must or should somehow be part of the norm.” The importance of normalcy lies in its engagement with the idea that people with disabilities are considered deviants in a society where the norm dictates that one must be non-disabled (Davis, “Constructing Normalcy” 6). Moving the focus away from the “abnormal,” disabled body and toward the construction of disability as a social problem allows Davis to claim that normalcy and disability are part of the same system (*Enforcing Normalcy* 2).

In *Disability Theory* (2008), Tobin Siebers defines ability as “the preference for able-bodiedness” and “the baseline by which humanness is determined, setting the measure of body and mind that gives or denies human status to individual persons” (8). The ideology of ability affects how we think about human bodies, creating binaries and different standards of values for human beings while describing disability as something that must be avoided at any expense (8). The preference for able-bodiedness refers to the predilection for a body that falls under the norm of the majority, and this preference introduces disability as a threat that “we flee in the past and hope to defeat in the future” (Siebers 9). Under the ideology of ability, then, disability is projected in time through its different historical approaches and the fears that it creates on a society intent on controlling—and sometimes eliminating—bodily and mental deviance with the help of medicine and technology.

Despite the positive aspects of the social model, there are also detractors to some of its fundamental principles. One is Margrit Shildrick (2005), who points out that the social model attempts to flatten the difference between disabled and non-disabled individuals by focusing on gaining access to equal rights and overcoming social and

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physical barriers (“Disabled Body” 767). One of the critiques that Shildrick positions is found in the connection between the social model and employment. Since this model has identified access to the labor market as one of the main barriers that disabled people face, it has sought corrections through the creation of legislation that ensures equal opportunities, such as the *Americans with Disabilities Act* (1990) and the United Kingdom’s *Disability Discrimination Act* (1996) (Shildrick, “Disabled Body” 766-767). In Canada, the fight for the rights of people with disabilities involved their inclusion in the *Canadian Charter of Rights and Freedom* (1982) owing to the actions undertaken by the Council of Canadians with Disabilities and other disability rights groups (Withers 85). According to Shildrick, these Acts “attempt to efface the uncertainty of disability by encompassing the view that everyone, including the disabled, can be productive workers” (“Disabled Body” 767). This excessive emphasis on productivity can be problematic, as “[t]he construction of docile bodies, subject to control, standardization and predictability is accomplished as an act of social justice” (766-767). Thus, the worth of disabled people is measured in their usefulness to a neoliberal system, and equality is reached with the subjection of disabled individuals to the same bodily (and mental) control as non-disabled ones.

Similarly, in “Minority Model: From Liberal to Neoliberal Futures of Disability” (2012), David T. Mitchell and Sharon Snyder criticize the discourses of the rights-based approaches to disability. While society and culture may have moved away from an eugenics vision, disability is now understood within a neoliberal paradigm that sees “all bodies as lacking capacities that are in need of market-based solutions” (42). They identify a difference between a previous era, where autonomous bodies in full capacity were celebrated as the norm to follow—as Davis theorizes—and our current era, where incapacitated, pathologized bodies exploited by late capitalism are becoming the standard to an increasing degree (“Minority Model” 45). This shift towards the pathologization of contemporary bodies goes hand in hand with the increasing neoliberal demands of productivity and the needs of corporations and the pharmaceutical industry, which “promises not to remove but to mask social symptoms as individualised failing” (45).

One of the key ideas developed by Mitchell and Snyder is their usage of the term “ablenationalism,” based on queer theorist Jasbir Puar’s concept of “homonationalism,” which refers to “the politicized normalization efforts taken up by gay rights movement activists in the effort to gain access to dominant social institutions” (“Minority Model”

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42). Homonationalism advances the idea that members of deviant communities that were once marginalized willingly comply with the ideas and norms of the dominant communities in order to gain access and integration (“Minority Model” 46). Applying this term to disability, Mitchell and Snyder coin the parallel concept of ablenationalism to theorize “the ways in which some aspects of disability have entered into the discourse of American exceptionalism as a normative claim” (42). Those disabled individuals that are closest to the norm of the dominant abled majority find inclusion and acceptance, whereas those who are unable to conform to normalcy are rejected integration (Mitchell and Snyder, “Minority Model” 47). In fact, ablenationalism works to select and situate certain anomalous bodies as “effectively and normatively disabled,” creating the representational model of the “able disabled” (47). Composed of “enhanced supercrips”—disabled elite athletes or supermodels, just to provide two examples⁸—the able disabled are celebrated and fetishized by a capitalist and consumerist culture in detriment of the “less able” disabled people (Mitchell and Snyder, “Minority Model” 48). Some disabilities, then, are normalized at the expense of the less accepted ones.

In *Feminist, Queer, Crip* (2013), Alison Kafer proposes the political/relational model of disability, which draws on the main ideas of the social model “but reads them through feminist and queer critiques of identity” (4). In her view, the wide distinction between impairment and disability created by the social model erases “the lived realities of impairment” and “overlooks the often-disabling effects of our bodies” (*Feminist* 7). Bodies and minds can suffer from conditions that are painful, traumatic, and disabling, and focusing solely on overcoming structural and architectural barriers “renders pain and fatigue irrelevant to the project of disability politics.” Besides, people who suffer from chronic illness, pain, or fatigue will not be healed exclusively with changes in their immediate environment (7). Kafer finds another critical issue in the social model’s rejection of medical intervention: some disability scholars and activists working within this model challenge the medical model and its linkage of disability to pathologization, victimhood, and failure. The problem lies in that this confrontation with the medical view of disability can come with a refusal of healthcare procedures on their part and a complete

⁸ The figure of the supercrip has been identified by scholars such as Andrew Spieltenner (2019), who argues that it is “a construction of how disabled people overcome and persevere” intended to reject the existence of physical and mental impairments. The danger of this figure lies in the fact that it “encourages the idea that the only way to exist and have value in this society is to follow a capitalist logic of production” (78). Other examples of supercrips in culture and media include “the autistic young medical doctor whiz kid, the blind person who sees people clearer than the sighted, or the remarkably pretty dying person who falls in love shortly before succumbing to death” (Spieltenner 78).

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denial of problematic feelings, such as pain or depression, because “admitting to struggling with our impairments or to wanting a cure for them is seen as accepting the very framings we are fighting against” (*Feminist* 7-8). While she is wary of the medical model, Kafer is also critical of this trend that prompts disabled individuals to completely reject medical treatment. Thus, her political/relational model does not oppose nor privileges medical intervention in those disabled bodies and minds that want or need it, but instead questions medical practices and recognizes that they are articulated through an ideological basis that defines—and creates—both normalcy and deviance (Kafer, *Feminist* 6). In addition, the political/relational model understands disability as a continuous set of questions, not as fixed answers materialized in firm definitions, and this is crucial to examine the membership of the category of disability: “Can it encompass all kinds of impairments—cognitive, psychiatric, sensory, and physical? Do people with chronic illnesses fit under the rubric of disability? Is someone who had cancer years ago but is now in remission disabled?” (Kafer, *Feminist* 10-11). This engaging discussion gives rise to contested debates that problematize the divisions between disability and illness, which will be explored in detail in the following pages.

3.3. Troubling Categories: Non-apparent Disabilities and “Passing”

As has already been shown, the membership of the category of disability has proven to be particularly difficult to define and apprehend, since bodily and mental variations in humans is manifold and complex. As Judy Roher observes,

There are differences in type of disability (in a reification of the mind/body split, disability is usually broken down as physical or intellectual), in impact (minor hearing loss versus paralysis), in onset (disability from birth/gradually becoming disabled/suddenly becoming disabled), in perceptibility (having a “hidden disability” and “passing” as non-disabled versus being unable to hide a disability), in variability (most disabilities change across time and space), and in prevalence (disabilities vary by sex, ethnicity, age, and environment). (41; qtd. in Shildrick, *Dangerous Discourses* 3)

These profound differences—in type, impact, onset, perceptibility, variability, and prevalence—reinforce the opening idea of this chapter, that is, the difficulty of producing a fixed definition of disability. Relevant to my analysis are the differences in perceptibility, as they are manifested in the issue of invisibility. According to Susannah B. Mintz (2015), invisibility “refers to diseases, conditions, and sensations that cannot be observed externally, such as chronic pain, cognitive or psychiatric impairment, or Deafness.” The term “invisible disabilities” encompasses these disabilities that “present

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unique challenges in a society already prone to suspicion about the reality status of illness and provoked to anxiety by incapacity and pain” (113). Thus, in an ableist society inclined to disregard the existence of disabled people, the experiences of those who do not reproduce the cultural stereotype of disability are further dismissed. “Unless someone identifies herself as disabled,” writes Kafer, “or is visually marked as disabled (for example, using a wheelchair or other mobility aid; carrying a white cane or accompanied by a service dog; or missing a limb or other body part), she is assumed not to be disabled” (“Compulsory Bodies” 80). This assumption is highly problematic: when those with non-apparent disabilities are incorrectly deemed to be able-bodied, they are rejected medical and governmental support and services and often see themselves excluded within disability communities (80).

A compelling example that illustrates these ideas is the case of chronic illnesses as invisible—or non-apparent, to employ Kafer’s term—disabilities, studied by Susan Wendell (2001). Wendell coins the terms “healthy disabled” and “unhealthy disabled” to acknowledge the thorny tensions between disabled identity and medical intervention (“Unhealthy Disabled” 19). On the one hand, her usage of “healthy disabled” includes people with “physical conditions and functional limitations [that] are relatively stable and predictable for the foreseeable future,” and it is an unfixed category with uncertain membership (19). It is mostly composed of people “who were born with disabilities or people who were disabled by accidents or illnesses later in life, but they regard themselves as healthy, not sick, they do not expect to die any sooner than any other healthy person their age, and they do not need or seek much more medical attention than other healthy people” (19). On the other hand, those individuals that are “unhealthy disabled” are affected by chronic illnesses, which are usually understood as “illnesses that do not go away by themselves within six months, that cannot reliably be cured, and that will not kill the patient any time soon,” diabetes and lupus being two key examples (Wendell, “Unhealthy Disabled” 20). They frequently involve symptoms that can be disabling for the person who experiences them, such as “pain, fatigue, dizziness, nausea, weakness, depression, and/or other impairments that are hard to ignore” (“Unhealthy Disabled” 23).

A central idea in Wendell’s analysis is that people with chronic illnesses do not always fit into the cultural picture of disability, as “[t]he paradigmatic person with a disability is healthy disabled and permanently and predictably impaired” (“Unhealthy Disabled” 21). Here is where the issue of (in)visibility comes into play: “passing” often

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marks the difference between healthy and unhealthy people with disabilities, because those who can be perceived as healthy may avoid the prejudices and acts of discrimination that people with more obvious disabilities face in their daily lives (Wendell, “Unhealthy Disabled” 29). Yet, as scholars have also noted, passing as healthy is a tricky issue because it reinforces the idea that disabilities are always visible and easily identifiable, and that what is not visible or evident is not worth taking into consideration (Pieri 564).

3.3.1. Mental Disability and the Problem of Naming

In their disruption of the body/mind dualism, mental illnesses have also produced many tensions within the categorization of disability and illness. To begin with, conceptualizing mental illnesses within disability studies has proven to be troublesome: while disability rights movements have been slow to incorporate the analysis and critiques produced by people with mental illnesses, the social model has been focused on physical impairments while ignoring those who face mental distress. Thus, mental health has been a side-issue within disability studies, which has failed to “adequately conceptualise the experience, phenomenon and constitution of mental health in critical and politicized ways” (Goodley 62; qtd. in Sapey et al. 2). Moreover, naming and classifying altered states of mind has constituted an issue on its own, which Margaret Price (2011) recognizes as “the problem of naming.” As has been stated already, the trouble to name and define disability has been a recurrent topic in disability studies, but it is more noticeable when it comes to the specific disabilities that affect the mind (*Mad at School* 9). To illustrate this point, Price lists the varied terminology used to refer to the impairments of the mind: “*psychiatric disability, mental illness, cognitive disability, intellectual disability, mental health service user (or consumer), neurodiversity, neuroatypical, psychiatric system survivor, crazy, and mad*” (9). Many of these terms are not exempt of criticism: for instance, while the umbrella term “madness” has often been used as “a shorthand for distress, mental illness or disorder,” some mentally ill people reject it and propose the term “distress” to avoid the stigmatization of their conditions (Sapey et al. 6).

What lies at the heart of the problem of naming is the body/mind dichotomy. In her 2015 article “The Bodymind Problem and the Possibilities of Pain,” Price employs the term “bodymind” to articulate the relationship between mental and physical processes and acknowledges that they affect and produce each other (269). I find this term useful to discuss the tensions between physical and mental disability in my analysis, since it accounts for the reality of mental and bodily experiences in a more productive way than

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dealing with body and mind as separated and isolated entities. Accordingly, Price’s conceptualization of bodymind operates within an inclusive definition of disability that reflects the plurality of impairments, conditions, and experiences, which contests the focus on physical disability prevalent in disability studies. In addition, Kafer incorporates the discussions about disordered states of mind to disability studies by employing the term “able-mindedness”—mirroring the term able-bodiedness—as “a way of capturing the normalizing practices, assumptions, and exclusions that cannot easily be described as directed (exclusively) to *physical* functioning or appearance” (*Feminist* 184).

In order to overcome the boundaries between disability, illness, and mental illness, Price draws on the work of Cynthia Lewiecki-Wilson to propose the term “mental disability,” which unites those with psychiatric and cognitive disabilities under the consideration that the disability is found in one’s mind (*Mad at School* 18). This framework does not imply that the disability is literally located in the brain, but that people with mental disabilities can share common experiences with those with other types of disabilities (18). In this manner, mental disability functions as an umbrella term that encompasses “cognitive, intellectual, and psychiatric disabilities, mental illness, m/Madness and a/Autism, as well as brain injury or psychiatric survivorship.” Its aim is not to raise differences between each of these specific subcategories, but to “enable coalition” (Price, “Bodymind Problem” 280). Instead of dividing further into smaller and fixed categories, this strategy unites the diverse experiences of people with different states of mind, attempting to be as inclusive as possible while respecting the individuality of the different embodied realities. Therefore, in this Thesis, the term “mental disability” will be used in its broadest sense to refer to all conditions of the mind, as Price and Lewiecki-Wilson intended, while the term “mental illness” will designate the specific illnesses that mainly affect the mind, such as depression or bipolar disorder.

One of Price’s reasons to avoid the usage of “mental illness” is that it “introduces a discourse of wellness/unwellness in the notion of madness,” as it is linked to “mental health,” a term chosen by the discourses of medicine and psychiatry and social services such as insurance companies. The well/unwell paradigm employed in these discourses is problematic, “particularly its implication that a mad person needs to be ‘cured’ by some means” (*Mad at School* 12). This critique is similar to the rejection of the pathologization of disability as articulated by disability advocates within the social model. The medicalized view of mental health implies that all efforts—from medicine, to therapy, to

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insurance coverages—must be directed at the sole objective of curing the patient. As Price notes, mental health insurance companies demand “progress reports” from therapists and social workers, and they cut off coverage when the patient is deemed to have achieved a sufficiently “well” state (*Mad at School* 12). This need to cure mental disability stems from the demand on hiding the most negative facets of the mind. Andrea Nicki (2001) observes that there is a “cultural demand of cheerfulness” which is especially harmful to “people with depression-centered mental illnesses,” who are forced to mask and deny their disorders (93). Because mental illnesses are not immediately visible to the naked eye, the individuals that live with them are marginalized by an ableist society that assumes “that they can simply ‘snap out’ of their conditions” (Nicki 81). Considering that a person can quickly overcome their condition ignores the reality of depression, which, for those afflicted, “is an undesirable state of unwelcome thoughts and doubts that fill every corner of the mind—the thought of death the worst intruder” (Nicki 95). In a very direct way, these ableist assumptions translate into prejudices, discrimination, and a lack of care and resources for people with mental disabilities. What this cultural insistence on cheerfulness—on being always happy and positive—ultimately reveals is the fear that anyone can suffer from mental distress and, therefore, be vulnerable and demanding of care (Nicki 94).

3.3.2. Assembling Definitions

As has been shown throughout this chapter, the boundaries between illness and disability are diffuse. Feminist scholar Ana Bê (2012) claims that disability studies must rethink its dualistic conceptualization of disability and illness, which in some cases resembles the ideas of the medical model. Besides, disability studies should introduce “more fluid, interlacing and interdependent models that focus on the importance of fostering a standard of well-being in the experience of illness” (368). The creation of these fluid models, such as the political/relational model theorized by Kafer, reconceptualizes our understanding of disabled bodyminds. Other scholars, such as Parr and Butler, argue that sensory impairment, illness, and mental difference are not “entirely separate personal, conceptual and political concerns” (9). The act of blurring the definitions of disability and illness allows for a reinterpretation of the conventional analyses of these two categories and their respective embodied experiences.

Thus, I would like to end this section by exploring the coalitions between disability and illness in order to draw their common ground. Jasbir Puar’s understanding

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of disability as assemblages proves to be a fruitful resource to carry out this task. In *The Right to Maim* (2017), Puar argues that disability exists “in relation to *assemblages* of capacity and debility, modulated across historical time, geopolitical space, institutional mandates, and discursive regimes” (xiv; my emphasis). This argument acknowledges the lack of fixation of disability and its fluid state, affected by time, space, and outside discourses. It also serves to encompass the different types of disability without conflating the varied experiences of bodyminds. Moreover, thinking about disability as a set of assemblages—and as set of continuous questions instead of fixed definitions, to recall Kafer’s political/relational model—serves to alleviate the tensions between the categories of illness and disability while simultaneously disrupting the already confronted body/mind dualism.

To further this argument, I would like to include Kafer’s understanding of disability “not as a category inherent in certain minds and bodies” but as a “collective affinity” (*Feminist* 11). Kafer draws on the work of historian Joan W. Scott, who describes collective affinities as “play[ing] on identifications that have been attributed to individuals by their societies, and that have served to exclude them or subordinate them” (216; qtd. in *Feminist* 11). Regarding disability, collective affinities would include “everyone from people with learning disabilities to those with chronic illness, from people with sensory impairments to those with mental illness.” Consequently, people who face each of these conditions can share disability politics “because all have been labeled as disabled or sick and have faced discrimination as a result” (11). Ultimately, it is a shared experience that joins disability and illness together. As Rosemarie Garland-Thomson (1997) suggests, disability “can be painful, comfortable, familiar, alienating, bonding, isolating, disturbing, endearing, challenging, infuriating, or ordinary. Embedded in the complexity of actual human relations, it is always more than the disabled figure can signify” (14). This subversive challenge that transcends the disabled figure allows me to position the next section of this chapter.

3.4. De-composing Bodyminds: Crip Theory

As previously indicated, the multiplicity of experiences and tensions embedded in the categories of disability and illness generates new knowledges and ideas. I would argue that some of the most interesting developments are happening within the field of crip theory, which will occupy the last two sections of this chapter. Crip theory is a contestatory approach to disability and disability studies that confronts the ableist ideas

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that regulate the social world, aiming to destabilize the negative positioning of disability in order to be able to “imagine truly ‘inclusive’ lifeworlds” (Long 83n7). Indeed, as this section will demonstrate, the approach of crip theory allows for the reconfiguration of the disabled bodymind as a productive site of new opportunities. As Dan Goodley (2017) points out, crip theory offers the possibilities of a queer reading of disability, thus framing the disabled body not only as a site of oppressions but also as a place of potentiality (89). Since disabled people embody othered positions in ableist societies, they “occupy *cripping* positions of subversion, connection and reappraisal” (89). The term “crip,” then, illustrates the potential for subversion.

3.4.1. Queer and Crip Coalitions

According to Carrie Sandahl (2003), sexual minorities and people with disabilities share a “history of injustice,” as “both [groups] have been pathologized by medicine; demonized by religion; discriminated against in housing, employment, and education; stereotyped in representation; victimized by hate groups; and isolated socially, often in their families of origin.”⁹ As a result, queer people and disabled people “have self-consciously created their own enclaves and vibrant subcultural practices,” the most significant affinity between both groups being their opposition to “norms of all kinds (corporeal, mental, sexual, social, cultural, subcultural, etc.)” (26). This similarity is observed in their critiques of the assimilationist tendencies of the fields and theories that preceded them. On the one hand, queer theorists critique feminist and gay and lesbian studies for excluding the most marginalized communities (such as bisexuals or transgender people) while advocating for representation and inclusion without dismantling the social structures that oppress these non-normative groups. On the other hand, disability scholars critique the relegation of disability to academic disciplines such as medicine and the social sciences, which have considered that disability is a problem to

⁹ As Sandahl points out in one of the endnotes of her essay, she employs the term “disability studies” rather than “crip theory” because at the time of writing, crip theory had not gained wide recognition in the academy nor among disability scholars (52n1). Even though disability studies confronts many ableist ideas in academic fields as well as in society, crip theory presents a more radical and contestatory approach, challenging several arguments developed by disability studies, such as its lack of an intersectional approach and its excessive focus on white disabled people. This idea is further developed by Robert McRuer, who states that crip theory “should be understood as having a similar contestatory relationship to disability studies and identity that queer theory has to LGBT studies and identity” (35). This project engages with this understanding of crip theory while acknowledging the usefulness of the analyses developed in the discipline of disability studies.

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be solved and cured, instead of a minority group with its own politics, culture, and history (Sandahl 26).

Another significant aspect of Sandahl’s analysis is her examination of the usage of the word “crip,” which she explores by looking at the term “queer.” She builds on Judith Butler’s usage of queer as a site of collective contestation rather than a specific identity, which must “remain that which is, in the present, never fully owned, but always and only redeployed, twisted, queered from a prior usage and in the direction of urgent and expanding political purposes” (223; qtd. in Sandahl 27). The term crip also signifies more than a specific identity, and it twists and expands to encompass different bodily and mental realities. Crip is the short form of the word “cripple,” which has been used as a derogative term to describe those with physical or mental disabilities. Jay Dolmage explores the etymological origin of this term, accompanied by a description of its sound and its signed properties:

The word “crippled” has impediment built into its consonants (in speech requiring the closure of the vocal tract and the use of the lips). See also the ASL sign for cripple, which utilizes the fingers to call up the slowed movement of the legs. The word is also related to the Old English *creopan*, or *creep*, a word with slowness built into its vowels, but also a word that locates bodies, literally, in the dirt—moving with the belly on the ground. But this is a word that has always been used to also connote the slowness of thoughts, as though the speed of thoughts could ever be clocked! The reclamation of the word *crip*, with its clipped sound, directly addresses the metaphor and the linguistic or rhetorical impact of the term. (103; qtd. in Price, “Bodymind Problem” 269)

Drawing on Dolmage’s description, the term crip is infused with the bodily and mental states of the people it contains: it creeps on the ground, slowly and refusing to stand on two legs, which is emulated by its American Sign Language (ASL) sign. It is hard on the tongue, and it sounds clipped. The slowness of movement and speech is a crip characteristic and gestures to a different way of being and existing in the world, one that is slow and that takes more time in comparison to normal movement. This idea manifests the existence of a crip conception of time, which will be explored in the last section of this chapter.

Due to its potential for expansion and its openness to inclusion, the term crip dismantles ableist ideas of bodyminds.¹⁰ As Sandahl points out, “the term *cripple*, like

¹⁰ Scholars such as Alison Kafer (2013) and Margaret Price (2015) argue that crip theory and crip politics are grounded in the notion of bodymind. The imbrication of mind and body has place in the expansiveness of the term crip, which aims to startle ableist assumptions of both bodies and minds (Kafer 15). According to Price, considering the bodymind allows for the formation of coalitions among the different experiences

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queer, is fluid and ever-changing, claimed by those whom it did not originally define” (27). Both words have undergone processes of rearticulation that have reworked their definitions as terms of empowerment: initially, queer was a pejorative term used against gays and lesbians, but it has been reclaimed by “those who may not consider themselves homosexual, such as the transgendered, transsexuals, heterosexual sex radicals, and others.” In a similar vein, the term *crip* has broadened to include “not only those with physical impairments but those with sensory or mental impairments as well” (Sandahl 27), and today it is used within communities of disabled people that use it as a proud description of their identity.¹¹ This receptivity to change and integration constructs queer and crip as terms from which to wield a contestation towards normative ideals of heterosexuality and able-bodiedness, respectively. By way of illustration, Sandahl quotes the words of academic and activist Eli Clare: “*Queer* and *Cripple* are cousins: words to shock, words to infuse with pride and self-love, words to resist internalized hatred, words to help forge a politics” (70; qtd. in Sandahl 36). Reworking words of injury into words of resistance has been thus a queer and a crip project. On top of that, both queer and crip have their own practices, encapsulated in the verbs “to queer” and “queering,” and “to crip” and “cripping.” For Sandahl, queering “describes the practices of putting a spin on mainstream representations to reveal latent queer subtexts; of appropriating a representation for one’s own purposes, forcing it to signify differently; or of deconstructing a representation’s heterosexism.” Disabled people practice crippling, which twists “mainstream representations or practices to reveal able-bodied assumptions and exclusionary effects” (37). Thus, queering and crippling serve to reveal the thin frontiers that separate what is considered to be “normal” and what is not; in other words, they are practices that collapse the very own idea of normalcy.

In *Crip Theory: Cultural Signs of Queerness and Disability* (2006), Robert McRuer further probes the potentiality of crip identity as a subversive location of cultural production. Drawing on Adrienne Rich’s fundamental concept of “compulsory heterosexuality,” McRuer coins “compulsory able-bodiedness” to theorize the

of disability (“Bodymind Problem” 270). Following their arguments, I will be employing the term “crip bodyminds” in my analysis.

¹¹ There have been certain controversies regarding the usage of the word *crip* within disabled communities. In a 2009 blog entry, Eli Clare discusses the etymology of this term, which has also been used to refer to the Crips, an African American gang based in Los Angeles. Clare attempts to piece together the simultaneous etymologies of “crip” and “Crips,” arguing that both have “long community histories of their own.” It is the first “crip” that calls to him: “I know where crip comes from in disability communities—the long histories of folks who have had cripple used against us” (see “Thinking about the word crip”).

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construction of able-bodiedness and heterosexuality. Central to his analysis is the connection that he draws between these two terms: “the system of compulsory able-bodiedness, which in a sense produces disability, is thoroughly interwoven with the system of compulsory heterosexuality that produces queerness” (McRuer 2). Therefore, the two systems constitute and reproduce a model of the human body that is both abled and heterosexual. Following this line of thought, Kafer defines “compulsory able-mindedness” to capture “the normalizing practices, assumptions, and exclusions that cannot easily be described as directed (exclusively) to physical functioning or appearance” (184n54). Both queerness and disability have the power to disrupt the heterosexual, able-bodied and able-minded “model man” promoted by cultural and social practices.

If, as has been shown, the critique of normalcy has been essential to disability studies and to the disability rights movement, crip theory takes its questioning one step further. Crip theory “takes a sledgehammer to—that which has been concretized” (McRuer 35), refusing to delimit and fix certain types of bodies and abilities as desirable and accepted. It functions “not as a positivity but as a positionality, not as a thing, but as a resistance to the norm” (Halperin 66; qtd. in McRuer 31). It is precisely this refusal to conform and delimit that creates opportunities for the formulation of new meanings and the potential to understand bodies and minds differently. As McRuer argues, queerness and disability are “about collectively transforming . . . the substantive, material uses to which queer/disabled existence has been put by a system of compulsory able-bodiedness,” and, moreover, they are “about imagining bodies and desires otherwise” (McRuer 32). Refusing to position able-bodiedness as the only desirable option gives ground to reconceptualize our understanding of disability and of crip bodies and minds.

One of the crip projects that McRuer articulates is “de-composition,” which entails a challenge to ableist notions of wholeness. By studying the demands of universities and corporate elites on professional and managerial skills that can be assessed through efficient, orderly, written compositions, McRuer suggests that the creation of organized texts is closely linked to the production of the stable, whole, coherent self (152), which is both abled and heterosexual. The institutional conceptualization of composition as a practice set to measure students and workers’ skills preserves “able-bodied hegemony, figuratively and literally constructing a world that always and everywhere privileges very narrow (and ever-narrowing) conceptions of ability” (151). In this way,

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an academic and professional activity such as composition becomes a reflection of the extent to which ableist assumptions are ingrained into every social and cultural activity. This is also observable in the construction of abled and disabled identities: able-bodied identity derives from discordant features that are supposed to form a uniform, ordered whole, like having the proper number of limbs, the proper dimensions of height and weight, unimpaired senses, acceptable mental functionings, having mobility, being free from non-disruptive behaviors and chronic conditions, and so forth (McRuer 156). Disabled identity, conversely, disrupts that wholeness: building on Eve Kosofsky Sedgwick's seminal definition of queer, McRuer defines it as "the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when the constituent elements of bodily, mental, or behavioral functioning aren't made (or *can't be* made) to signify monolithically" (156-157).

Born in that disruption of wholeness, critical de-composition aims to challenge the ableist, disciplinary requirements of coherence and efficiency, rejecting the demands of finished products that springs from heteronormativity (McRuer 155). Away from compulsory ideals, de-composition practices favor working and reworking, disrupting, never finishing nor providing closure. These projects that resist closure and turn instead to access "other possibilities" become "queer/crip projects" (McRuer 159). McRuer intends that disability studies and queer theory "remain locations from which we might speak back to straight composition, with its demand for composed and docile texts, skills, and bodies" (170). With its critique of the heteronormative finished product and its rejection of mandatory cohesion, crip de-composition becomes a practice that valorizes the experiences and realities of crip bodyminds.

3.4.2. The Crip Project of Failure

Another project that both queers and crips know well is failure. In *The Queer Art of Failure* (2011), Jack Halberstam provides a queer reading of this notion that can also be applied to the experiences of those with disabled bodyminds. He begins by acknowledging the importance of negative affects "such as disappointment, disillusionment, and despair" that disturb "the toxic positivity of contemporary life" (*Queer Art* 3). In neoliberal capitalist societies, success is linked to heteronormativity, whiteness, wealth—and I add—ability. While the ideology of positive thinking narrates success as something that happens only to those who deserve it because they have worked hard for it, failure is always a fault of the individual who has not tried hard enough to

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succeed. The danger of these ideals lies in the fact that they ignore the different structural conditions that operate behind oppressions (Halberstam, *Queer Art* 3). Precisely, the binary of success and failure is no alien to disability studies and crip theory. Many discourses—especially the medical and eugenics ones—have conceptualized disability a failure of the bodymind, and only through certain appearances approved by ableist logics can disabled people achieve some resemblance of success—the supercrips and the “able disabled” as exposed by Mitchell and Snyder being an excellent example to illustrate this point.

Even though failure has “darker territories” aligned with “futility, sterility, emptiness, loss, [and] negative affect in general” (Halberstam, *Queer Art* 23), this notion is not inherently negative. For Halberstam, failure offers positive qualities and rewards that are worth exploring: “Under certain circumstances failing, losing, forgetting, unmaking, undoing, unbecoming, not knowing may in fact offer more creative, more cooperative, more surprising ways of being in the world” (*Queer Art* 2-3). Thus, this notion allows us to reap different rewards than those of success: by exploring and mapping different routes and realities we can detour and get lost. And, paradoxically, these detours encompass a way of knowing, because they can lead to other ways of finding—and creating—meaning (Halberstam, *Queer Art* 24-25). For disabled people, taking detours means failing at following the single straight road of success delimited by an ableist society. But that failure can also entail walking paths other than the tragedy story, the life in the hallways of the hospital, or the desperate search for a cure to be abled again. Certainly, Halberstam’s queer idea of failure is also crip, in the sense that it involves de-composing—to apply McRuer’s term—the whole, stable, abled self by failing at reproducing the systems of compulsory able-bodied/mindedness and compulsory heterosexuality.

Despite the fact that Halberstam’s articulation of failure offers a fruitful analysis to crip theory, some crip scholars such as Merri Lisa Johnson (2015) have shown their concerns regarding this term. Building on Mitchell and Snyder’s idea that disability has been described as “the master trope of human disqualification” (3; qtd. in Johnson 253), Johnson claims that crip identity is already embedded in the nastier sides of failure, and that Halberstam does not account for the “lived catastrophe of failure for (some) disabled people” (253). That is, the actual experiences of people with disabilities can be ugly, painful, and overwhelming. Thus, for Johnson, Halberstam pays insufficient attention to

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the many negative affects that accompany this notion, as “[t]he idiom of failure is so enmeshed with actual loss for those of us with psyches-that-shatter” (255). Drawing on her personal experience of mental illness, Johnson argues that failure can entail complete loss for those with “psyches-that-shatter”: in particular, hers involved the near loss of her academic job, the loss of many friendships, and a situation of near bankruptcy (254-255). Nevertheless, Johnson concludes that the positive and negative aspects deserve to be accounted for “in a more precise typology of failure” that acknowledges its pleasures, “embodied in choices to stand apart from social norms of gender, sexuality, reocentricity, and romantic affiliation” and its distress, manifested “in lives gone haywire, symptoms run rampant, personal lives devolving into uninhabitable havoc” (264).

Relevant to the crip project of failure are two key ideas formulated by queer phenomenologist Sara Ahmed: the figure of the killjoy and her conceptualization of unhappy archives. Within a feminist framework, Ahmed defines the killjoy as “the one who gets in the way of other people’s happiness” (“Feminist Killjoys”). The feminist killjoy, then, gets in the way of other people’s happiness by pointing out sexism and gendered oppression within a patriarchal society, since talking about injustices and violence means that one becomes an obstacle in the happiness of other people (“Feminist Killjoys”). Seen as someone who gets in the way of happiness, the killjoy can also be illustrated with Andrea Nicki’s critique on the cultural demand for cheerfulness, which forces those living in the negative aspects of failure to conform to hegemonic standards of happiness, to hide their painful conditions and negate their illnesses so as not to disrupt the happiness of others.

The killjoy is also present in Ahmed’s seminal book *The Promise of Happiness* (2010), where she offers “an alternative history of happiness . . . by considering those who are banished from it, or who enter this history only as troublemakers, dissenters, killers of joy” (17). Observing the lack of studies about unhappiness in philosophical literature, Ahmed assembles what she calls “unhappy archives” (17), developed in contraposition to the “happiness archive” derived from philosophy’s “ideas, thoughts, narratives, images, impressions about what is happiness” (*Promise* 15). Gathered from the challenge against happiness, these unhappy archives thus come from “[f]eminist critiques of the figure of ‘the happy housewife,’ black critiques of the myth of ‘the happy slave,’ and queer critiques of the sentimentalization of heterosexuality as ‘domestic

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bliss” (Ahmed, *Promise 2*). Therefore, the unhappy archives acknowledge these figures banished from normative ideals and considerations of happiness, such as the already mentioned feminist killjoy, the unhappy queer, or the melancholic migrant (17). I would further argue that a crip archive of unhappiness can also be assembled from the many critiques against the medicalization and pathologization of disabled bodyminds and compulsory able-bodiedness and able-mindedness. These crip archives would allow for a recognition of disability not as a tragedy—not as a fixed, individual, stable identity—but as a place of possibilities, where its manifold facets can be taken into consideration. In doing so, they would engage in the task of accounting for both the positive and negative aspects of failure, as Johnson states.

3.4.3. Archival Cripistemologies

Having considered the potential of crip archives, the final part of this section addresses the production of knowledge derived from crip bodyminds—that is, the epistemic knowledge coming from crip experiences of disability and illness, which is called “cripistemology.” As Merri Lisa Johnson and Robert McRuer (2014) explain, the approach of cripistemology allows us to think “from the critical, social, and personal position of disability,” expanding the focus of this knowledge to crip subjectivities composed of “psychological, emotional, and other invisible or undocumented disabilities” (“Cripistemologies” 134). Coined by Johnson in 2010, cripistemology offers an opportunity to question what we know (and unknow) about disability.¹² As has been explained, some disabled individuals may fail to achieve the desired integration into society. However, in that failure, they can find new potential for their own productivity, away from the demands of neoliberal policies. Johnson and McRuer exemplify this idea with Ahmed’s notion of the killjoy, which has been reclaimed by disabled people “as a site of productive misalignment with cultural instructions to be (or act) happy in oppressive circumstances.” And “[i]f a cruelly optimistic culture insists that we fake it till we make it, the crip killjoy refuses to play along” (“Cripistemologies” 136). This crip strategy of refusal thus becomes “a refusal to insist—a refusal to act in accordance with the system of compulsory able-bodiedness—that requires individuals to mask, suppress,

¹² In her contribution to a virtual roundtable on cripistemologies hosted by McRuer and Johnson (2014), Susan Schweik crips the etymological meaning of the word epistemology: “‘Epistemology’: from Greek ‘epistashi,’ ‘knowing how to do’ or ‘understanding,’ with its deeper trace of ‘histasthai,’ to stand (apostasy has the same trace). In ‘cripistemologies,’ ‘crip’ comes up against the core ableist assumption that one must stand in order understand” (McRuer and Johnson, “Proliferating” 155).

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and disregard discomfort in the process of determining what is possible, of what we are capable” (136). It diverts energies to the development of other modes of living that actively challenge the impositions of the healthy, abled, “model mal.” By embracing failure, the crip killjoy refuses to cooperate with neoliberal demands of capacity and productivity, rejecting the concealing of their symptoms, conditions, and deviations, and turning instead to position their disabled bodymind at the center. In this way, this crip approach also enlarges the understanding of disability beyond the single, “stable” physical impairment to include other types of disabilities, such as certain chronic illnesses or mental disabilities—and to accept the most troubling aspects of each of these categories.

An excellent example of a cripistemological practice is Alyson Patsavas’s work in her 2014 article “Recovering a Cripistemology of Pain: Leaky Bodies, Connective Tissue, and Feeling Discourse,” where she focuses on bodily and mental pain as a source of knowledge by and from disabled people. Interweaving crip theory with her personal experiences of pain, treatment, and recovery, Patsavas describes her cripistemology as “a process of knowledge production that situates pain within discursive systems of power and privilege” (205). She critiques the structural conditions that devalue those who live with pain by combining the process of “cripping”—as developed by Sandahl (2003) and already examined in this section—with standpoint epistemology, a philosophy of knowledge central to feminist epistemology that “acknowledges that the subject positions from which we produce knowledge matter” and “grants that marginalized positionalities offer unique vantage points from which to expose systems of oppression” (205). Thus, since disabled people have been historically excluded from the hegemonic, “proper” forms of knowledge production (205), a cripistemology of pain is set to expose the ableist conceptions that have ignored the meaning of pain in disabled bodyminds. For instance, one of these conceptions is the belief that chronic pain is a devastating tragedy that makes life not worth living (Patsavas 203). As Patsavas observes, cultural discourses in the West tend to oversimplify pain, conceptualizing it as the cause of devastating feelings while overlooking the fact that pain is intersected by complex cultural, historical, and political phenomena (204). Cripistemologies serve, then, to devise an alternative archive of knowledge about disability that challenges ableist assumptions and counteracts the eugenic model with its genocidal visions of the present and the future of disability. They recognize the value of situated knowledges about disabled bodyminds produced by

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people with disabilities, by those relegated to the margins—by crips. Most importantly, they reject the pathologizing of disability while accepting that it can be negative, traumatic, and painful sometimes—and that these experiences deserve to be inscribed and verbalized as well.

3.5. Crip Times, Crip Futures

According to Kafer, there are two main temporal frames in the different approaches that attempt to encompass disability: one generated within medical and scientific discourses, and another born in the critiques of disability studies (*Feminist* 25). On the one hand, the analysis of the first framework reveals that the notions of time and futurity have permeated the categories of illness and disability for a long time. Specifically, several disciplines such as medicine have been conceptualizing disability in temporal terms:

“Chronic” fatigue, “intermittent” symptoms, and “constant” pain are each ways of defining illness and disability in and through time; they describe disability in terms of duration. “Frequency,” “incidence,” “occurrence,” “relapse,” “remission”: these, too, are the time frames of symptoms, illness, and disease. “Prognosis” and “diagnosis” project futures of illness, disability, and recovery. Or take terms such as “acquired,” “congenital,” and “developmental,” each of which is used to demarcate the time or onset of impairment. (25)

These terms—many of which have been adopted in our everyday conversations—attempt to apprehend disability and illness in a temporal frame that can be easily quantifiable and measurable, thus homogenizing the diverse experiences of bodily and/or mental distress. On the other hand, disability studies and disability rights movements have also relied on notions of time to articulate their discourses, with the difference that they stress the transitory character of the categories of “non-disabled” and “able-bodied”—and even “temporarily able-bodied”—to remind us that “the abled/disabled distinction is neither permanent nor impermeable” (Kafer, *Feminist* 25). By doing so, these movements reappropriate and reformulate the medical understanding of disability, destabilizing the static picture of disabled and abled bodyminds.

In its own contestatory way, crip theory also engages with the temporalities of disability and illness: it operates with what is known by some scholars as crip time, which entails an entirely different understanding of time, one that acknowledges that people with disabilities navigate a world full of ableist barriers. For this reason, disabled individuals “might need more time to accomplish something or to arrive somewhere” (Kafer, *Feminist* 26). An example of crip time can be found in the case of a person in a wheelchair, who must navigate a building to get to a lift or ramp that allows them to reach their

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destination. It can also be illustrated by those individuals with speech impairments, who take more time than what is considered “normal” to utter an entire sentence; or in the case of a person with a depression-related mental illness whose symptoms make it impossible for them to work full hours, or even to work for days or weeks. Most importantly, crip time does not only mean flexibility and accommodation of those who, due to their non-normative bodyminds, need more time to perform their tasks or simply to exist in the world. It is also, as Kafer claims, a challenge “to normative and normalizing expectations of pace and scheduling,” a challenge that stops normative time to meet disabled bodyminds where they are (*Feminist* 27). In this manner, crip time “is flex time not just expanded but exploded,” and it requires that we recognize “how expectations of ‘how long things take’ are based on very particular minds and bodies” (27). It serves to account for the real, lived ways in which people with disabilities move through and operate in their environment.

Crucial to crip time is its connection with queer ideas of temporality, comprised in the notion of queer time. In *In a Queer Time and Place: Transgender Bodies, Subcultural Lives* (2005), Halberstam locates the emergence of queer time “at the end of the twentieth century, from within those gay communities whose horizons of possibility have been severely diminished by the AIDS epidemic” (2). Back then, the fears and anxieties towards the “constantly diminishing future” led to a new emphasis on the present moment—the “now”—and on the pressing need to exploit the time at hand (2). Queer time disturbs normative formulations of time that assume that there is a clean, linear transition “out of childish dependency through marriage and into adult responsibility through reproduction” (Halberstam, *Queer Time* 153). A key issue for his analysis is reproductive time, which generates and maintains normative logics and “is ruled by a biological clock for women and by strict bourgeois rules of respectability and scheduling for married couples.” Presented as the desirable, logic steps to follow, family time signals “the normative scheduling of daily life (early to bed, early to rise) that accompanies the practice of child rearing” (Halberstam, *Queer Time* 5).

Against these heteronormative logics, queer subcultures imagine their futures outside of “the paradigmatic markers of life experience—namely, birth, marriage, reproduction, and death” (Halberstam, *Queer Time* 2). Thus, queerness is a set of “strange temporalities” (*Queer Time* 1), a formulation that Kafer takes in order to engage with the strange temporalities that spring from medical processes such as diagnosis and prognosis,

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which can be particularly dislocating for those who live with conditions that cannot be fitted into traditional categories: “How might we understand the experiences of those with chronic fatigue and chronic pain, or those with multiple chemical sensitivities (MCS), struggling for years to find a medical professional or social services provider to recognize their impairments?” (*Feminist* 37). The process of inhabiting the world while disabled may involve a sense of being “trapped” in a time that never seems to move forward, especially for those individuals who have not yet received a medical diagnosis or the proper help and accommodations they need. In this vein, Kafer proposes the term “time of undiagnosis” to convey the lost time spent in “the shuttling between specialists, the repeated refusal of care and services, the constant denial of one’s experiences, the slow exacerbation of one’s symptoms, the years without recognition or diagnosis, the waiting” (37). While the perceptions and experiences of time are different for everyone, the conditions of those “unhealthy disabled” put their lives on hold while they wait for their cases to be recognized.

Another claim made by Kafer is that illness and disability can “render time ‘queer’” (*Feminist* 34). Time is a key issue in the production of normalcy, “such that engaging in particular behaviors at particular moments has become reified as the natural, common-sense course of human development” (Kafer, *Feminist* 35). Just like queer people, individuals with altered bodyminds do not always follow the linear development that is expected of an adult in a capitalist neoliberal society: certain illnesses and/or disabilities entail the need of receiving care as well as medical and financial support, thus manifesting that the fiction of the productive, fully independent, and healthy adult is impossible to achieve. And while some experiences of disability and illness may lead to seclusion and avoiding socialization and personal relationships, others entail being unable to reproduce as a consequence of their symptoms or medical procedures, just to name a few examples. Moreover, disability and illness can change the perception of time, causing it “to slow, or to be experienced in quick bursts.” This may “lead to feelings of asynchrony or temporal dissonance; depression and mania are often experienced through time shifts, and people with various impairments move or think at a slower (or faster) pace than culturally expected” (Kafer, *Feminist* 34).

Along the same line, Ellen Samuels (2017) engages with the most negative aspects that permeate crip time. Drawing on her experiences with chronic illness and pain, Samuels acknowledges the difficulty of living with an altered bodymind in a world

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created by and for the abled. Crip time, in her words, is “broken time,” as “[i]t requires us to break in our bodies and minds to new rhythms, new patterns of thinking and feeling and moving through the world” (Samuels). The slowness of crip time can be a source of profound discomfort, because “[i]t forces us to take breaks, even when we don’t want to, even when we want to keep going, to move ahead” (Samuels). In certain occasions, living with a bodymind that experiences disability and/or illness means being unable to follow normative schedules of time, even when the person needs or wants to do so. “Crip time is time travel,” writes Samuels. “Disability and illness have the power to extract us from linear, progressive time with its normative life stages and cast us into a wormhole of backward and forward acceleration, jerky stops and starts, tedious intervals and abrupt endings.” Thus, slowing down and turning inwards can become a negative and frustrating experience when it includes delaying or entirely missing desired situations and life events. This unsought slowness is demarcated by the reality of impairments and conditions, which can sometimes be painful and distressing: “With each new symptom, each new impairment, I grieve again for the lost time, the lost years that are now not yet to come” (Samuels). For those with an acquired disability, the loss of a previous condition of able-bodiedness/mindedness can be met with fears and anxieties about a future that now appears dim and strange.

These fears are in part rooted in what Kafer calls a “nostalgia for the lost able mind/body” (*Feminist* 43). This assumption “[i]llustrates the extent to which the nondisabled body/mind is the default position, as if all bodies/minds are purely abled until something happens to them, as if mind/body variation were not a common occurrence” (43). Precisely, the future has been used as a tool to measure time according to ableist standards that consider disabled individuals as a hindrance to the normative development of life. The term “curative time” is coined by Kafer to refer to the temporal frame applied to disability and to disabled people, which is “an understanding of disability that not only expects and assumes intervention but also cannot imagine or comprehend anything other than intervention” (*Feminist* 27). In doing so, curative time frames disability in a discourse of adequacy, where the only worthy disabled bodymind is the one that has been cured or is at least working towards being cured (Kafer, *Feminist* 28). Here, cure entails “the elimination of impairment but can also mean normalizing treatments that work to assimilate the disabled mind/body as much as possible.” Then, once cured and normalized, disabled people are celebrated as “the sign of progress, the proof of

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development, the triumph over the mind or body” (28). The discourse of curative time considers that disability, impairments, and deviance are conditions that ultimately worsen genetic material, drain medical, material, and governmental resources, and destroy families. Besides, finding a cure for disability justifies oppressive medical interventions and practices such as sterilization, segregation, or institutionalization, which are executed on the premise of worrying about the future of disabled people, and of disabled children in particular (Kafer, *Feminist* 31).

Against the eugenicist logics of controlling the future and erasing non-normative bodyminds, crip theory defends a future in which disability is seen as part of human life. Kafer’s crip project aims at imagining an elsewhere and “elsewhen” that values and understands disability in a different light: “as political, as valuable, as integral” (*Feminist* 3). Imagining accessible realities allows for a rearticulation of the tragedies of disability and illness as opportunities to reclaim futures that reject ableist assumptions and ideals of bodily and mental perfection while accepting—and embracing—bodily and mental deviance. All in all, I would like to finish this chapter by connecting Kafer’s ideas to Robert McRuer’s last sentence in *Crip Theory*: “It’s a crip promise that we will always comprehend disability otherwise and that we will, collectively, somehow access other worlds and futures” (208). I place my work in this crip promise of imagining the categories of disability and illness otherwise, of de-composing ableist assumptions, and of generating alternative possibilities that allow the many different bodyminds to exist.

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4. Drawing the Voice of the Disabled Bodymind: David Small's *Stitches* and the Art of Breaking Silence

In *Stitches: A Memoir* (2009), David Small presents an autobiographical account of his childhood and teenage years in 1950s Detroit. Composed of five parts, Small's coming-of-age narrative portrays his upbringing in an uncommunicative family and the loss of his voice after a cancer diagnosis that resulted in the removal of one of his vocal cords. Certainly, silence and the inability to express oneself with words play an important role in the story: victim of his parents' repression and secrecy, David¹³ undergoes two surgeries at the age of fourteen to treat his cancerous growth without knowing what is happening to him. Forced to deal with a medicalized, altered body, a detached family, and years of lies, he retreats to his visual subjectivity and his artistic creativity to break a life of silence, both physical and emotional. Both a New York Times Bestseller and Winner of the American Library Association's Alex Award—as noted in the 2009 edition by W. W. Norton and Company—*Stitches* resonates with the wider public, offering a window into Small's personal experience.

It is not surprising, then, that *Stitches* has received wide critical attention from a variety of fields and disciplines: for instance, Astrid Böger (2011) and Leigh Gilmore and Elizabeth Marshall (2013) have examined this graphic narrative from the lenses of psychoanalysis and trauma theory. There is also a strong critical production on the role and the perils of vision in *Stitches*, as demonstrated in the works of Ilana Larkin (2014) and Michael A. Chaney (2016). Scholars such as Dale Jacobs and Jay Dolmage (2012), Christina Maria Koch (2016), and Gesine Wegner (2016) have focused on the notion of staring in *Stitches* and the effects of the medical gaze on the disabled body. For Wegner, who frames her study of *Stitches* in the interactions between trauma theory and disability studies, Small engages with the recent trend of including representations of physical pain for a better understanding of the complex experience of disability (5). Wegner accounts for the most negative and painful aspects of disability, which, as has been observed in the previous chapter of this Thesis, have been in occasions disregarded within the field of disability studies. Building on the path opened by these scholars, the analysis that follows

¹³ Given the autobiographical nature of *Stitches*, throughout this chapter I will be using the name "David" to refer to the character in the book, and the surname "Small" to refer to the author who is drawing and writing the pages of this graphic narrative. This practice will be also adopted in the next two chapters of analysis.

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offers a critical discussion of the complexities of the experience of disability—and its linkage to illness and pain—as shown in *Stitches*, while also examining the fruitful crip qualities of this graphic narrative.

In the first section of this chapter, I will draw on the works of Jacobs and Dolmage (2012) and Elisabeth El Refaie (2012 and 2019) to examine the role of the medical gaze in Small’s text with an emphasis on the use of x-ray visualization techniques. By employing skilled arthrological connections, Small reinscribes the medical abuse of David’s body in the neglect he suffers at the hands of his parents, who hide the truth from him. The second section will turn to the portrayal of David’s disabled bodymind. Katalin Orbán (2014) gestures to the connection between Small’s depictions of his embodied subjectivity and the visualizations of the interior spaces of his own body. I am interested in showing how, through his engagement with bodily interiors, Small challenges the medical gaze and constructs an alternative crip archive of knowledge about his experience of cancer and voicelessness. For this reason, the author employs visual cues such as gaps and voids to create a passage to enter—and to encounter—his own disabled bodymind, away from prying medical eyes. Finally, the last section turns to the diverse silences that plague this graphic narrative. Special attention will be given to Betty, David’s mother, as her untold experience of illness and her closeted lesbianism haunts David’s memory. I will draw on Sara H. Beskow (2011), one of the few scholars that pays close attention to the figure of David’s mother, to further analyze the rough relationship between David and Betty. Specifically, the analysis will investigate the queer and crip cues hidden in the verbal and textual qualities of the text to construct an unexpected connection between mother and son. By resorting to his artistic creativity and his therapist’s teachings, David begins to break the many silences that have plagued him throughout his life, which ultimately leads him to step outside the oppressive family home and follow his own path.

4.1. “Surely this is not me”: Cancer, Silence, and the Medical Gaze

Small begins his story with his six-year-old self, a quiet, withdrawn boy who enjoys immersing himself in the act of drawing. The first pages situate the narrative in the city of Detroit in the 1950s—with its smokey chimneys, gray factories, and industrial waste—and invite the reader into the illuminated threshold of his house (see Small 11-13). Inside, David lies on the living room’s floor, crayons in hand, drawing in silence while his mother washes the dishes in the kitchen. The first sound heard in this wordless introduction is presented in fig. 1.1, which contains a first frameless panel of David’s mother, coughing,

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with her eyes completely obscured behind her glasses. The kitchen is barely a blurry, dark scribble behind her. In a frameless caption located above the woman, Small explains the range of sounds coming from his mother: “Mama had her little cough... Once or twice, some quiet sobbing, out of sight... Or the slamming of the kitchen cupboard doors. That was her language” (Small 15). This description is accompanied by four framed panels, the first one illustrating a closed door, illuminated by the light of an open window nearby. Below, three panels depict the woman slamming the kitchen’s cabinets with a scowl on her face. There are no balloons in this composition, as the only words present here refer to the onomatopoeic “WHAP! WHAP!” that signals the action of slamming.



Fig. 1.1. “Mama had her little cough...” (Small 15).

This page serves to introduce David’s mother as a detached, repressed woman unable to verbalize her thoughts and feelings. Her only release seems to be relegated to the noises she is able to make in the two domestic spaces where she is confined: the slamming in

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the kitchen, and the silent sobbing in her locked bedroom. The visual depiction that Small renders of his own mother—her absent eyes, her face lacking warmth or love towards her son—unveils her lack of communication towards David. In this way, she is “entirely unreadable in any communicably human way. Her eyes, the basic vehicle through which humans connect, communicate, and express love, are missing” (Larkin 186). As I will show in the last section of this chapter, her seclusion and her inaccessible demeanor not only affect her way of relating to the world, but also create a lasting, traumatic damage in David.

As Small readily demonstrates, this lack of communication does not only characterize his mother, but it is also exhibited in David’s father, his brother Ted, and David himself. Small introduces a gloomy family atmosphere where all the members seclude themselves to engage in noisemaking: after work, David’s father locks himself in the basement to punch a boxing bag, and Ted beats the drums in his room while David, holding his teddy bear in silence, observes them from a distance (see Small 17). There is no space for words, affection, or a reciprocated look. Predictably, David, as an inhabitant of a wordless house, also inherits this orientation towards speechlessness and ends up developing his own silent language: “And I, too, had learned a way of expressing myself wordlessly...” (Small 18). Small draws his six-year-old self in bed, sweating a fever, while his mother enters the room carrying a tray of food and medicine. In the next panel, she checks his body’s temperature and feeds him cough syrup (see Small 18). On the next page, shown in fig. 1.2, Small chooses a layout composed of two smaller, framed panels where David’s mother picks a teddy bear from the floor and throws it at the boy, and a larger, frameless panel where the child sleeps, embracing his recovered toy. While the blurriness of his room in the background is conveyed through dark watercolors splashed on the page, a small circle of light illuminates the quiet face of the sleeping boy. Below the image, the text reads: “Getting sick, that was my language” (Small 19).

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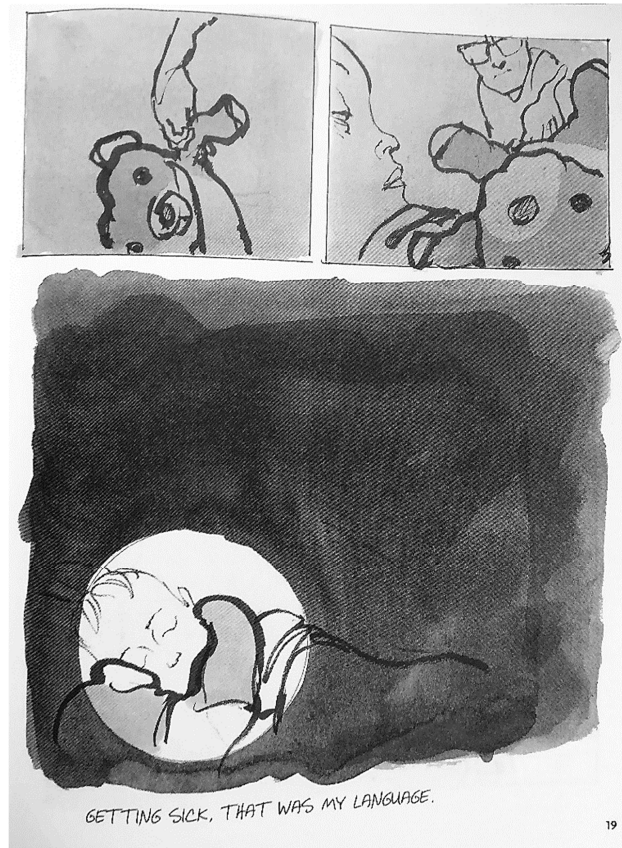


Fig. 1.2. "Getting sick, that was my language" (Small 19).

In his frequent bouts of illness, David finds a way of expressing himself without words, just as the other members of the family communicate through blows, hits, beatings, and loud noises. Besides, illness is what grants David a certain degree of attention from his mother, who only seems to care about him when he lies in bed, sick: even if she shows no love or tenderness towards David, she still provides him with the minimum medical attention during his childhood.

However, *Stitches* does not only present illness as David's means of expressing himself without words and receiving maternal attention: illness is also a physical reality for the boy, a constant issue in his daily life that subjects him to discomfort and pain. Small soon lets the reader know that David was a sick child, "born anxious and angry," with sinuses and a digestive system that "didn't work as they should have" (20). His

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father, a renowned doctor, administered treatments for his ailments since he was born and became the boy's first encounter with the medical system: "Dad prescribed the medicines for my frequent bouts with this and that. Dad gave me shots and enemas. Dad put me on his treatment table and 'cracked my neck,' our family nickname for the osteopathic manipulations he had learned in medical school" (Small 20-21). This description is accompanied of images of David's small body being manhandled, pinched, and probed as he cries in horror and lies inert on the bathroom's floor (see Small 21). But his father's administrations did not stop at basic medical care at home. This treatment, as David learns as a teenager, turned out to be the root of his cancer: "it was dad the radiologist who gave me the many x-rays that were supposed to cure my sinus problems" (Small 21). Following the medical beliefs of the 1960s, which regarded the x-ray as "a wondrous new technology with the ability to cure all manners of disease" (El Refaie, *Visual* 149), David's father regularly administered x-ray shots to his son to treat his asthma and sinus problems.

Since this radiological administration holds special importance in *Stitches*, I would like to draw attention to two key moments where x-rays haunt the narrative. Divided in three rectangular panels of the same size, the silent page shown in fig. 1.3 introduces one of the many occasions when David receives the x-ray shots. The first panel presents a view of the x-ray machine: the x-ray generator is seen from David's perspective, and its dark circle—the tube that produces the x-rays—is pointed at the child. An extreme close-up of David's face is portrayed in the second panel—only his eyes, nose, and mouth—and in the third, an image of the child is seen from afar, alone and tied to the radiology room table as the machinery hovers above him. Fig. 1.4 leaps a few years into the future, to a time when David is already a teenager who has undergone two surgeries to treat his cancer and is facing the loss of one of his vocal cords. The page presents the same layout as fig. 1.3, divided in three rectangular, identical panels. The first one shows the light of a lamp, seen from below, which casts its light on David's face just like the x-ray generator illuminates his childhood face in the previous figure. A close-up of David's face is encapsulated in the next panel, his eyes clearly seen, and his expression more serious and defined. Lastly, David's parents stare at the boy, both with inscrutable expressions and eyes hidden behind their glasses.

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Fig. 1.3. As a child, David receives x-ray shots to treat his sinus problems (Small 22).



Fig. 1.4. As a teenager, David is unable to confront his parents' secrecy (Small 232).

Stitches illustrates the medical gaze through its detailed depictions of the x-ray technology that David was subjected to as a child: as he lies still on the radiology room table, the boy's body is fully accessible and ready to be seen and scrutinized by experts who will then maneuver and categorize it according to medical descriptions and scientific data. As noted in the previous chapter, this medical gaze allows to create a discourse on what is considered "normal" and what is "deviant." The authority of the radiologists is reinforced through David's description of his father and his team as "soldiers of science," able to access the most recondite parts of the body, wielding x-rays as their weapons (Small 27). An image of an army of doctors accompanies the text, all wearing glasses that obscure their indistinguishable faces and standing in the same pose of triumph. Influenced by the wonders of his father's job and the medical beliefs of the time, David characterizes x-rays as "miraculous wonder rays that would cure anything" (27), but, as he later learns years later, this impressive technology hides a nefarious side.

According to Lisa Cartwright, x-rays are "an extreme example of a technique that renders its viewing subject an object of a pervasive disciplinary gaze—a truly radiant gaze—that threatens to perform a quite literal disintegration of the body" (108; qtd. in Koch 33). This idea of radiology as a disciplinary gaze engages with Foucault's articulation of the Panopticon and disciplinary power, which is "exercised through its

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invisibility, at the same time it imposes on those whom it subjects a principle of compulsory visibility” (187). The spatial structure of the Panopticon, reflected in the physical space of the radiology room, renders visibility and control possible: David stays in its center, alone with the x-ray machine, while the radiologists remain outside, observing everything and controlling the device from a crystal screen that renders them invisible—in fact, they do not even appear in the page shown in fig. 1.3. Furthermore, the act of stepping into a radiology room to receive x-ray shots reenacts what Foucault calls the “technique of examination,” through “which power, instead of emitting the signs of its potency, instead of imposing its mark on its subjects, holds them in a mechanism of objectification” (187). In this disciplinary power, the examination is “the ceremony of this objectification” where the subjects are presented as objects “to the observation of a power that was manifested only by its gaze” (Foucault 187-88). Tied to the radiology table, David undergoes a ceremony of visualization of his insides: his bodily surface is accessible and visible while the x-ray generator hovers over him, projecting the rays that will capture a steady, clear image of his interiors that will be later observed and consumed by a medical expert. As the boy lies on that table, he is not “David” but a “patient,” thus becoming the object to be analyzed.

In addition, the visual repetitions found in these pages embed two arthrological connections worth analyzing. The first one deals with the ceremony of visualization, which, as I suggest, also takes place in David’s home: if one pays close attention to the structure of the layout in fig. 1.3, it can be seen that its composition—the x-ray generator above, then David, then the device once again—resembles David’s entrapment between the machine and the radiology room table. Unable to move or go anywhere, he lies still, powerless against the treatment exerted on him. The repetition of the layout structure in fig. 1.4—a source of light, then David, and then his parents—signals that, just as his childhood self is trapped in the medical machinery that takes his radiographs, his teenager self is confined with his parents, who also have full access and visibility to his body while remaining themselves inaccessible. The visual mark of his parents’ inaccessibility is revealed in the depiction of their glasses, which “mask their eyes and make their affective states impossible to fathom” (El Refaie, *Visual* 148). There is yet another connection between these two figures in their portrayal of light casted over David, as they both present a luminous source—the x-ray generator and a lamp—at the top. Throughout this graphic narrative, the usage of spotlights, artificial lights, and illumination engages with

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the visualization of the radiology treatment that David underwent as a child: whenever David has light casted over his body, an exterior force is observing and surveilling him. These ideas lead me to suggest that the connection between figs. 1.3 and 1.4 works not only to show David's subjection to the medical gaze, but also to symbolize the dehumanization that his parents exert on him: David is always rendered visible, illuminated, and accessible for them to scold him whenever they see fit. At the same time, they refuse to reveal the truth about the boy's illness.

The encounters with the x-ray machine still take place into David's teenage years, as radiology remains the instrument that reveals the nature of the growth on his neck, which has not fully developed yet. After the insistence of his parents' colleagues, David visits the hospital to get the lump checked (see figs. 1.5 and 1.6). The page shown in fig. 1.5 introduces a silent sequence that illustrates David's body seen from different angles while he stands still to get his radiograph taken: the first panel depicts the boy seen from above, with a scowl on his face, the second one shows his body seen from the perspective of the x-ray machinery, located behind him, and the last panel presents his profile as he stands pressed against the device. Fig. 1.6 shows the doctor, located on the left side of the first panel, holding the resulting radiograph and exclaiming "Good news, sport!" (Small 132). In the second panel, the doctor explains the contents of the x-ray to David: "Looks like it's only a sebaceous [*sic*] cyst" (132). The boy's mother sits on a chair in the background of the panel, her physical distance from David and the doctor suggesting her lack of involvement in her son's medical issues.

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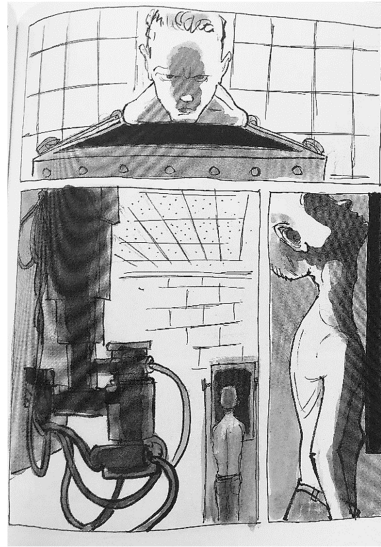


Fig. 1.5. David receives x-ray shots to examine his growth (Small 131).



Fig. 1.6. The doctor explains the contents of the radiograph (Small 132).

Interestingly, while only half of the doctor’s face is visible and his eyes are obscured by thick glasses in the first panel of fig. 1.6, David’s insides are clearly visible: the curvature of his neck, his spine, and the round shape of his growth are accessible to both the doctor and the reader. Moreover, the position of the radiograph in the panel—which is held in a way that it casts a shadow over David’s neck, exactly on the spot where his growth is developing—allows the reader “to study the X-ray, which is drawn in a much more detailed and photorealistic style than the rest of the page, and to try to understand what exactly it is showing us” (El Refaie, *Visual* 149). The reader is then invited to examine the radiograph along with the doctor, participating in the medical gaze exerted on David’s body. Another idea that springs from fig. 1.6 is the inaccessibility of medical images: although in Western medicine doctors follow the custom of showing “visual evidence of cancerous tumors” to patients and their families, these visualizations remain inaccessible to them “and thus not fully comprehensible, even if a medical professional is on hand to provide advice” (*Visual* 145). In fact, the development of “increasingly powerful digital-imaging technologies” in the late nineteenth century made the interiors of the body accessible to medicine, but the interpretation of the images developed by this technology “requires the mediation of the medical gaze” (El Refaie,

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Visual 128). Even though technology provides a clear vision of the insides of the boy, only an educated medical expert has access to the meaning of such an image, who then must decipher and explain its contents to David and his mother.

As seen in the previous examples, the way in which Small draws and encapsulates this graphic narrative directs the reader to follow the diagnostic process led by a medical expert, thus recreating the effects of the medical gaze over David's body. This idea is also exhibited in the next two figures, which depict David's childish attempts to understand what a growth is and the recognition, years later, that one is growing on his own neck. The scene shown in fig. 1.7 takes place during David's childhood, when he and Ted sneak into his father's home office. With David peering over his shoulder, Ted skims through one of his father's medical textbooks, looking at its depictions of bodies and close-up images of genitals. The older brother then explains his findings to his curious younger brother: "That's a titty! That's a man's thing" (Small 53). The children soon find a picture of a cancerous growth on a man's neck, which David meets with a mixture of astonishment and repulsion. Not knowing how to categorize it, he asks Ted: "Eeuw! And what's that? A titty? A thing?" (see fig. 1.7). In the second panel, Ted explains the contents of image to the younger boy: "No, stupid. That's a growth" (Small 54). Interestingly, David does not immediately start asking more questions about the growth, as he did while staring at pictures of genitals: instead, he stares in silent confusion. The third panel displays a close-up of his furrowed eyebrows, and the next three panels of the sequence zoom into the image that the child is seeing.

Then, years later, David sees a growth in real life for the first time, on his neck. The first framed panel of fig. 1.8 contains a close-up of David's face as he stares at his own reflection in the bathroom mirror. On the right side of the panel, next to his face, there is a smaller, frameless panel that repeats the scene shown in fig. 1.7: David and Ted as children, lying on the floor and going through their father's medical textbook. The eyes of teenager David widen in recognition: his neck now looks like the neck of the photographed man he saw as a child. Along with this realization, David also recalls his brother's explanation: "That's a growth" (Small 118). Below, a frameless panel repeats the medical picture of the man's growth with vivid detail and a black background.

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Fig. 1.7. David and his brother stare at their father's medical textbook (Small 54).



Fig. 1.8. As a teenager, David notices a growth on his own neck (Small 118).

According to Jacobs and Dolmage, the panels featured in fig. 1.8 exemplify Thierry Groensteen's notion of general arthrology, "as both of these panels are linked to previous panels through the network of the memoir as a whole" (81). The repetitions of the image of the medical textbook and the two children staring at it produce a "reinscription of meaning" that forces David "to synthesize or assimilate both the Othering of the medical gaze and a newly unfamiliar sense of self" (81). To recall Malcom MacLachlan's arguments (2004), shown in the previous chapter, this scientific and medical gaze forces individuals to conform to their own expectations of the shape that their bodies must adopt (7). The repetition of the growth signals David's recognition of "something unnatural" growing in his own body—something that does not take the shape of what a healthy neck should look like. David is thus internalizing the medical gaze and exerting it on himself: as he inspects his neck in the mirror, he immediately associates his own reflection with the medicalized image found in his father's medical textbook. For Wegner, the images of the medical textbook allow the reader to track the evolution of the illness in David's body: "the reading process begins to mirror a diagnostic process" that encourages the reader "to trace the signs of his sickness that develops over the following pages" (13). If David has learnt to recognize the growth on his own neck, so has the reader, who can now go back to the previous pages and compare the medical image with

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Small's depictions of the boy's neck, thus mirroring the process of deciphering visual evidence followed by the doctor who explores David's radiograph in fig. 1.6. This mirroring of the diagnostic process can also be observed in the fourth panel of fig. 1.7, where the open medical textbook that lies on the floor and the part of Ted's head that occupies the left side of the image indicate that the panel depicts what David's child eyes are seeing. In this manner, the position of the scene demands the reader to situate themselves in David's place, peering over Ted's shoulders and trying to understand the mystifying picture.

These repetitions and connections between panels and pages serve to engage with the images that recurrently plague David throughout *Stitches*. As Orbán notes, “[t]he lack of (verbal) knowledge about the body haunts the memoir—both in a range of childhood terrors and in the concealment of the illness and its consequences from David” (179). A particularly engaging example is found in the human fetus kept in a laboratory jar that David finds in one of his solitary adventures at his father's hospital. Dazzled by his discovery, the child stares at the jar and imagines that the fetus takes the lid off, breaks free from his confinement, and chases him through the hallways (see Small 39-40). Years later, as he studies his reflection in the bathroom mirror, David imagines that the fetus he encountered as a child is growing inside the lump on his neck (see fig. 1.9), thus creating “a connection that is made by the affordances of arthrology in the comics form” (Jacobs and Dolmage 82). Throughout his memoir Small frequently employs “bordered boxes [that] give way to borderless panels and full bleeds” to indicate that David is dreaming, imagining, or hallucinating (Gilmore and Marshall 25). The first four frameless panels at the top of fig. 1.9 are a prime example of this graphic technique, while the framed, rectangular panel at the bottom of the page leads the reader out of the oneiric space—the onomatopoeic “knock knock” sound on the door acting as a cue that brings David back to the reality of the family house.

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Fig. 1.9. David imagines the fetus growing inside his lump (Small 147).

El Refaie points out that this monstrous fetus recalls Julia Kristeva’s notion of the abject: “anything that crosses the boundaries of the body, such as waste materials and bodily fluids, is perceived as unsettling, because it is neither completely separate from nor entirely part of the illusive ideal of a ‘clean and proper self’” (*Autobiographical* 68-69). Against the idea of the whole, stable self, malignant tumors “seem to develop a life of their own and threaten the bodily order from within” (*Autobiographical* 69). By imagining a fetus—a strange, almost-human form that is both self and other—growing inside his own neck, David attempts to visualize the conflicting form that is his growth. I would further argue that this comparison signals that the growth, which is part of David but not fully “him,” is as alien and mysterious to the teenager as the fetus he encountered as a child. Furthermore, as the fetus stares back at David in the last unframed panel of fig. 1.9, holding his gaze and maintaining “a frown and scowl very similar to David’s frequent expressions as a teenager later in the narrative” (Koch 36), it also stares back at the reader

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that observes this page, demanding their acknowledgement and challenging the diagnostic process.

Another important entanglement with the medical gaze is found after David undergoes the two surgeries needed to treat his cancer. Back home from the hospital and still sore, he spends two weeks sleeping and watching TV, but when he starts to feel better, he decides to check his surgical scar by himself. Standing in front of the bathroom mirror, the boy peels the bandages off and stares at the result, which is shown in fig. 1.10. In a framed panel that extends over the whole page, David stares at his reflection as he closely examines the huge scar on his neck, noticing its stitches and the droplets of blood on its borders. Tilting his head to his right to get a better look, he attempts to touch the edges of the wound. The spare background includes the shadows casted by the mirror and the bathroom tiles. Fig. 1.11 presents an interesting structure, as the three close-ups of the surgical stitches are drawn in full detail, without frames containing the panels, looking as if they were actual stitches crossing the page. The text of the caption box located above the first depiction of the scar reads: “A crusted black track of stitches; my smooth young throat slashes and laced back up like a bloody boot” (191). Disconcerted by his reflection and by the strange shape found in the mirror, he attempts to negate his new reality: “Surely this is not me.” However, the scar, which resembles a void barely stitched together in the last panel, reassures him that what he is seeing is part of himself: “No, friend. It sure is” (Small 191).

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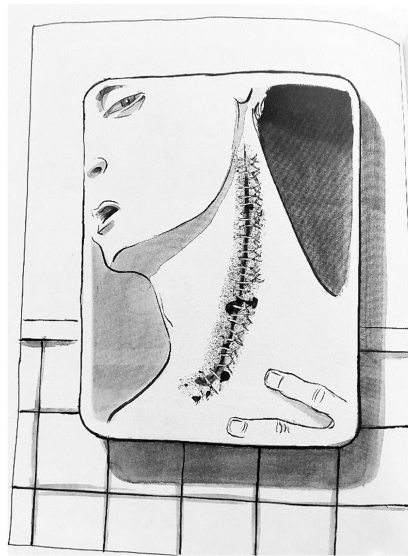


Fig. 1.10. David sees the surgery scar on his neck for the first time (Small 190).

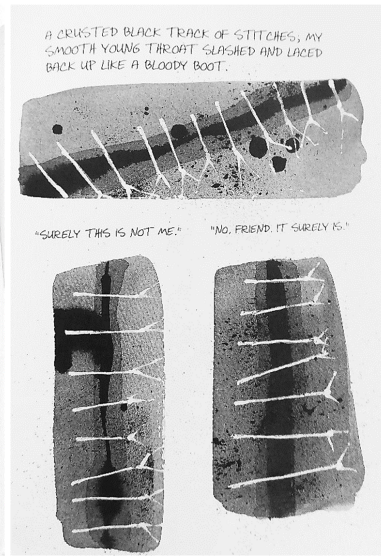


Fig. 1.11. "Surely this is not me" (Small 191).

I would suggest that this scene of David staring at his own scar for the first time serves a double purpose: first, it allows David to confront the medical gaze, and second, it manifests the fracturing, disrupting nature of cancer. Since David's face is contained within the bathroom mirror—which is itself enclosed within the framed space of the panel—the reader does not get a direct representation of the gaping wound, but a depiction of what the boy is seeing on his reflection. According to Wegner, the bathroom mirror is a powerful symbol in *Stitches*, as it provides “a critical engagement with the medical gaze” (13). This mirror proves to be the medium through which this graphic narrative evokes “the Lacanian idea of the self that comes to recognize itself” and where “David notices the cancer growth at his neck and later encounters his scar for the first time” (Wegner 14). In this scene, the reader receives David's own experience of uncovering the bandages to find his lacerated throat, not an image from a medical textbook, nor a radiograph deciphered by his doctor. Thus, David's reflections on the mirror challenge the objectiveness of the medical gaze while showing the boy's subjectivity.

This engagement with the self through the mirror is connected to the second purpose of the scene, which uncovers David's experience of cancer. As El Refaie notes, cancer is “a faulty and unregulated cell proliferation that disrupts bodily structures,

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functions, and processes at the original site and sometimes, through local spread or metastases, in other parts of the body” (*Visual* 119). The terror of this unpredictable disease lies not only in its bodily destruction, but also in its disruption of the boundary between the self and the non-self, as the body turns against itself. People who suffer from cancer perceive how the disease “changes the way they relate to their own bodies” (*Visual* 119). Susan Sontag further notes in *Illness as Metaphor* (1978) that “[i]n cancer, non-intelligent . . . cells are multiplying, and you are replaced by the nonyou.” Cancer is then understood “as the overwhelming or obliteration of consciousness” (71). I consider that the graphic layout of these pages—David’s image on the left, and the talking scar left by his cancer on the right side—exemplifies this disruption of the boundary between self and other. Here, the “non-self” is exemplified in the wound that speaks back to David, demanding recognition as part of his embodied self.

Victim of his parents’ failure to provide adequate care, David’s growth is left unattended for two years as it develops and worsens. Small depicts his teenage pre-operation self, slouching on a couch, arms crossed and scowling (see Small 151). His father, standing and smoking, scolds the boy for his bad posture with detailed medical explanations while omitting attention to his growth, which is David’s most pressing health issue: “This will surely lead to a compression of the (puff) vertebrae resulting in permanent deformation of the spine such as (puff puff) scoliosis or spondylolisthesis” (Small 151). Encapsulated in wide word balloons not found anywhere else in the narrative, David’s father exposes the boy to his medical talk, that is, “the technical, specialized language doctors use to refer to symptoms, diagnoses, illnesses, treatments, and bodies” (Frank 6; qtd. in O’Brien 272). David’s father wields his medical authority over him based on modern Western medicine’s “presumed expertise and the supposed truth of data,” exercising his power through the usage of a specialized language that serves to “regulate and give meaning to the lived experiences of bodies and minds” (Couser, *Recovering Bodies* 19). Just like his medical treatments, his father’s medical talk regulates and controls David’s body while ignoring the ailment that actually afflicts him.

This indifference towards David’s health is extended to different moments of the boy’s life: one of the most notable incidents takes place right after David gets his lump checked and the doctor suggests that he needs to undergo surgery in order to remove it (Small 133). Despite his serious diagnosis, David’s growth is left unattended, free to roam the boy’s throat while his parents occupy themselves with travels, parties, and the

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acquisition of luxury items: “Around that time dad must have gotten a promotion or a raise. The lump in my neck had to wait while he took mother on a shopping spree” (Small 137). Böger notes that the narrative in *Stitches* introduces “some of the larger issues of that time, including . . . the intense pressure to conform to certain social standards (in particular, those revolving around the hetero normative, middle-class American family) in the period following World War II” (606). David’s parents attend numerous parties surrounded by their colleagues and neighbors, which reflects “the upwardly mobile middle class of the 1950s” (Böger 608). Money is always an issue whenever a doctor suggests that David needs a hospital stay to treat his growth; yet Small illustrates a sequence of his parents buying several cars, household appliances, and expensive furniture, framed by clapping hands that celebrate their success at recreating the consumerist American values of the time (see Small 136-43). Noticeably, David is completely absent in these pages, which visually reinforces the neglect that he suffers.

After surgery, David is forced to negotiate the results of external medical intervention on his body, his post-operation self, and his acquired disability. At home, the neglect continues after David loses his voice, since the fact that he actually had cancer remains hidden from him. His family turns silent on him once again, each member carrying on as usual and acting as if nothing had happened to him. David, who soon realizes that something is wrong, reflects on the situation in a scene shown in fig. 1.12. The first panel depicts the family eating together under the dining room’s lamp. David stares at his food, Ted eats without taking his eyes off the plate, Betty’s back is turned to the reader—her face and expression completely invisible—and the father compliments his wife’s cooking, completely oblivious to his youngest son’s internal turmoil. David’s unease is verbalized in the rectangular caption box located right above him: “Back at home all was the same! Dad never there except occasionally for one of mother’s dry, burned little meals; mother coiled tight inside her shell of angry, resentful silence; my brother in his, and I in mine” (Small 187). The second panel presents a close-up of David’s and his father’s faces, each located at an extreme of the panel. While the father eats with his eyes turned downward, David looks up, defiant. The caption above this panel reads: “Of course, my silence was no longer a matter of choice” (187).

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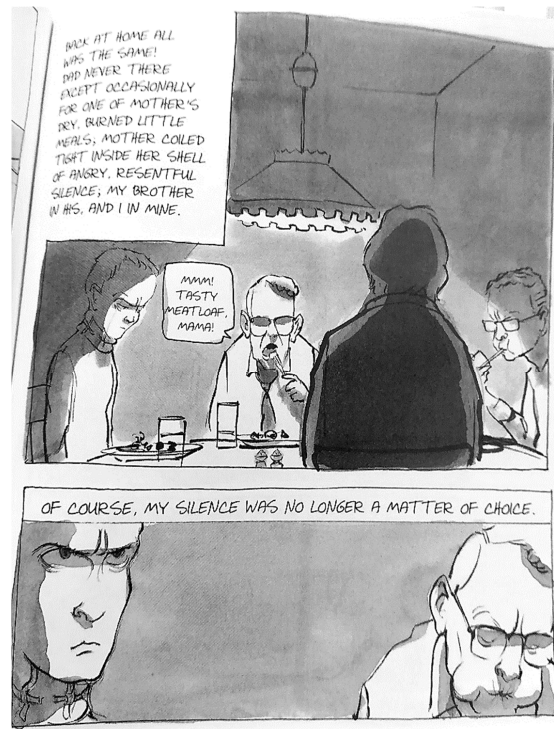


Fig. 1.12. “My silence was no longer a matter of choice” (Small 187).

The captioned, unspoken line of text—“my silence was no longer a matter of choice” (Small 187)—and David’s angry, glaring eyes reveal that the boy’s withdrawal into his own silence is now unwanted and completely involuntary. The silence imposed by his uncommunicative family becomes literal after the two surgeries that remove his vocal cord and leave him with nothing but a bare, rasping whisper. In this manner, Small cleverly constructs and visualizes a wicked and ironic parallel between David’s newly acquired inability to speak and his repressive, unsupportive family members. This lack of support turns the family home into an unsafe place to heal: even when the youngest son experiences a traumatic, painful event and is forced to adapt himself to a new physical reality, the other members of the family retreat to their usual enclosed spaces of silence. Their insuperable emotional distance is conveyed through the lack of interactions between them—each family member is focused on their own plate—and their overt physical distance at the table. It is also worth noticing the disposition of the characters on this page: David is sitting across his brother, who like him, endures his silent parents.

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Then, the father is sitting right under the lamp, which recalls the light of the x-rays, able to see everything, and the mother, sitting across her husband, is out of the light and casted in shadows, inaccessible to the reader. If sources of light are related to seeing and understanding—as in seeing the interiors of the body or revealing the cancerous nature of a growth—it is no wonder, then, that Small chooses to depict his parents in this fashion: in the illuminated spot at the table he draws his father, whose radiology treatment ends up being the cause of David’s cancer as he himself confesses to the boy; and his mother, who never revealed anything to David and who remains a silent, veiled figure even after her death, is drawn in the shadows.

Furthermore, fig. 1.12 also allows for an interesting articulation of the physical space of the family home in *Stitches*. In “Graphic Pathogeographies” (2014), Courtney Donovan examines the concept of place in graphic narratives about health and disease and analyses Small’s portrayal of his family home and the hospital he frequents during his childhood. In the case of the family home, Donovan argues that Small “conveys the unhappiness and tension of the home and its residents through the use of shadow and light.” As seen in the dimly illuminated dining room, “[c]asting certain rooms and places in the house as darker helps to provide the reader the sense of the pervasiveness of negativity and unhappiness throughout the house” (“Graphic” 276). The interiors of the house, dark and suffocating, convey the hostile situation at home: a family dinner, which is an opportunity for the family members to sit together at the table and involve themselves in easy conversations about their daily lives, turns into a moment of resentment, distress, and anger—especially for the youngest son.

The difficulty that David experiences to settle into his newly disabled body is magnified by the secrecy of his cancer and the harmful silences of his parents and doctors. David only manages to find the truth about his body and his illness by sneaking into his mother’s writing desk and finding a letter that she was writing to his grandmother: “Dear mama,” reads Betty’s letter. “David has been home two weeks now, of course the boy does not know it was cancer” (Small 204). In his review of *Stitches*, Scott St. Pierre (2011) asserts that David is disabled not only by his surgery and his acquired voicelessness, but because his parents infantilize him, “treating him as a child who cannot ‘handle’ the truth” and who cannot be trusted to be an informed subject. After David uncovers the truth of his cancer, he is forced to go back to the world he knew, now voiceless, without care or support. The scene shown in fig. 1.13 visualizes David’s understanding of the fact that

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his new disabled self has no place in the abled world he once knew: “Back in school, at first wildly self-conscious... I soon learned... When you have no voice, you don’t exist” (Small 212). The first two panels introduce a close-up of David’s face, with his usual frown intact. Below the words “I soon learned,” the second panel presents a repetition of that first close-up image of David, but this time the outlines of his face and shoulders are composed of thick, pale strokes that fade into a blurry image. Then, the boy disappears completely in the last panel, becoming nothing but a white, invisible shadow lost in the crowded hallways of his high school. While the background shows a crowded hallway where the superimposed figures of the students are occupied in different activities and talking to each other, David is reduced to a shapeless form that stands still in front of his open locker, alone.

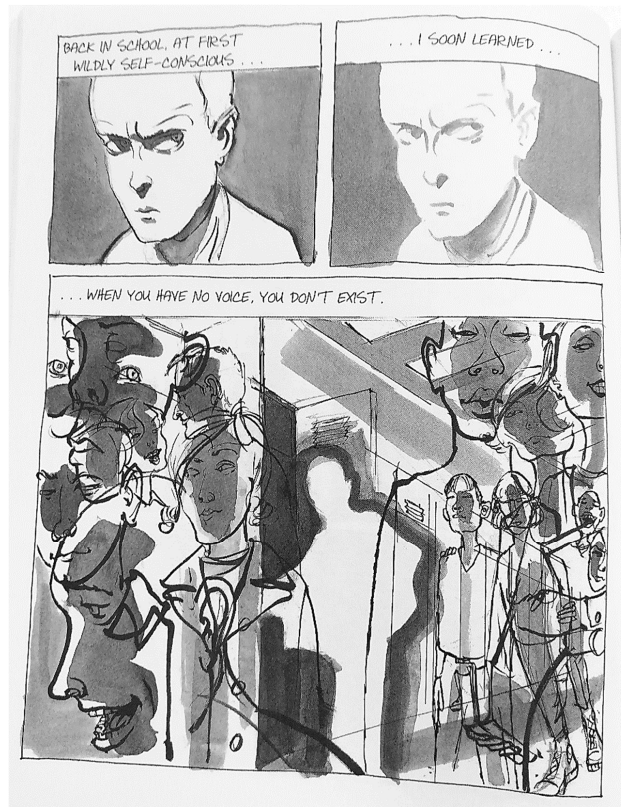


Fig. 1.13. “When you have no voice, you don’t exist” (Small 212).

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For Koch, *Stitches* “engages with and complicates [the] social model of disability.” According to the ideas developed by this model, “David has a speech *impairment* that can mostly be explained by medical causes, but it is his social environment that *disables* his ability to express himself” (31). While painful and traumatic by themselves, the surgical scar, the removal of one of his vocal cords, and the subsequent voicelessness (his impairment) are not as damaging to David as the disabling environment that he must face at home and now at school as well. He even feels isolated from his close friends: “Even among my old friends I felt invisible, a shadow flickering around the edges of every event” (Small 213). This lack of communication, of meaningful connections, family relationships, and friendships dehumanizes David to the point that he feels that he is no more than an invisible shadow, lost in the background while everything happens around—and without—him.

As the only mark on his body is his surgical scar, David’s disability is invisible at first sight, and he can pass as abled as long as he does not attempt to speak. To recall Kafer’s arguments, those with non-apparent disabilities are incorrectly assumed to be able-bodied and may face a lack of support and access to needed services (“Compulsory” 80). In this way, passing as non-disabled can be problematic, since what is not visible may be disregarded as not worthy of attention (Pieri 564). To continue with the graphic interplay of invisibility shown in the previous figure, I suggest that its last panel inverts the radiograph of David’s neck analyzed by a doctor in fig. 1.6: here, the white, shapeless form that is David contrasts with the clear, radiographed depictions of the insides of his body, capable of showing even the tiniest fragments of his bones. If the x-ray machine renders the innermost nooks of his body visible to both trained and untrained eyes, David’s disablement renders him invisible among his peers and family—and therefore invisible in the space of the page.

Crucial to the engagement with David’s disability are the powerful representations of his physical and mental distress, as observed in the riveting frameless panel from fig. 1.14, which exposes the boy’s intense emotional suffering. The quick, wide messy strokes illustrate a face that contorts itself inside a screaming mouth, constructing a never-ending tunnel that progressively digs deeper into the site of his cancer. Unable to confront his parents and rendered invisible among his family and friends, David has no place or way to express his needs and feelings. The following page, depicted in fig. 1.15, presents what David actually manages to say to his parents in his new “rasping whisper” (Small 235).

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It depicts David, sitting on the couch, looking upwards, with his mouth barely open and the slash of the surgical stitches crossing the right side of his neck. The small word balloon that comes from his mouth has dashed borders to indicate the whispering voice through which he addresses his parents' secrecy: "And what about you? Have you nothing to say to me?" (235).



Fig. 1.14. "How I wanted to respond"
 (Small 234).



Fig. 1.15. "What I actually said in my
 new rasping whisper" (Small 235).

David's screaming faces are reproduced in an infinite loop, as he is trapped inside his own mouth, visually locating both the site of his cancer and his disability. Apart from depicting David's speechlessness and his entrapment inside his own self, the scene shown in fig. 1.14 also deals with "David's state of mind at the time: isolated, without a connection even to the people closest to him, and seemingly without any means of expressing himself" (Böger 613). The clever use of repetition highlights David's lack of progression and "leads to further isolation and a feeling of terror" (613). Moreover, these pages reveal the difference between what David is able to project outside—a raspy voice, barely audible, to confront parents that have imposed silence on him for years—and what he must swallow and turn inward—the silence imposed on him, the fear, the physical pain, the rage, and all the negative feelings that can come with a recently acquired

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disability for which he receives no support. Through a skillful usage of thick strokes and black ink, Small is able to visualize the experience of both physical and mental distress and to expose the complexities of a disability that intersects with pain and trauma.

4.2. Dreams, Voids, and Gaping Holes: A Cripistemology of Voicelessness

One of the most enthralling characteristics of *Stitches* is the linkage of David's body to interior spaces. Orbán notes that "[e]mbodied subjectivity is frequently figured in the book as an interior space, often represented as a body cavity or as an architectural interior" (180). As he is facing the aftermath of cancer and adjusting to his life with an acquired disability, David turns to his daydreams and fantasies, where he travels to old houses, empty movie theaters, hallways, and bombed temples, and also enters into the mysterious spaces of his own body. These inner locations are sometimes charged with negative withdrawal to expose David's lack of connection with the outside world, but they are "also narrated as uncharted interiorities to be positively discovered" (Orbán 180). It is this journey through these hidden, inner places that allows Small to talk about his disabled bodymind.

In contraposition to the usage of light analyzed in the previous section, Small employs diverse visual gaps and dark voids to signal David's lack of control over his body. As Wegner remarks, "David's experiences are repeatedly visualized by black holes and waves that he gets drawn into . . . As he falls and is swept away, his own body escapes his control." The darkness that surrounds the boy "emphasizes his overall feeling of loss and total surrender" (11). Drawing on Wegner's work, I locate the beginning of David's engagement with interior spaces in his loss of control over his own body. This idea is manifested in the moments before David's first surgery, in a scene where he lies on the operating table, observing everything in silence while the doctors get ready to work on his "cyst" (see Small 164). The fourth panel, displayed in fig. 1.16, shows the anesthesiologist setting the oxygen mask over David's face, with the blinding surgical room's light shining bright behind him. The round, dark shape of the oxygen mask seen from below creates a void that is repeated in the form of a swirling spiral in the last frameless panel of the page.

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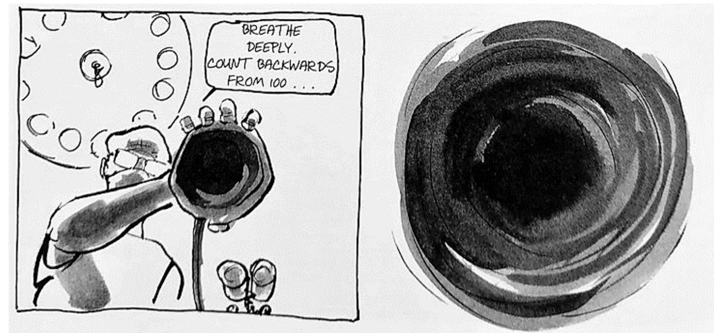


Fig. 1.16. “Breathe deeply. Count backwards from 100...” (Small 164).

That gaping, swirling void represents the effects of the anesthesia on David, as well as the lack of control that the boy has over his body while the doctors operate on him. This loss of control is not traumatic because of the medical intervention per se—David’s surgery was extremely necessary to treat his cancerous tumor—but because the boy never knows what is actually happening to him: that he is bound to undergo a second operation because his throat is in a worse condition than expected, and that he actually suffers from cancer and is going to lose a vocal cord as a consequence.

The images of the swirling voids that suck David in are sometimes accompanied of visions of the boy entering—or falling into—interior bodily spaces. The page shown in fig. 1.17 evokes this idea by portraying a nightmare that plagued David during his childhood, after a visit to his father’s hospital. David and Ted accompany their father to see the radiographs taken by his team, both children enthralled by the clear images of internal tissues, organs, and bones: “My brother and I liked seeing the x-rays of little kids’ stomachs, the stuff they had swallowed like keys and pop beads... and cracker-jack prizes” (Small 28). After being heavily scolded by his mother for losing his shoes at the hospital, David dreams that he is being swallowed into the dark voids of the interiors of an organ, presumably the stomach of one of the children whose radiograph he had been staring at. Small chooses to depict this space seen from the inside, in a wide, frameless panel that occupies most of the surface of the page. Quick, wide brush strokes give shape to the ribs and the spine, which are the only barely distinguishable bodily forms in the image. Turned upside down with his face contorted in a scream, David attempts to free himself from the claws of the monstrous fetus—a recurrent character in his daydreams and nightmares, as I noted in the previous section—that tries to drag him down amidst a whirlwind of the objects in that little kid’s stomach: keys, pop beads, and the little cowboy

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figurine. A small, framed panel located at the top left of the page contains an image of David sleeping after being chastised by his mother. The small block of text above the boy reads: “Sent to bed with no supper, I dreamed that night of the little man in the jar” (Small 45).



Fig. 1.17. “I dreamed that night of the little man in the jar” (Small 45).

If child David travels to the haunting interiors of the radiographed stomachs full of figurines—the remnant of the radiology treatment he endured—teenager David goes on a journey through the insides of his own mouth—the site of his cancer and his disability. After his second surgery, the boy falls into his inner world of dreams and terror through the dark void provoked by the effects of the anesthesia (see Small 179-181), inviting the reader to accompany him on his expedition. Fig. 1.18 presents a composition of three rectangular, frameless panels that signal the oneiric nature of the sequence. The text addresses the reader in the caption above the images: “Step inside your mouth with me for a moment, won’t you?” (Small 182). Below the words, a tiny human figure enters a gigantic, cavernous mouth, holding the row of teeth on his shoulders to open the dark

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space. Then, as the figure starts to crawl, there is a warning: “Careful on the tongue! It’s slippery!” (182). In the third panel, the figure, which starts to resemble David seen from behind, stops at the opening formed by the vocal cords and the throat. The text narrates this discovery to the reader: “Now, you see down there? Those folding screens over the tunnel of your throat? Those are your vocal cords. When air flows over them they vibrate like the strings on a cello” (182). The dream sequence continues in the two framed panels of fig. 1.19, where Small includes a striking visual representation of the gap by employing two close-ups of a throat seen from the inside. The first image portrays a healthy throat with its vocal cords intact, which seems to reinforce the importance of these “folding screens”: “Your vocal cords make the sounds of your voice, your curses and your prayers” (183). Below, in an extreme close-up, the reader encounters David’s throat after his surgery, with a gap located right where his missing vocal cord used to be. The caption above reads: “When I woke up from operation #2, I had only one vocal cord, and with only one vocal cord the sound you make is...” (183).

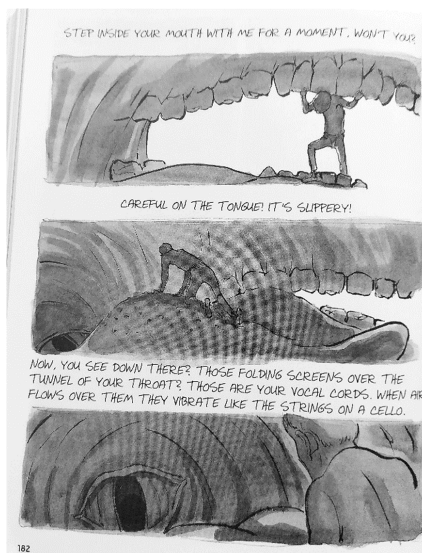


Fig. 1.18. David steps into his own mouth (Small 182).

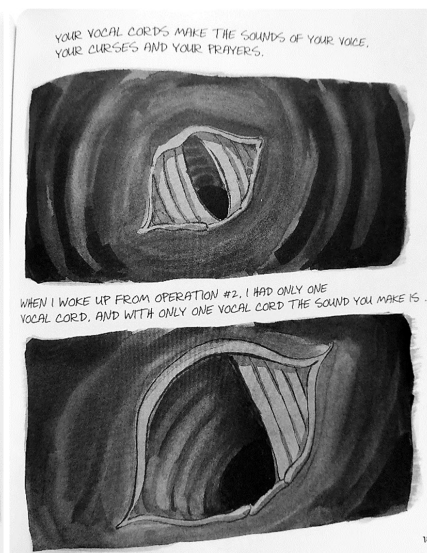


Fig. 1.19. “With only one vocal cord the sound you make is...” (Small 183).

As stated in the previous section, only medical personnel have access to a visual understanding of medical images. El Refaie remarks that this argument is also true when applied to the visualization of the interiors of the body: “it is only medical professionals

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and morticians who are likely to have clear, detailed visual memories of its interior spaces; the rest of the population is reliant on pictures to fill in the gaps in their knowledge” (*Visual* 142). Small decides to fill that gap by drawing his own throat, thus granting access to those who are not versed in medical knowledge. Through the depiction of his dreams, “interior bodily knowledge is momentarily imagined to be possible—for both David and the reader, both ‘me’ and ‘you’” (McGavin 189). Reproducing a subjective image of the interiors of his throat without delving into detailed, precise anatomical correctness provides Small with the means to contest the medical gaze exerted over David, hence manifesting his own particular experience of cancer and his voicelessness.

David’s withdrawal into his own subjectivity continues as the boy returns home from the hospital and is then forced to go back to his life. Feeling further isolated and detached from his peers at school, he begins to skip classes and seeks refuge in the solitary movie theater, where he repeatedly watches the same movie. This scene is introduced on the pages shown in figs. 1.20 and 1.21, which present the same layout structure, consisting of two silent panels and David’s own internal monologue captioned in boxes above the images. Fig. 1.20 starts with a first panel of David sitting alone in the movie theater, the rows of empty seats behind him and the projection on the screen illuminating his face. The second panel includes a panoramic view of the place, with the light of the projector shining on the back and David’s figure illuminated in white. Small narrates the plot of the movie that his teenage self always watched: “I sat through the same movie again and again... A scientist takes an experimental drug that gives him x-ray vision. Driven mad by what he sees, he goes into the desert and tears out his own eyes” (215). The first caption of the following page, displayed in fig. 1.21, translates the action directly into the fantastic interiors of David’s enlarged mouth: “At home, late at night, I began to have the sensation that I was shrinking down... And living inside my mouth” (Small 216). With a row of enlarged teeth and gums behind him, David closes his eyes and crosses his arms in the first panel. Below, the boy embraces himself in the open space of his gigantic mouth, where he is nothing but a tiny, lonely figure.

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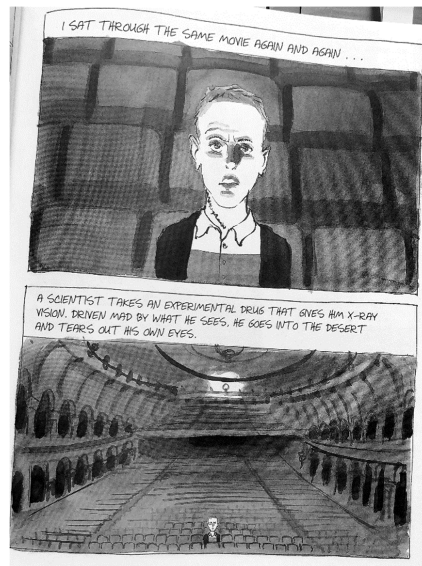


Fig. 1.20. David watches a movie in the solitary movie theatre (Small 215).

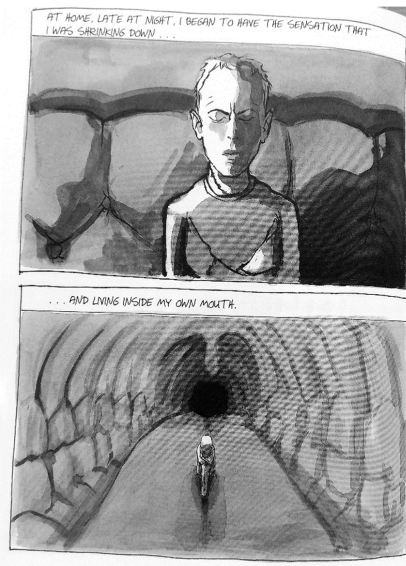


Fig. 1.21. At home, David feels that he is shrinking down inside his mouth (Small 216).

These pages establish an arthrological connection between the interior space of the movie theater—where light and darkness interplay, and where vision plays an important role—and the insides of David’s mouth. The space of his mouth mimics the distribution of the movie theater: the shape of the seats behind David in the first panel of fig. 1.20 resembles the shape of the teeth seen in the first panel of fig. 1.21. Similarly, the arcs created by the row of seats on both sides of the movie theater mirror the structure of the rows of teeth in David’s mouth. And while the focal point of the movie theater is the projector—a source of shining light—the dark gap created by the missing vocal cord is the centerpiece of David’s mouth. At his oppressive, silent family home, the sensation that he is shrinking inside his mouth absorbs his every thought: while his whole world is turning against him, his only escape lies in the interior spaces that are to him both familiar and alien.

The narration of this scene continues on the next page, where Small describes the strain that the wordless mouth provokes on David: “[a] hot, moist cavern, in which everything I thought, every word that came into my brain, was thunderously shouted back at me” (Small 217; see fig. 1.22). A frameless panel contains the scrawny, naked figure of David covering his ears while he sits in the hollow, cavernous space. Then, on the next panel, now framed to signal David’s real location on his couch at home, he continues with

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his reflections: “I was scared to go up to bed, afraid that the screaming in my head would be heard by the family” (217).

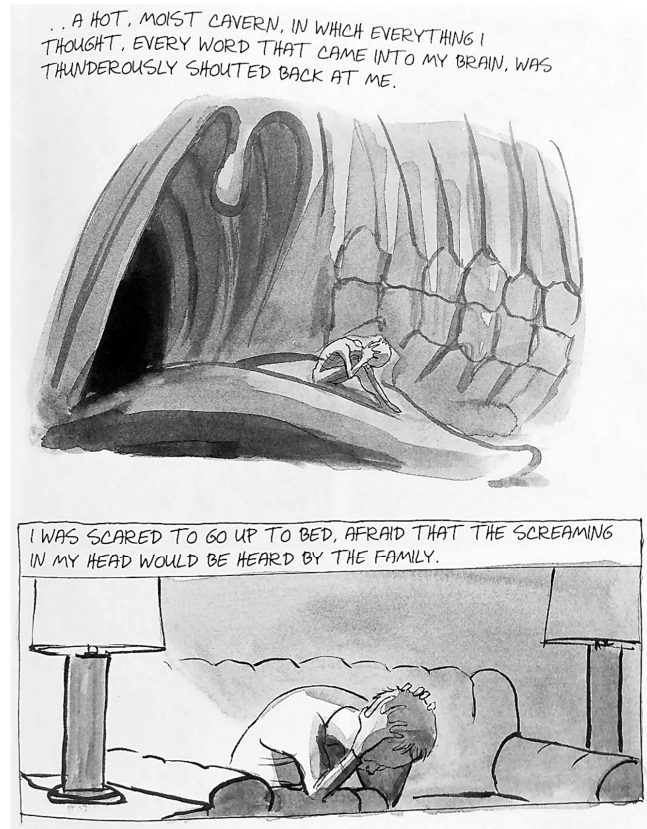


Fig. 1.22. “Every word that came into my brain, thunderously shouted back at me” (Small 217).

The linear connection between the two panels in fig. 1.22 is manifested through the repetition of its visual elements: first, David’s body, sitting in the same position in both panels, and then the background—the cavernous interiors of his mouth and the dimly-lit living room of his home—both seen from the same angle. Thus, Small creates a juxtaposition between David’s mouth and the oppressive family home. Both locations are full of secrecy and betrayal: as McGavin observes, David “is as oblivious to his cancer’s metastasis inside his body as he is to its secret causation,” which he only manages to understand in retrospect (198). By drawing and writing his graphic narrative, Small returns to his old family home and revisits the physical space of his cancer and the gap that it left on him, producing thus a criptestemology of his own reality of voicelessness—

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to employ Merri Lisa Johnson and Robert McRuer's term (2014). Through his ingenious articulation of a disabled bodymind that faces pain, trauma, and exclusion, Small resituates the importance of his own understanding of cancer and disability, accounting for the idea that disability can be painful and charged with negativity while rejecting its pathologization and default medicalization.

The compelling connections between David's body and architectural interiors continue in his dreams and nightmares. In one of his most recurrent dreams, David visits a mysterious, destroyed temple that seems to symbolize his ill body, as Small revisits "visually and verbally, the years of his sicknesses and of life in the family home" (McGavin 199). The two frameless panels of fig. 1.23 introduce one of the many occasions when the boy struggles to reach the interiors of the temple: the first panel shows David squeezing his body through a tiny entrance, with a pile of debris and undistinguishable furniture at his side. In a caption above this first panel, Small continues the description he started in the previous page: "... emerging each time, with the same sense of disbelief and despair, into that temple whose guts had been bombed" (242). The bottom panel shows David's dwarfed figure seen from behind as he stands on his feet to observe his surroundings.

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Fig. 1.23. In his dreams, David visits a destroyed temple (Small 242).

Just like the architecture of the movie theatre, the insides of the temple resemble the interiors of David's mouth, with the rows of arcs simulating his teeth, and its dark gaps mimicking the opening of this throat. As David is forced to adjust his life to an acquired disability, to confront the hidden, silent development of cancer, and to swallow his parents' lies, he keeps revisiting the site of his trauma and visualizing the damaged body that he cannot apprehend through words alone. In this manner, his dreams display the most traumatic and painful aspects of his cancer and voicelessness: destroyed places, debris, a fragmented throat with only one vocal cord, his mouth containing his entire body—all these depictions represent the distressing experiences of his disabled bodymind.

Towards the end of this graphic narrative, a much-wanted confession provides David with another opportunity to evoke his disabled bodymind. But before he receives

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this secret blow, Small enhances the tension in his narrative. While his teenage self was healing and coming to terms with his trauma thanks to his weekly visits to a therapist, the rest of his family “seemed to be quickly falling apart”: first came the accidental discovery of his mother lying in bed with another woman; then the “news from Indiana” (Small 274), where David’s grandmother had attempted to burn her house down with her husband still inside; and finally, his father’s decision to confess the truth behind David’s radiology treatment. Taking the skeptical boy for a ride down to the river at night, the father begins his confession: “In those days we gave any kid born with breathing difficulty x-rays. Two-to-four-hundred rads. Any sort of breathing difficulty... Asthma, for instance, or something like your sinus condition. That was therapy back then” (Small 285). In the next page, David finally hears the words that stitch the gaps of his understanding about his body: “I gave you cancer.” The resulting shock of this revelation turns David inward, into his bodymind and his memory—a process that is deftly shown in figs. 1.24 and 1.25. In fig. 1.24, David returns to the radiology room where he is, once again, a child in front of an x-ray generator. His head, seen from above, seems to be deformed and elongated. Three panels at the bottom of the page depict an extreme close-up of his childish face, his double-pupil eyes looking in every direction. Then, fig. 1.25 introduces a frameless image that occupies the whole page, where child David’s head is superimposed onto teenager David’s face.

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Fig.1.24. David returns to the radiology room (Small 290).

Fig. 1.25. Child David and Teenager David coalesce into a single face (Small 291).

The juxtaposition of the heads of two different selves of David, at two different periods of his life, suggests that what is shown in fig. 1.25 is a radiograph not of the literal insides of his ill body, but of the mental distress and trauma he has undergone since his childhood. By layering these two past selves together in the same image, Small reevaluates these conjoined faces—two versions of his past, at very different stages of his illness and at different stages of knowing the truth. Through a general arthrological connection that operates within the wider network of relations comprised by all the panels in this graphic narrative, David’s teenage body moves through time to return to the space of the radiology room, thus reinscribing this older version of David into his childhood self. In this manner, Small converges the teenage version of David that stares at his father’s face, stunned by his revelation, with David’s even younger self, who looks upwards, unaware and innocent, towards the x-ray generator. The x-ray shots that the child is receiving are causing the cancer that teenager David is still facing and that Small is rendering on the page, decades later, for a reader that becomes a key witness of this process of remembering and knowing. This visual exercise of rendering illness, disability, and memory as experienced by three distinct selves is possible thanks to the openness of

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the medium of comics. According to Holmes, “[t]he materiality of language in comics erases the distinction between the spoken, the thought, the seen—between fantasy, memory, hallucination, imagination—all images on the same visual plane (just as past, present, and future are all accessible)” (152). Engaging with his pictorial identity through the production of two different time frames allows Small to assemble body and mind, past and present, space and memory.

Against the clear, medicalized, and “objective” visions of his bodily interiors provided by x-rays, Small revisits and visualizes the insides of his own body according to his situated understanding. Although traumatic and painful, these representations—his lacerated neck, his empty throat—function as a means for contesting diagnostic procedures, thus engaging with crip readings that articulate disability not as a site of medical oppression but as a place that entails potential (Goodley 89). Reading these inner visualizations and the discovery of these interior spaces as crip potentiality, I would further argue that *Stitches* constructs a cripistemology of voicelessness, an alternative archive of situated knowledge about his own experience of disability—embedded in negativity, trauma, and pain, but also in creativity and survival—that confronts the default pathologization of his disabled bodymind. *Stitches* does not end with David being “normalized” or becoming abled again, as Jacobs and Dolmage remark (87). Instead, David turns to the privacy of the most recondite corners of his body to uncover and explore his disabled existence, acknowledging it as part of himself. Visiting the void left by his vocal cord, growing a human fetus on his cancerous neck, or fragmenting his body on the radiology room table are visual devices that render his own experience of cancer and voicelessness away from the penetrating medical gaze.

4.3. Breaking Silence

Hearing his father’s confession allows David to finally move away from his suffocating home. Far from his unsympathetic family and still negotiating his disabled existence and the secrecy imposed on him, David turns to art and devotes himself to becoming a renowned artist. But even if David receives verbal truth and a certain closure from his father, his mother is a completely different case: a repressed, uncaring maternal figure that only talks to the boy in reprimands and chastisements, Betty lingers as one of the silences that haunt David throughout this narrative.

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As has been noted already, David is deeply affected by his mother’s emotional detachment, to a point where he learns to observe and anticipate her silent withdrawals and her swift changes in mood, a characteristic that is, as Beskow points out, a common trait observed in children that grow up in abusive environments (33). An example of this idea is found at the beginning of *Stitches*, when Small introduces the first scene of the family reunited at the dining table in complete silence. While David’s parents and Ted eat without looking away from their plate, David observes his mother, looking for tell-tale signs of her mood: “The mere moving of her fork a half-inch to the right spelled dread at the dinner table. Her furious, silent withdrawals could last for days, even weeks at a time. Because she never spoke her mind, we never knew what this was all about. We two boys didn’t, at any rate” (Small 16) Ignoring the silent wrath of his wife, David’s father continues eating, while David and Ted stare at their mother, not daring to speak.

Silence follows mother and son even when they confront each other, as observed in the scene that narrates the night before David’s second surgery. As David is facing a severe prognosis, his parents and doctors do not know whether he would survive. Believing that her son is dying, Betty decides to visit him in the darkness of the night. Weeping her eyes but not looking directly at the boy, she asks David whether she can get anything for him (see Small 171-72). Incredulous about his mother’s sudden outburst of kindness, David lets her know that he wants his copy of Vladimir Nabokov’s *Lolita* back—a “smutty” book that Betty had stolen from the boy’s room to burn it (see Small 173). Even in what could have been David’s final moments, Betty is unable to talk to him openly, and David, angry, refuses to reply. Their confrontation continues in the hospital room as they stare at each other without a word. That staring is reflected in fig. 1.26, in two panels that present an interesting composition: the faces of David and Betty are depicted next to each other, each one cut into a half that assembles a whole face.



Fig. 1.26. Mother and son (Small 174).

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But the panels in the previous figure do not only reflect a tale of familial confrontation and motherly betrayal—Betty indeed ends up giving a new copy of *Lolita* to David, only to take it away later, when she learns that the boy survives his surgery. I read this compelling visual parallelism as a reflection of the relationship between mother and son: as their faces are divided in a half then encapsulated within a framed panel, each character seems to be “trapped” into their own space, confined to their role and forced to keep up appearances within a family with no communication, no love, nor even fondness among its members.

Another connection between mother and son can be traced through *Stitches*’ engagement with gender non-conformity and repressed sexuality. In the case of David, the first cues of his gender non-conformity are shown in his childhood’s obsession with Alice from Lewis Carroll’s famous *Alice’s Adventures in Wonderland*. Wanting to escape from his oppressive family home, he falls in love with Alice’s capacity to travel “to a land of talking animals, singing flowers and dancing teapots” (Small 56). Placing a yellow towel on his head to simulate her long, blonde hair—which, he believes, granted Alice the ability to travel to that wonderful place—David runs out to the street to play out his fantasy, which is soon ruined when he faces the rejection of his neighbors: “Other mothers pulled their children indoors when they saw me coming” (Small 57). After he retreats to the local park to play alone, he is chased by a group of bullies that yell slurs at him: “Fag! Queer! Homo! Sissy!” (Small 60). David’s gender ambiguity is further reinforced in the narrative through David’s contrast with his brother Ted, “whose gendered conformity is conveyed instantly by the cowboy costume he wears” (Chaney 136). Ted, who impersonates a cowboy, plays with toy guns, and loudly beats his drums, embodies a clearer idea of traditional, hegemonic masculinity than David, who dresses as Alice and retreats to the house to draw in silence. It must be noted that David’s gender ambiguity and his failure at performing traditional masculinity are only hinted at in his childhood and not further explored in the narrative.

The displays of gender non-conformity in David’s childhood contrast with his heteronormative depiction as an adult in the last part of the book: when David escapes the family home and becomes an artist who can make a life for himself with his craft, he is drawn as a slim, masculine young man who wears a scarf around his neck to cover his surgical scar (see Small 302). Noticeably, this older David is sketching a woman’s body on his easel while three attractive, feminine young women surround him, showing interest

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in him and praising his work and his looks. David even looks back at the reader, with a small, content smile showing on his face. In his reading of this scene, Chaney connects older David's masculinity to capitalist productivity, arguing that his scarf becomes a fetish "of the heterosexual male artist's vitality, which in turn depends upon the validity of the artist as a capitalist subject." Artistic creativity, as he notes, must be profitable both in the productive and in the reproductive sense: "[t]o become an artist . . . is to become a man for David Small" (142). Jacobs and Dolmage observe that the validation that David receives from these women seems to confront the de-sexualization that many disabled individuals face: "[o]ne social impact of disability is that people with disabilities are often de-sexualized, disabled men are emasculated" (86n63). Building on these ideas, I would further argue that this scene of David drawing before the easel, surrounded by three women sexually interested in him, engages with his desirability both as a productive artist that has managed to make art a profitable "home" and as a heterosexual man that is able to gain women's attention, ultimately fulfilling—and settling into—normative life expectations. In this manner, becoming a renowned artist entails leaving his yellow towel and his fantasies of turning into Alice behind and becoming a—(hetero)normative, masculine—man. Once again, these ideas are not further exploited in the story, which leaves the reader with glimpses of the life that this older David is able to construct when he steps outside the overbearing control of his silent, distant parents.

Betty's situation provides a complex reading of her sexuality and the gender roles she is trapped into. The first hint of her queerness appears when David mentions the huge change that he perceives on his mother at the parties that his parents host at home, while his growth is developing. During these parties, his mother becomes someone he hardly recognizes: Betty's eyes are clearly seen behind her glasses, her face is kind, and she smiles as she looks at Mrs. Dillon, a surgeon's wife and friend of David's parents (see Small 113-114). In fact, the smile she directs at the other woman is one David never sees directed at him. But the main incident that reveals her mother's lesbianism—to David and to the reader as well—takes place years later: while David is recovering from his two surgeries and visiting his therapist, he accidentally catches his mother lying in bed with Mrs. Dillon. In a frameless panel, Small includes a close-up of Betty's eyes, clear and serious (see fig. 1.27), accompanied by a description of the emotional outburst that the encounter provoked on his teenager self:

After that awkward moment, while my own emotions ricocheted between extremes of betrayal and foolishness, anger and confusion, what stayed with me

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for the longest time was the look mother gave me, itself full of complex feelings, few of which, I'd guess, had to do with me. I just happened to be the one who stumbled into the room at the wrong moment, a moment she must have known was coming her whole life. (Small 273)



Fig. 1.27. Betty's eyes (Small 273).

Small's clear, detailed drawing of his mother's eyes, "full of complex feelings" (273), attempts to account for the silent, hidden life that Betty leads on the margins of her existence as a mother and wife. Beskow argues that Betty fails to live up to the standards that were required of housewives in the 1950s, always occupied with housework and taking care of their children (28-29). In this way, "[i]t is therefore no surprise that she finds it difficult to raise two children, when she in fact is living a life that is essentially based on lies. She not only struggles with the confines of the kitchen, but also the metaphorical closet" (Beskow 29). Although the text does not delve into her life, I consider that Betty's unhappiness permeates this graphic narrative as she is forced to follow the defined markers of straight time towards reproductive adulthood (Halberstam, *Queer Time 2*)—getting married, having children, being a wife and a mother—thus developing a normative life project while hiding a queer identity that is never voiced nor explored. Interestingly, Small does not seem to want to understand his parents' lives or motives. Gilmore and Marshall remark that he "does not tell the story from any other perspective than his own, nor does he include a fictionalized version of his parents' point of view." In their view, what Small conveys to the reader is that "he grew up with people who were incapable of providing him with what he needed and, in fact, almost killed him"

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(33-34). The lack of content that humanizes and softens Betty, who mistreated her son and never communicated nor revealed the truth of his cancer surgeries to him, seems to be a deliberate artistic choice. I read Small's refusal to explore Betty's queer, hidden life as a graphic and textual recreation of the silent, uncaring mother he vividly experienced: to the reader, he constructs Betty as an opaque, obscure figure whose motives, wants, and needs are never fully understood.

Another meeting point for mother and son is found in their respective bodies. David's struggles with cancer and voicelessness are well accounted for in the narrative, as I have demonstrated in the previous sections of this chapter. However, in Betty's case, her own troubles with illness are veiled. As Sarah Brophy and Janice Hladki (2014) note, the reader is forced to look at "[t]he paratextual inclusions and the end of the memoir" (253-55) to know more about this woman. Small includes a photograph of his mother in her younger years at the end of *Stitches*, along with a description of her health problems, which he only managed to uncover years after her death at 58 years old: she had been born "with her heart on the wrong side of her chest, she suffered from multiple heart attacks towards the end of her life," and she had "only one functioning lung" (Small 327). Even though the medical stories of mother and son never intertwine, I would like to draw attention to two instances where Small provides a glimpse of how their relationship could have been, had he previously known what he learnt about his mother after her death. The first instance, shown in fig. 1.28, takes place after David gets his growth checked for the first time—after his radiograph is scrutinized by a doctor and his mother complains about the costs of the operation (see Small 133). After leaving the doctor's office, mother and son walk together in the empty hospital hallway, David right behind Betty, with his face down. Small chooses to portray this scene in one of the double hospital mirrors set at the blind corners of intersecting hallways. While mother and son are reflected in one of the mirrors, the other reflects an empty hallway. Fig. 1.29 corresponds to the second instance where Small employs this device: the moment when David, as an adult, visits the hospital to bid his farewell to his dying mother. This time, the action is contained within a framed panel that depicts David on the left side, walking alone in the hospital hallway, and on the right, the same hospital mirrors that once reflected him and his mother.

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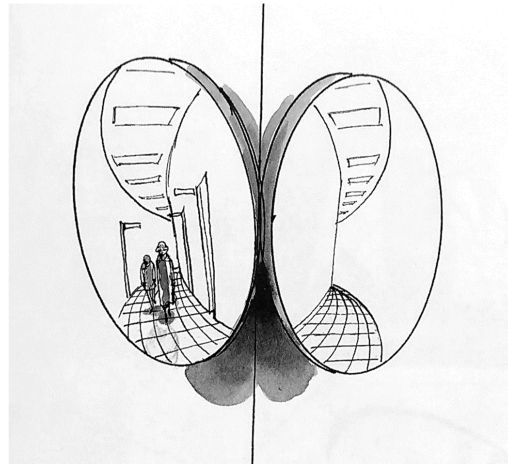


Fig. 1.28. The hospital mirrors reflect mother and son (Small 135).

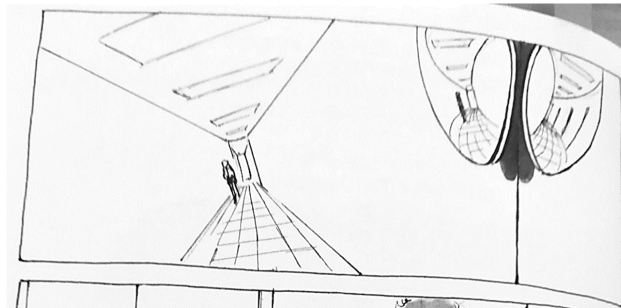


Fig. 1.29. Alone, David visits his dying mother (Small 304).

The arthological connection that springs from these panels ultimately reveals that, although certainly similar in their medical records, the personal paths of mother and son never actually cross each other. As Small writes at the end of the book, “[m]aturity, reflection and some family research have unearthed a few facts, which give a slightly different picture of this taciturn and difficult person” (327). Furthermore, the moment when David visits his dying mother directly inverts the moment Betty stood in his hospital room, thinking that he was about to die from cancer. Not only David knows that this time the goodbye is final, but also both mother and son are now unable to speak: Betty, lying in the hospital bed, has a tube down her throat that prevents her from talking, and David had spent his car ride to the hospital screaming alone. Ironically, after his silent upbringing, his therapy to gain his voice back includes screaming, singing and talking: “I had learned that screaming thickens up the vocal cords. Already this had given me back

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something of a voice. So, I took every opportunity to be alone, to scream, or sing, or tell myself stories as loud as I could” (Small 303). Small does not elude the irony of the unbridgeable silence that follows them until their last moment together: “She couldn’t talk and neither could I. I had been screaming for so many hours that I, too, was voiceless” (Small 306). Amidst all the tubes and medical devices, David sees Betty’s face and eyes, which are drawn with more detail than anywhere else in the narrative (see fig. 1.30). In their final goodbye, he looks at his mother and caresses her face with a gentleness and care she never provided for him.



Fig. 1.30. David caresses his mother for the first and last time (Small 307).

Small’s depictions of his mother’s eyes, “filled with vulnerability and regret,” allow the reader to understand that David is “finally able to see his mother realistically, as a fragile, unhappy, and mentally unstable woman” (Larkin 207). Beskow notices the wide “contrast between the weak person lying in the hospital bed, and the angry person David knew growing up” (43). There is thus a linkage between the silent panels shown in figs. 1.27 and 1.30, as both manifest the humanness and vulnerability that lie behind her coldness and detachment.

These moments that dwell between silences open the door to a crip reading of the text. I consider that these encounters disclose a queer/crip connection between mother and son, constructed through graphic linkages, paratextual information, and visual and verbal clues scattered through the pages. As Chaney remarks, David’s gendered humiliation in his childhood is entwined with the storyline of his mother’s affair with

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another woman (136). In addition, both mother and son fail to meet the system of compulsory able-bodiedness as theorized by McRuer (*Crip Theory 2*): David, with his experience of cancer and his voicelessness, and Betty, with her hidden health complications, escape the representation of the normative, healthy, abled bodymind. But the case of the mother is even more complex: according to Brophy and Hladki, Betty exemplifies “what Robert McRuer (2006) terms ‘a queer/disabled existence’ . . . a painful example of the experiential, embodied, and interrelational costs of ‘able-bodied heterosexuality’s hegemony’ (31)” (253-55). These costs are visualized in Small’s thorough search in archives and family stories to find the truth about his mother’s health condition and in David’s accidental discovery of her lesbianism. Sentenced to a lifetime of secrecy and painful silence, Betty maintains the façade of an able-bodied, heterosexual identity until the very end.

While his mother never abandons her silence, David finds ways to break his by throwing himself into his creativity and his interest in art. But before David makes a living for himself through his drawings, he meets a figure that offers him guidance to overcome his rough, stormy relationship with his mother and his silent family home. At fifteen, struggling with the disabling environment that appears before him after the loss of his voice and his parent’s mistreatment, David’s anger and rebelliousness grows unbounded. He is then sent to “an all-boys school in the east,” which “put a strong emphasis on sports, Bible studies and manual labor” (Small 231). However, the efforts to discipline David into a productive young adult are fruitless, as he escapes the school three times and is finally sent back home “with the advice to seek psychiatric help” (231). This turbulent moment marks the beginning of David’s weekly therapy sessions. Despite disliking the idea of receiving therapy at first, he soon learns that his reluctance is unfounded: not only does he finally encounter a medical professional that acknowledges what he has been through, but also the therapist is the first adult in the story that does not infantilize David by telling the boy the truth that he so desperately needs to hear: “A boy who has had cancer... A boy whose parents and doctors did not tell him he had cancer... A boy who had to find out the truth on his own... Is this crazy? . . . No one had been telling you the truth about anything. But I’m going to tell you the truth” (Small 252-53).

As shown in fig. 1.31, Small chooses to visually represent this moment with a layout composed of three rectangular panels that depict extreme close-ups of the eyes of the boy and his therapist. “Your mother doesn’t love you,” says the therapist on the first

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panel, with huge, expressive rabbit eyes. By choosing to draw his therapist as the White Rabbit from *Alice's Adventures in Wonderland*, Small seems to indicate that the figure of an adult that acknowledges David and treats him like an equal is as fantastical and strange to the boy as the rest of the characters and the fantasy world of Alice that he cherished in his childhood. As Larkin observes, “[c]oming from a repressed household with such a furious mother, an empathetic analyst willing to talk and to listen to David’s feelings must have seemed like another world” (206). The second panel shows David’s eyes focused on his therapist, while the last one returns to the older man, who delivers his final sentence: “I’m sorry, David. It’s true. She doesn’t love you” (Small 255).



Fig. 1.31. “She doesn’t love you” (Small 255).

Hearing the words “your mother doesn’t love you” ultimately helps David to stop seeking maternal care in the figure of his mother. This fact, although harsh, provides David with the means to recognize his painful trauma, caused by a life of enforced silence

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and familial secrecy, and to work towards overcoming it. This recognition, I argue, is manifested through an arthological connection that binds this page and the pages shown in figs. 1.3 and 1.4: the layout structured in three panels, with David’s face in the middle, is replicated here. The focus of light that appears in the first two panels of figs. 1.3 and 1.4 now becomes the eyes and face of the man that reveals the truth to David. The repetition of the layout with the change in the first panel—authenticity instead of surveilling light, words instead of trauma—and the presence of wide balloons that contain the therapist’s words signal that, for the first time, the cycle breaks: David finally hears the truth from an adult that cares about his wellbeing. According to Larkin, David has finally found “an empathetic figure who can help him to find the truth: a figure who can both see and be seen” (207). Through his appointments, David manages to work through his silence and, for the first time, begins to speak about what happened to him: “After life in a house where silence reigned and free speech was forbidden, that office, three times a week, became a haven for me. There, things began to make sense... Including the terrors of the night and my dreams” (Small 268).

Cheered by his therapist, who encourages his artistic aspirations and compliments his drawings, David pursues his dream of becoming an artist. He finally decides to leave home at sixteen and moves to an “one-room apartment in Detroit’s inner city” (Small 295), where he befriends a group of artists—a bunch of social outcasts living in a decaying home that make David feel “more normal” and “less lonely” (Small 300). But David’s orientation towards art started early in his life: as pointed out in the first section of this chapter, the first scenes of this graphic narrative depict the child drawing at home, lying on the floor. The fantasy world that the child captures with crayons and papers grants him an escape from his strained family home, as depicted in figs. 1.32 and 1.33. Wanting to imitate his heroine, he immerses himself into the drawing page and travels to another world, far away from his home. The sequence displayed in figs. 1.32, narrated without panels, reproduces the three stages of David’s body entering the space of the page: he kneels in front of the paper and inserts his head, which is quickly swallowed along with his arms in the second picture, until only his legs are visible in the last one. Fig. 1.33 presents David travelling to the fantasy world that his drawing opens for him: the boy squeezes his body through a narrow channel, and falls into a rounded, hollow space where a multitude of cartoon characters, grateful for his presence, welcome him with open arms. The living room remains visible in the top left corner of the page.

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Fig. 1.32. David immerses himself into his drawing page (Small 62).

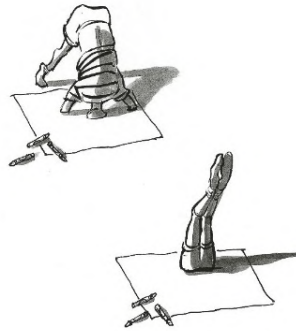


Fig. 1.33. The boy arrives at his fantasy world (Small 63).

Sathyaraj Venkatesan and Anu Mary Peter (2018) remark the importance of the scene shown in fig. 1.32, as “the surfaces of the drawing paper and the page of the memoir in which it is drawn conflate into one inseparable plane,” which Small conveys by employing “cinematic lighting techniques such as chiaroscuro and soft light” (“Poetics” 108). These remarkable graphic techniques are also featured in fig. 1.33, which presents another linkage with the interiors of the body: David’s fantasy world is shaped like a stomach, and the channel through which he travels takes the form of an esophagus. The depiction of the stomach, with thick lines that delineate its shape and dark watercolors that convey its deep surroundings, makes escapism through art “thoroughly visceral” (Chaney 135). Moreover, the fact that the aperture of the esophagus—the escape route—“opens into the floor of David’s childhood home” allows to locate “the domestic as the site of a psychological wound whose bandages are made of ink and panels” (135). David leaves the real, oppressive space of the family home to travel into the world of his art and his imagination, which will ultimately lead him to his survival.

In the process of stitching the wounds of his childhood and teenage years by using the tools of comics, Small employs the words that he lacked so many times and the images that accounted for everything he could not say—and for everything he saw but could not

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understand. Art provides David with the capacity to surpass “the constraints of conformity and emotional cataclysm through drawing, thereby gaining a psychological space and creative haven” (Venkatesan and Peter, “Poetics” 108). This idea is evinced in the observations that David makes when he becomes an adult able to support himself with his job as a drawing teacher in New York: “Art became my home. Not only did it give me back my voice, but art has given me everything I have wanted or needed since” (Small 302). For Böger, this creativity becomes literal in the formal devices that Small employs to revisit his past: “The individual panels are ‘stitched together’ with the gutter functioning not only as a frame, but also as a suturing device exposing wounds from the past which are thus contained, and therefore made safe—if still painful—for scrutiny from the distanced perspective of the present” (604). Ultimately, with its visualizations of gaps, voids, and dreams, of disabled bodyminds and truths left unsaid, *Stitches* finds a powerful companion in the medium of comics, with its caesuras between packed panels, its fragmentation, and its production of meaning from the empty spaces of the gutter and the packed spaces of the panels.

At the end of *Stitches*, Small creates another gripping oneiric sequence that engages with his intention of breaking the silence that has haunted him throughout his life. In his last dream, David becomes again a six-years-old boy that lives alone in a house with a garden and “a high enclosing wall” (Small 315). His only entertainment is a remote-control toy car that he accidentally loses, and the only way to retrieve it is to go outside and leave the safety of the house. As he looks outside the window, he hears a sweeping noise that comes from the other side of the garden: “Then, hearing a sound, I turned and, for the first time, looked out over the garden wall. What was that old building?” (Small 322). Peering through the glass, David notices a mysterious figure that sweeps the path that connects his house to that other building. The building turns out to be “the one where grandma had been locked away. The old Central State Asylum” and the figure “was my mother, sweeping the path, clearing the way for me to follow” (Small 324). As his mother invites him in, David realizes that his grandmother, who had been admitted to the asylum after burning her house, is looking at him from the windows. Larking emphasizes the significance of this last scene: the fact that Betty is the one sweeping the path “suggests that, if not an inmate of the asylum herself, she is at the very least a custodian of the insane and her move to invite David to enter the building implicates him in the intergenerational chain of psychosis” (203).

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It should be noted that mental disability is not explored with the same depth as David’s physical illness and subsequent acquired physical disability: Small only hints at the abuse that his mother may have suffered at the hands of her own mother—there is in fact a scene where a terrified Betty forbids six-year-old David to call his grandmother “crazy” after the old woman scalded his hands with hot water (see small 102). Consequently, the topic of mental disability remains a closed, unexplored, path in *Stitches*. Still, Small ends his graphic narrative with the refusal to follow his mother’s invitation to the Central State Asylum: the words “I didn’t” (Small 325) occupy the last page, in a blank space where no images are used. This absence of drawings, along with the bold letters in the white page, signal his final triumph over repressed silence. While Böger notes that *Stitches* is about “actively conquering silence” as David “painstakingly speaks up for himself and confronts his parents” (614), I consider that this graphic narrative engages with the act of breaking it: David’s therapy sessions and his orientation towards artistic creation provide him with the means to undo the repression that has been enforced on him, which ultimately helps him to refuse to follow the footsteps of his mother and grandmother.

In the act of creating *Stitches*, Small is not only actively engaging with his identity as a disabled person who has endured cancer, but is also taking his representation back from the medical gaze and its pathologizing, ever-seeing eyes. It is also worth noticing that David does not gain his artistic abilities “because of” his physical impairment. As St. Pierre points out, “[a] story like this one is highly susceptible to the impulse to interpret the growth of one skill set—drawing/writing ‘comics’—at the expense of a complimentary physical deficit—the author’s loss of speech.” David proves to be extremely creative since his early childhood, and his dreams of making art his profession and home develop in parallel to his struggles with his acquired disability. Similarly, *Stitches* does not show a narrative of “overcoming” disability: David learns to live with his impairment, and when he slowly gains his voice back thanks to his oral exercises, there is no celebration. As Wegner declares, David does “not seem to yearn for his pre-disabled body” nor celebrates “his success of having overcome his disability after he partially learned to speak again,” but accepts instead his body and his voice as they are, “the markers of his trauma as part of himself” (14).

Small implicates the reader in his visualizations of the exteriors and interiors of his body, his embodied experiences of illness and disability, and his life in the family

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home where silence, repression, and betrayal reign. These visualizations go hand in hand with an absent part of the story haunted by silences, such as his mother's closeted queer/disabled existence, and the remnants of undisclosed mental disability. These silences signal a hidden story that attempts to repeat itself as the past haunts the present, but David steps backwards and decides to draw his own path.

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5. The Self-Surveilling Archivist: Crippling Embodiment and Recreating Diagnosis in Ellen Forney’s *Marbles*

“I have been stable now for 17 years” is the earnest, heartfelt testimony that Ellen Forney discloses to her audience in a 2019 TEDxSeattle event (11:46). Her talk, titled “Finding Balance in Bipolar,” narrates her personal journey after being diagnosed with Bipolar I Disorder (BI-D) at 30 years old. It covers her struggles to maintain her artistic creativity and find stability while coping with mental illness. Defining herself as an artist, a passionate storyteller, and a mental health advocate, Forney enhances her speech by including slides with visual and textual materials taken from her graphic narrative about bipolar disorder *Marbles: Mania, Depression, Michelangelo, & Me* (2012), the object of analysis in this chapter. Divided in nine chapters, with black-and-white ink drawings and extensive, handwritten text descriptions, *Marbles* offers a space for the reader to examine Forney’s journey towards balance—perilous and full of uncertainty, failures, and achievements—which she makes sure to show in detail. As Roz Warren writes in her 2013 review of *Marbles*, Forney’s artistic strength lies in her ability to show “anything and everything”: “An annotated breakdown of the DSM-IV’s ‘Criteria for a Major Depressive Breakdown’ is followed by a four-page depiction of a photo shoot for a porn comic” (44). Through her rich, exhaustive visual storytelling, Forney takes the reader through a journey where she unashamedly unveils the many different aspects of her lived experience of mental illness.

Just like David Small’s *Stitches*, *Marbles* has received multiple literary awards, such as Best Graphic Novel of 2012 by Washington Post and Time Magazine, and Winner of the National Association for the Advancement of Psychoanalysis 2013 Gradiva Award (“Press”). These acknowledgements have also translated into a wide critical reception: Forney’s exhaustive inspection of the stereotype of the “crazy artist” and the disruption that BI-D brought to her identity as an artist are well accounted for by scholars such as Kristen Gay (2016), Nicole Eugene (2017), and Bethany Ober Mannon (2019). Forney’s graphic subjectivity is analyzed by Silke Horstkotte and Nancy Pedri (2016), who pay close attention to the visual and textual rendering of the autobiographical self and the inscription of the body on the page. Sidonie Smith and Julia Watson (2018) track the many representations of the act of reading in *Marbles*, which Forney employs in three different ways: to visualize her psychic states, to scrutinize her diagnosis in a therapeutic

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exchange, and to research visual and verbal archives, both scientific and artistic (“Contrapuntal” 33). For Jodi Cressman (2018), who explores how Forney handles her diagnosis by searching for the company of famous individuals that lived with mental disability, *Marbles* “reads like a narrative of accretion, a collage . . . of unframed free-hand drawings, reproductions of works of art and book passages, double trucks, photographs, sketches, and statistics” (8). It is precisely the collage-like quality of *Marbles* that allows me to engage with the productive archival practices devised by the author to revisit her post-diagnosis identity. By extending the analysis opened by Cressman, I will investigate how Forney designs and creates her own crip archive as a tool that contests objective, medicalized views of her disorder. This archive is composed of several levels, which include the many notes, charts, sketches, autobiographies, medical texts, reading materials and photographs through which Forney assembles her visual and verbal testimony of BI-D.

In the first section of this chapter, I will analyze the representational strategies used by Forney to articulate the ways in which BI-D is inscribed in and leaves its trace on the body. Here I will build on the work of Courtney Donovan (2014), who notes that Forney “emphasizes how the contrasting moods of mania and depression create distinct embodied experiences” (“Representations” 238-39). The analysis will argue that BI-D becomes an embodied experience in a very literal sense, as Forney employs distinct textual and graphic devices to visualize her manic and depressed selves as well as the troubling, fluctuating stages of transition between them. The second section will focus on a particular level of Forney’s archive, Ellen’s notebook, to critically examine the fruitful rendition of self-surveillance in *Marbles*. Ellen’s extenuating efforts to adapt herself to her new identity are clearly reflected in the many notes and charts that she creates in her notebook to record every single aspect of her life: mood, medication intake, daily activities, sleep, thoughts, and fears. This process of observing, tracing, and enacting self-surveillance leads Ellen to question both her role as a creative, productive artist as well as the consequences of depending on medication to continue working. In addition, the afflictions provoked by her inability to work and create art—with the subsequent loss of income after her depression settles in—allow me to investigate how this text engages with capitalist ideas about work and productivity. My last section delves into Forney’s assemblage of the rest of the levels that compose her archive—autobiographies, indexes, reading materials, Ellen’s sketchbook, and photographs. Gathered from external and

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internal sources, these levels manifest Ellen’s efforts to gain a clearer insight of her disorder amidst her precarious balance of therapy sessions, exhausting medications, and the swift changes produced in her bodymind. Through her comprehensive practices, Forney mimics and resists the diagnostic procedures that put a medical label on her disorder and objectivize her experience of BI-D. Throughout, I will contend that Forney resists the label “Bipolar I Disorder 294.6” by constructing an archive that details her distinct, individual experiences of manias, depressions, and all the changes, failures, and growth in between.

5.1. Bipolar I Disorder as an Embodied Practice

Marbles begins in the middle of Ellen’s last big mania, right before receiving her diagnosis. The reader is situated in the tattoo parlor where Ellen is getting her first tattoo, which she planned in a sprint of manic energy. The very first page contains a depiction of her profile, her eyes closed as she endures the electrical sensation that the touch of the needle produces on her body: “Every time Owen traced a new line with his needle, I could SEE the sensation—a bright white light, an electrical charge, up and to the right” (Forney 3). This sudden charge of pain that resembles an electrical current helps her to focus on her own body: “It connected with my right temple and ran through my body. It pinned me in Owen’s chair. The focus relaxed me” (4). There are no further explanations this early in the narrative, but the fact that Ellen needs her attention to be brought back to her physicality is important: the high energy levels that she feels during her mania scatter her mind in all directions, and the pain produced by the needle, which is described in a “language of brilliance” (Cressman 5), helps her to concentrate this flow of energy on her body. Besides, the fact that the beginning of *Marbles* shows Ellen getting her tattoo done produces an interesting interplay with the graphic process that Forney follows to draw herself: while she is inscribing her own body on the page by using traditional art tools—inks and pen—her autobiographical avatar is simultaneously having her body filled by tattoo ink.

As shown in fig. 2.1, the visualization that Forney renders of her thought process when planning her tattoo becomes a perfect example of the workings of Ellen’s mind under the influence of mania. Unaware of the diagnosis that she will soon face, Ellen decides to get a tattoo in her whole back that reflects both her connection to water and her passionate interest in comics: “I’d been musing about the what and where for my first—and, I resolved, only—tattoo. I wanted it to be meaningful. Suddenly, a network in my

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head lit up!!” (Forney 6). This network of ideas extends over the course of two pages: in a double spread that does not follow any conventional layout—no frames or panels, nor gutter—Forney draws numerous balloons, connecting arrows, and onomatopoeias, with Ellen’s open, bright eyes and mouth on the left side of the page. Her sudden strike of inspiration is drawn as a bolt of lightning that surrounds her face, thus connecting her creativity during mania to the bolt of pain she feels under Owen’s needle. Below her minimalistic face, a big word balloon with spiky framed lines illustrates her thinking process: “Where: my whole back” (6). Inside, smaller balloons contain each of her separate ideas with arrows that connect them throughout the two pages: “with energy going up – site specific fit – positive, joyful” (6). These striking connections continue under numerous onomatopoeias such as “Ping! Ping! Dzzt!” and stop at the bottom right of the second page, where Forney includes a small notepad in which she annotates the resulting idea for her tattoo: “Full-back water tattoo by Kaz!” (7). As she explains, “I always kept a notepad in my pocket because I had ideas like popcorn, and I’d forget them if I didn’t write them down” (7).



Fig. 2.1. Ellen is planning her new tattoo (Forney 6-7).

By employing such a non-conventional composition, Forney bends the formal aspects of comics to capture not only the split logic and the disorganization of her manic mind, but

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also its power and creativity. The scattered, boundless thoughts “burst outwards, beyond the frame and, even, the boundaries of the page” to mirror “Ellen’s experience of her manic phase” (Cressman 7-8). As I will note in the following pages, this boundlessness in the visual is a recurrent device to depict in Ellen’s mania.

Walking through the snowy street at night after leaving the tattoo parlor with her fresh linework, Ellen imagines “an elegant nod of approval from the universe,” and everything around her feels “magical and intense, bursting with universal truth” (Forney 11). This connection and this overflowing goodness that she feels after getting tattooed are soon challenged in the second chapter of *Marbles*, where Ellen visits Karen, her psychiatrist, and learns for the first time that she meets the medical criteria for bipolar disorder. After the outburst of ideas, connections, energetic transitions, and visual excess of the first pages, Forney employs a traditional layout with panels that easily demarcate the different encapsulated scenes. The first one depicts Ellen sitting in Karen’s office, denying her newly received diagnosis: “My mother and I both have bipolar tendencies, but I’m not like, bipolar bipolar” (Forney 15).

After observing her patient’s resistance, Karen brings the *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV)*¹⁴ to work Ellen through the symptoms of bipolar disorder: “Let’s take a look at the symptoms” (15). In the next three pages, both psychiatrist and patient analyze each listed symptom and its manifestation in Ellen’s behavior and daily life. Fig. 2.2 depicts one of these pages: on the right side, Forney draws the description of the symptom as stated in the *DSM* in a framed, rectangular panel, with Karen’s finger pointing at it. Then, on the right side, she draws her own manifestation of said symptom in an irregular, bubbly panel that disrupts the orderly panels of the *DSM*. For instance, in the first panel, the description of the *DSM* addresses the first symptom of bipolar disorder, which refers to augmented self-esteem: “B. During the period of mad disturbance, three of the following symptoms have persisted and have been present to a significant degree: (1) Inflated self-esteem or grandiosity.” In two caption boxes close to the depiction of the book, Forney writes: “I had to admit this one. I’d had a sudden realization not long before, out of nowhere.” The next panel portrays Ellen wearing a luxurious dress and holding a drink as she talks to a famous,

¹⁴ Smith and Watson note that the *DSM* “has been the official handbook of the American Psychiatric Association since 1952.” Forney employs the fourth edition of the *DSM*, but the updated fifth edition was released in 2013 (“Contrapuntal” 46n5).

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fashionable figure: “If I was at a party—and Madonna was there—I wouldn’t be intimidated at all!! (Why Madonna? I don’t know!)” (Forney 16). The next two rows of panels show Ellen realizing that she also fits the description of the next two symptoms described, a “decreased need for sleep,” and being “more talkative than usual” (16).



Fig. 2.2. DSM vs. Ellen (Forney 16).

The composition of this layout remarks the wide division between the clinical, “objective” descriptions provided by the *DSM* and Ellen’s own manifestation of each symptom: her experience of illness is not neatly outlined, nor fitted into a coherent, linear description, but instead floats free, goes back and forth in time, and interrupts logical thinking. According to Irene Velentzas (2017), the particular depiction of the *DSM* in these pages, with its “straight book lines, the neat linearity of the printed text, and Karen’s finger tracing a line under each BAD symptom,” helps to “emphasize the medical model’s linear understanding of disability that supports the curative disability narrative.” Instead, the portrayal of Ellen’s symptoms “subverts the suggested categorical homogenizing and linear experience of disability presented by and through the *DSM* and the standard

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diagnostic narrative sequence” (Velentzas). Furthermore, the scene presented in fig. 2.2 is one of the earliest examples of the medical gaze being exerted over Ellen’s bodymind as it attempts to categorize and organize her experience.

When Ellen realizes that she meets the criteria for a BI-D diagnosis, the significance of the term “bipolar” falls on her like a heavy weight. Fig. 2.3 shows a close-up of Ellen’s inexpressive face in a spread with no framed panels. She stares blankly at no particular point in space while a card under her neck reveals her new medical label: “Bipolar I Disorder 296.4.” Above her image, Forney narrates the impact of the newly acquired disorder on her younger self: “My own brilliant, unique personality was neatly outlined right there, in that inanimate stack of paper. My personality reflected a DISORDER—SHARED by a group of people. This sank in like the sun had gone behind the clouds—like I’d had been covered by a heavy blanket, like a parrot” (19; emphasis in original). The usage of capital letters and underlined words—a textual device extensively employed in *Marbles*—signals the wrecking shock that Ellen experiences when she realizes that her particular “brilliance” is a “shared” mental disorder that completely dissolves her uniqueness and her individuality, as it is observed in many other individuals. Fig. 2.4 presents a spread that contains the words that Karen had previously said to Ellen—“Let’s take a look at the symptoms”—repeated throughout the whole page, with no spaces between the different sentences.¹⁵ Bold white letters surrounded by a black, thick scribble cross the therapist’s words, reading “YOU ARE CRAZY” (Forney 20). The wide size of the font and the lack of drawings on this second figure suggest that the reader is forced to take in the implications behind that short—yet powerful—sentence. Thus, they are also “confronted with the observational medical gaze of diagnosis, experiencing the scrutiny and categorization that Ellen rebels against in subsequent panels” (Velentzas).

¹⁵ As the caption notes, the structure of the page imitates a “magic eye stereogram,” which reveals a “clear, irrefutable 3-D image” (Forney 20). In the appendix, Forney points out that she had originally intended to create a real “single-image stereogram,” which is “a computer-generated pattern that creates an illusion of three-dimensionality from a two-dimensional object” (241). In order to see the words “YOU ARE CRAZY,” the reader would need to cross and uncross their eyes quickly. However, to preserve the continuity of the narrative, she opted to draw instead a copy of a stereogram in page 20 (241).

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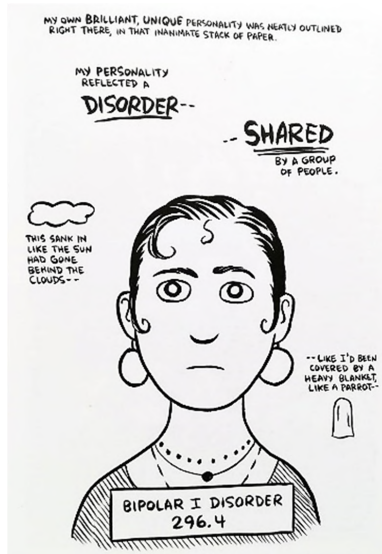


Fig. 2.3. Ellen receives her official diagnosis: "Bipolar I Disorder 296.4" (Forney 19).

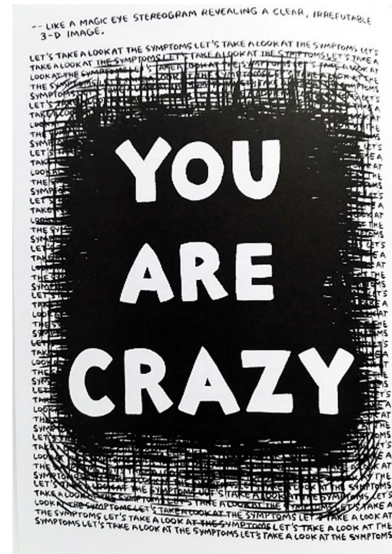


Fig. 2.4. "You are crazy" (Forney 20).

The visual strength of the previous figures lies in Forney's capacity to convey the heaviness of the diagnosis through an intricate interplay of words and images. Interestingly, Ellen "does not return the reader's or the medical gaze," but instead "is represented as an object to be looked at, not as an individual who does the looking" (Velentzas). Ellen's individuality is rendered invisible by her clinical label, "permanently 'boxed in,' not by the conventional frames of a comic panel but by her medical definition and DSM code: Bipolar I Disorder 296.4" (Cressman 7). I would further suggest that the detailed descriptions of the symptoms of bipolar disorder provided by the *DSM* work in a similar fashion to the x-ray in *Stitches*: both provide clear, "objective" visualizations of an individual's body and mind as promoted by scientific and medical discourses—labeling and categorizing them, but also stripping any individuality from them. Ellen resists being grouped with others to avoid having her "brilliant, unique personality" rendered invisible by a medical label. This resistance towards her new identity extends to the first decision that Ellen makes after her diagnosis: she will not take any medication to support her condition, afraid that its side effects would flatten her creative spark and endanger her job as a cartoonist. Art is not only Ellen's job, but also the cornerstone of her life: "Art was my blood, my heart, my life" (Forney 24). She soon devices a way to

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keep working despite her unmedicated, constant swinging between mania and depression: “I’ll plan various comics projects to do when I’m depressed! The manic-me-now will take care of the depressed-me-then!! I’ll write them down and start them now, to finish later! I have plenty of ideas!” (Forney 29).

Throughout *Marbles*, Ellen’s mania is depicted with thick, glossy, lines, expressive eyes and mouths, an abundance of word balloons that contain her endless talk, and frames that bend and break, unable to contain her in the traditional layout of comics. A compelling example is found in the preparation for the party that she throws for the release of her book *I was 7 in ‘75* and her thirtieth birthday. The bursts of enthusiastic, turbulent energy prompt Ellen to follow multiple plans and projects, sometimes all together at the same time: “I could do them TOGETHER as ONE BIG BIRTHDAY PARTY for EVERYONE who was 7 in ‘75!! We were ALL turning 30!!!!” (Forney 51; emphasis in original). Once again, her excessive enthusiasm and her high energy when planning are conveyed in the textual through the usage of underlined, uppercase letters that almost seem to burst out of word balloons. The resulting celebration is found in the double spread presented in fig. 2.5, which depicts and extensively describes each of the many activities that take place in the party: singing, dressing-up, games, live performances, readings, and the elaborate preparation that each of these shows requires. There are no panels or frames, as the actions are divided by lightning-like arms that emanate from Ellen’s head, located on the left side of the composition. Her big, open eyes seem to stare at the reader, and her forehead is covered by stars and dashes that highlight her intense staring and planning. At the top left of the page, the contents of the first division show the venue of the event—“Local club owner Steve agreed to host at cool local club”—while the next divisions show the party dress that a friend designed for her and a close friend that plays on the stage with her band, respectively.

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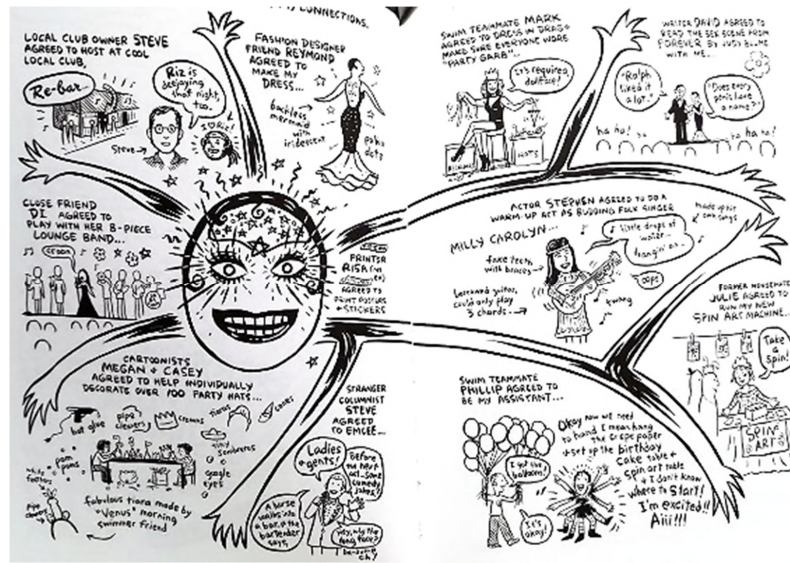


Fig. 2.5. Ellen's big birthday and book release party (Forney 52-53).

Forney highlights the chaos, the fragmentation, and the multiplicity that her mania creates by employing a non-conventional layout that halts the narrative flow and forces viewers to take in each activity in an unconnected, unguided manner. Just like the spread shown in fig. 2.1, the formal aspects of this composition disturb the reading experience and force the reader to follow the workings of Ellen's mind. Satharaj Venkatesan and Sweetha Saji (2019) note that Forney "uses an array of expressive non-diegetic graphic signs to relay her manic condition, characterized by celerity, passion and creativity." Some of these graphic signs are emanatas, which are "special effects lettering, motion lines and distinct panel shapes that enhance the content" ("Drawing" 8). Besides, the lack of panels and gutter signal that every activity takes place quickly, almost overlapping each other. The absence of these graphic elements and the visual surplus of the spread construct Ellen's manic experience of time as something that she experiences in "quick bursts," to recall Kafer's conceptualization of the strange temporalities of disability as shown in chapter 3 (*Feminist* 34).

Another engaging example of the visual representation of Ellen's mania is found in fig. 2.6, where she talks about all her upcoming projects and her sexual experiences as a bisexual woman in one of her visits to Karen's office. The first panel shows Ellen's face with huge, expressive eyes that stare at the reader. Her incessant chatter covers the

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background of the entire panel—an unstoppable force that cannot be contained within word balloons. In fact, her words break the frame of the panel in the bottom right corner and flow into the next frameless panel, which encapsulates her even bigger face with even bigger eyes while her barely legible chatter surrounds her in a swirling spiral: “That’s normal for me, though, all these different kinds of projects... and the sexy stuff is kind of my niche, all that sex positive and queer stuff which has to do with me, too, being really out, kind of a bisexual role model...” (Forney 49). Tiny black stars decorate the blank backgrounds of both panels, indicating Ellen’s high levels of activity and energy.

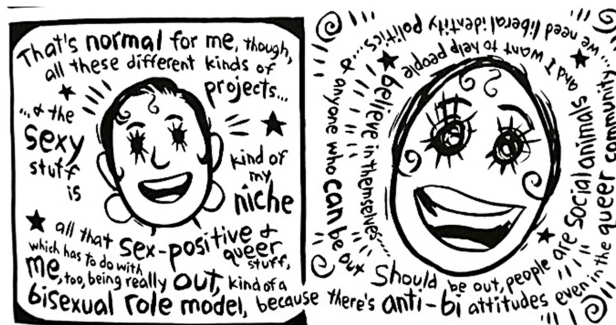


Fig. 2.6. Ellen’s mania (Forney 49).

The visual depictions presented in figs. 2.5 and 2.6 provide a wide contrast with the way in which Forney represents herself when she falls into the pits of depression. Fig. 2.7 introduces two panels belonging to the fourth chapter of *Marbles*, after Ellen leaves Karen’s office feeling “a big cry welling up” and runs to cry alone in the bathroom. Sitting on a toilet, Ellen sobs hard as she covers her face with her hands. Huge tears stream down her face and thick dashes surround her, conveying the movement of her trembling shoulders. The caption above her reads: “Crying could turn into sobbing, harder and harder. It felt like I was falling into a big hole, like I wouldn’t be able to stop” (Forney 98). Her energetic, intense chatter, which ran free and loud in fig. 2.6, is nowhere to be found: in this panel, she is silent as she cries, and sparse balloons contain her thoughts: “Get a grip, get a grip... I’m drowning... People can hear me. I’m pathetic” (98; emphasis in original). In the second panel, Ellen looks at herself in the mirror while embracing her sketchbook.

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Fig. 2.7. Ellen's depression (Forney 98).

The stark clash of graphic styles between figs. 2.6 and 2.7 gestures to Donovan's idea of the distinct embodied experiences that Forney creates to portray her manic and depressive states ("Representations" 238-39). It also highlights the difference between the two versions of Ellen as theorized by Smith and Watson, who indicate that "Forney represents the visual corollary of the manic state as an explosive, hypersexualized woman who is out of control in her excesses," while Ellen's depressive state is depicted in the shape of "a woman abandoned to blob-like withdrawal into self-loathing and self-erasure" ("Contrapuntal" 37). If her bright eyes and big smile convey her energy and her communicative strength during mania, Ellen's drooping posture—arms embracing her trembling body, hunched shoulders, curved back—transmits her dejected and somber mood, which urges her to cover and protect her own body.

I would argue that an instance of the "self-erasure" mentioned by Smith and Watson is also found at the beginning of Ellen's first severe depression, shown in fig. 2.8. When her depression finally sets in, she is reduced to a set of minimal lines, unable to leave the safe spaces of her bedroom and couch. In a spread that occupies the whole page, Forney narrates the sparse, slow movements that her depressive self manages to make inside her home: she wakes up from the bed, curls herself up in a blanket, and sits on the couch, where she needs to lie down again. By employing a composition with sparse drawings and no panels, frames, nor word balloons, Forney conveys the sluggishness, the blankness, and the bleakness that depression brings. Ellen's body is reduced to its barest expression: an oval symbolizes her head, and small, meager lines compose her torso, arms, and legs when she is not covered by the blanket.

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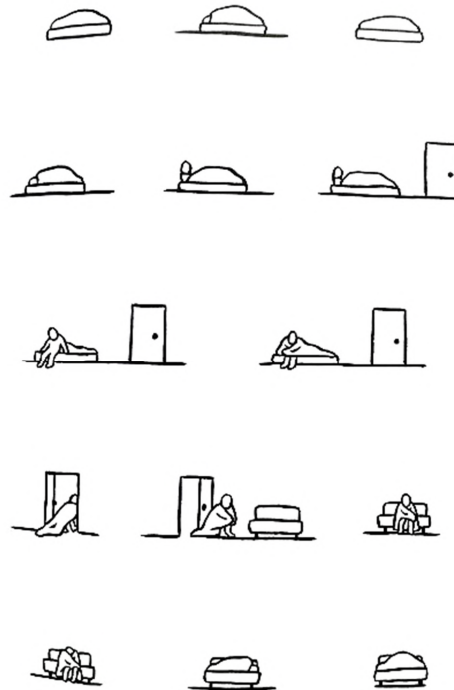


Fig. 2.8. The blankness of depression (Forney 77).

In this manner, while Ellen’s figure is almost rendered invisible, the furniture that surrounds her becomes more prominent. To Robin Alex McDonald (2019), who asserts that depression “constitutes a turn toward unusual objects which . . . can appear as imposing, strange, and even *queer*” (97), the “hyperpresence of the bed” in this sequence signals an avoidance of the usual objects that composed the rituals of Ellen’s daily life and “a turn toward objects that deliver the immediate comforts or refuge necessary for coping.” The bed, then, “becomes the central axis around which life itself is organized, while other objects (the telephone, which opens one up to a world of social communications; the toothbrush, which signifies the maintenance of the body; the refrigerator, which stores fresh produce for nourishing meals) recede into the periphery” (McDonald 103). Ellen is thus reduced to the bed she is in and to the blanket that hides her body from sight—both from the sight of others and from her own eyes. Her depressive self is depicted “with a bleak image of her cocooned body, an image in which physical and mental characteristics are erased” (Mannon 148). In this way, depression lifts any

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individuality from her, and she becomes nothing more than a lump that is unable to speak or interact with anyone, her facial features and her rich, eye-catching clothes gone.

This sequence also gestures to the distinct experience of time and movement suffered in depression. In her brilliant analysis of the usage of metaphors in graphic narratives about illness, Elisabeth El Refaie (2019) maintains that “comics about depression are . . . able to convey the sense of temporal stasis and entrapment that seems to be very common among sufferers of the disease” (*Visual Metaphor* 183). In her analysis of the previous sequence, she observes that “the close visual resemblance between the very first and the last image on the page of Ellen hiding under her duvet encourages a circular reading path, which in turn implies that there is no meaningful progression at all” (*Visual Metaphor* 182). The lack of frames and gutter conveys this entrapment, as the repetition of movements—from the bed to the couch, from the couch to the bed—transmits Ellen’s stillness and passivity. Likewise, this entrapment provoked by depression interferes with normative notions of time and productivity as envisioned in capitalist societies. According to McDonald, “[l]ike queerness’s spoiling of heteronormative maturation, depression’s frustration or disruption of chrononormativity—what Elizabeth Freeman defines as ‘the use of time to organize individual human bodies toward maximum productivity’—is also partially responsible for its classification as a pathology” (102). Ellen’s experience with depression can be conceptualized under these terms, as she “wastes” productive time by laying down in her bed and sofa all day, unable to participate in any other activity: her inactivity and her feelings of worthlessness interrupt her life.

The unbridled energy that Ellen maintains while manic is completely gone during her depression, and she soon learns that she needs to summon “herculean effort” to pull herself together for a short period of time to carry out her tasks, such as interviewing her admired cartoonist Judy Blume or drawing weekly “7 in ‘75” comic strips (see Forney 79). I would like to extend the discussion of interrupted, unproductive time in Ellen’s depression to argue that it also engages with the most negative aspects of crip time as developed by Ellen Samuels (2017) and articulated in the third chapter of this Thesis. The slowness of crip time as experienced by Ellen during her depression is not always desired, since it forces the disabled person to stop and take unwanted breaks even when they want to keep going (Samuels). Not only does Ellen’s inability to follow a normative, active schedule affect her work, her income, and even her social and family life; it also changes

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the expectations that others have of her. When Ellen talks to her mother and her psychiatrist and mentions that she is able to get out of bed “only to fall asleep on the couch,” both congratulate her on managing to do so while depressed. “I was struck by how low their expectations of me had become,” Forney writes (81). Even the thought of suicide “seemed like an awful lot of effort.” Her feelings of being a failure only increase as her depression continues: “I had no sense of purpose. I felt like I was missing my skin” (Forney 84).

Having analyzed Forney’s visualization of her embodied manias and depressions, the brief moments of transition between Ellen’s manic phase to her first severe bout of depression are also worth exploring. After one of her high waves of manic energy prompted Ellen to drive two of her cartoonist friends to a stranger’s house in the middle of the night to play dress-up (see Forney 66-67), she goes back to research to plan her upcoming comic projects. However, while she is reading in the library, she feels a sort of “sickness” creeping in (see fig. 2.9). A composition of three framed panels with perfectly aligned captions illustrates a close-up of Ellen’s profile, reduced to minimalistic, cartoonish lines that represent her eyes, nose, hand, and the book that she is reading. “I had a tickle in my throat, and there was pressure in my nasal passages. I’d forgotten this part, too,” the text reads in the first panel. In the second one, as she scrubs her eyes, Ellen notices the physical symptoms that her body is displaying: “During a manic episode, depression seems entirely impossible. At the end of a high, though, I’d get sick.” In the last panel, as she attempts to focus back on her reading, a small onomatopoeic “snif” accompanies her image to signal the beginning of her sickness. This physical symptom is connected to a particular sensation that precedes a huge change in her mood: “I had a sinking feeling, like I was about to get fired, or dumped” (Forney 68).



Fig. 2.9. The stages of transition between mania and depression (Forney 68).

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Ellen’s body feels the depression settling in before she even notices the changes in her mood—her physicality is thus forcing her to remember what depression feels like. Forney also conveys the transition between moods through the visual: while frameless, chaotic panels, and her energetic appearance governed the pages that narrate her manic phase, now the repetition of minimal, framed panels evinces that her mood is changing.

The transition from mania to depression turns out to be irreversible after Ellen leaves the second stage version of her big birthday and book release party feeling “exhausted” and “completely deflated” (Forney 69). A week after the event she calls Karen in a panic, a scene illustrated in fig. 2.10. The visual composition of the two panels differs completely from the stylistic choices that accompany her manic self: the serrated borders of the panels and word balloons disclose the tremendous distress that Ellen is feeling while her depression is creeping in. In the first panel, her phone reproduces the call center voice message—“If you are in crisis, please press zero to be connected to our emergency backup service”—while Ellen repeats the words “crisis, crisis, emergency.” The second panel visualizes Ellen’s feeling that her head is “a cage of frantic rats”: her eyes are drawn at the bottom of the jagged panel, while above, a mass of swirling, aggressive rats contorts itself within a nest-like shape that mimics her head. The small balloons contain Ellen’s panicked response to her psychiatrist: “Karen! I’m scared. Yes, I’m safe... I guess” (Forney 69).



Fig. 2.10. Panicking, Ellen calls her psychiatrist for help (Forney 69).

Promptly after this sequence, Ellen’s previous decision of not receiving medication disappears amidst her new feelings of powerlessness and desperation. Karen decides to put her on lithium, and Ellen accepts, not failing to notice that this new

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treatment sentences her status as a bipolar patient: “[l]ithium made it official: I was bipolar 1 crazy” (Forney 71). Moreover, Ellen is still worried about the long list of side effects that lithium produces, which include hand tremor, blurred vision, skin problems, cognitive problems, and cognitive dulling, among many others: “my hands and eyes were two of my essential work tools . . . how could I work with ‘cognitive dulling’?” (Forney 72). Being a mood stabilizer unable to “lift a depression that’s already begun” (72), lithium has no power to make her feel better. Thus, Ellen curls up in her couch, unable to move or go anywhere, and, of course, unable to produce the work that she had planned while manic: “It was clear: there was no way I’d be able to dredge up the energy or sass to do the comics I’d planned—half-planned. The manic-me-then had no power to take care of the depressed-me-now” (Forney 73). With this grim realization, Ellen faces her first major depressive episode and starts her struggles with medical treatment and self-surveillance.

5.2. “Watch getting work done. Watch obsessing”: Balancing Self-Surveillance

For Ellen, learning to live with BI-D entails a close, excruciating practice of monitoring and observing her bodily and emotional changes to avoid triggering an acute episode of mania or depression. A year and a half after diagnosis, a combination of medication and talk therapy manage to stabilize her condition, but all of a sudden one of her drugs starts troubling her health: “But my platelet level did keep dropping. Less than a month after finally—finally—feeling like I’d had surfaced, I had to switch to a new medication, neurontin. My mood lifted... And lifted... And didn’t stop lifting. I could feel myself getting swept away” (Forney 134-135). This sudden alteration scares Ellen and prompts her to start a daily journal to check and keep track of every single change in her mood and behavior: “I desperately tried to keep track of what was going on with me. I bought a spiral-bound notebook and started keeping a journal. How could I keep track of my mind, with my own mind? . . . I did my best to record my emotional rollercoaster, using words and pictures” (Forney 136).

The inability to rely on her own mind to keep track of the necessary data to manage her disorder leads Ellen to the physicality of a notebook, which acts as a grounding space for her to focus, regulate her racing mind, and write down her ideas and data. By using the tools of her trade—the textual and the visual—Ellen forces herself to monitor every single aspect that involves her bodymind. An engaging reproduction of the contents of this notebook is shown in fig. 2.11, which depicts a spread with no panels or gutter that

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contains one of the many handwritten charts created by Ellen to surveil herself. Several rows and columns itemize the entries that she is recording: “meds,” “previous night sleep,” “mood,” and “notes.” Below, the columns are all filled with different data and descriptions: “7 hrs. / frazzled / 1 mg klonopin at noon.” Seven caption boxes scattered through the page narrate the contents that Ellen includes in her notebook: “Charts! Lists! Descriptions! Theories! Analyses! Theories! Banalities! Venting!” (Forney 137). On the bottom right of the page, Forney draws the profile of her past self writing in her notebook. Next to her, a scrap of lined paper shows her handwriting: “When is ‘happy’ TOO happy??” (137). This layout composition serves to emphasize the overwhelming magnitude of the task she is carrying out: as Ellen appears in a corner, fixated on her work, the vast amount of personal data that she needs to survey every day occupies most of the page, dwarfing her figure.

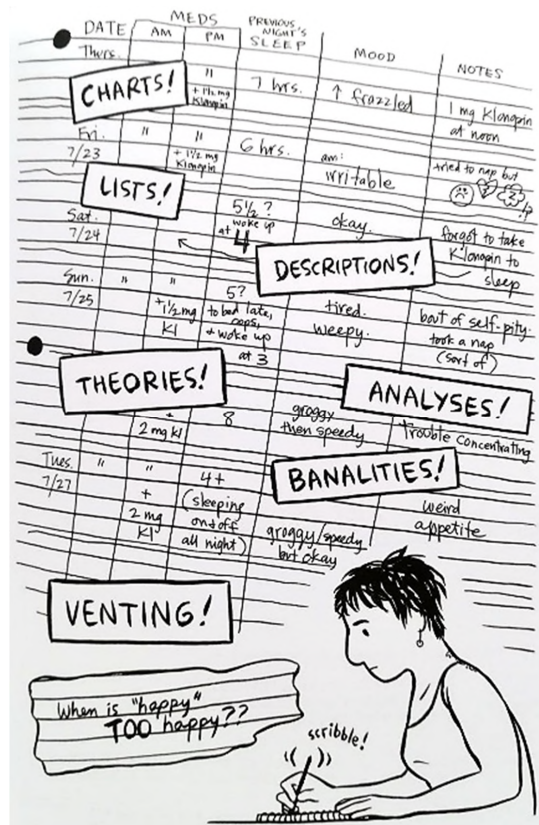


Fig. 2.11. Ellen monitors her bodymind in her notebook (Forney 137).

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That last handwritten scrap of paper—“When is ‘happy’ TOO happy??” (173)—offers a compelling analysis of the capitalist emphasis of happiness and wellbeing. As mentioned in the third chapter of this Thesis, Andrea Nicki examines the demand of cheerfulness, where people with disabilities, especially those who face any kind of depression, are forced to be optimistic and positive all the time (94). Many disabled individuals feel reluctant towards sharing the most negative aspects of their bodyminds. However, this plays out differently for Ellen, since living with BI-D entails the close monitoring of the signs of “too much happiness,” because they may trigger an acute episode of mania. While depression has, of course, its own perils, the charming, feel-good energy of mania may be too tempting to avoid and can easily lead Ellen to burn herself out and crash. Despite the added difficulty of having to be cautious around her “good” moods, the fact that Ellen is actively engaging with her own treatment by making these extensive charts and closely surveying herself gestures to her refusal to be a passive patient of BI-D—an idea that will be examined at greater length in the following pages.

Precisely because of the dangers provoked by a “too muchness” of her feelings—either “too much happiness,” or, on the contrary, “too much grief and sadness”—Ellen needs to be always watching herself: closely observing her own bodily symptoms, emotions, mood, behavior, medication intake, and daily activities while trying to come to terms with her identity as an artist with BI-D. As shown in fig. 2.12, the pages of her ruled notebook become a testimonial of the constant, exhausting process of surveilling and monitoring her bodymind and her life: “Watch sleeping. Watch eating. Watch socializing. Watch getting work done. Watch obsessing” (Forney 138). The words are complemented by a sketch where Forney depicts her huge eyes with swirling pupils and a mass of five smaller heads that sprouts from them. Each of these conjoined heads—which contains a small word balloon that reads “watch it”—represents Ellen in one of her different daily activities: loving, sleeping, eating, drawing, and getting dressed up.

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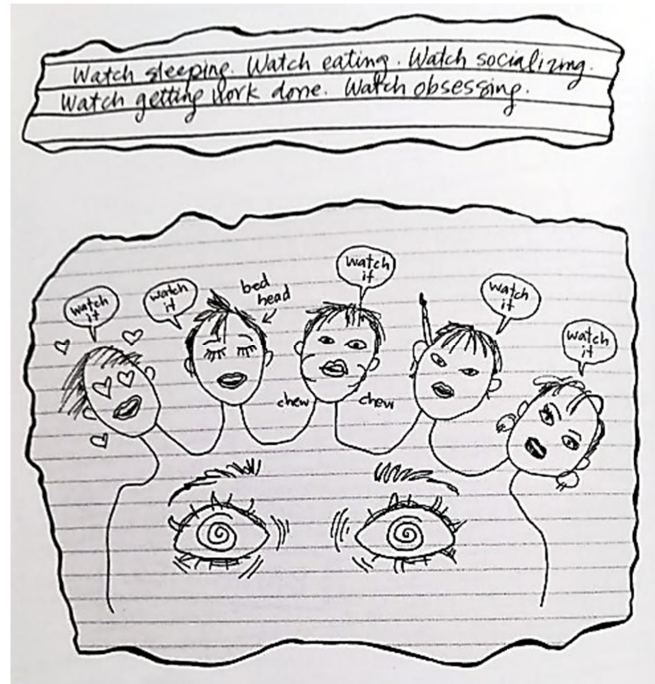


Fig. 2.12. “Watch obsessing” (Forney 138).

Becoming both observer and observed, Ellen willingly internalizes the healthcare practices necessary to manage her disorder and then exerts self-regulation through her own disciplinary control. The visualization of these five, smaller “Ellens” breaking out of her head conveys the fact that self-surveillance takes place in every single area of her life simultaneously. Moreover, each of the activities she carries out—sleeping, eating, creating, etc.—comes with a clear warning sign: too much of it, and she may risk slipping into an acute manic episode. Under this taxing procedure, even the process of self-surveillance poses a threat: obsessing over her emotions, activities, and behaviors can also be a symptom of an upcoming episode. As one of the most engaging parts of the *crip* archive, Ellen’s self-surveillance notebook visualizes her struggles with the intense management that her disorder requires: she is forced to adopt both the roles of “doctor” and “patient” in order to find a treatment that helps her to avoid triggering acute episodes.

With the elevated price of her medicines and her weekly visits to her psychiatrist’s office, Ellen soon learns that managing her disorder and caring for her health comes with a high cost. The monetary costs of receiving and maintaining a treatment for her bipolar

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disorder are extremely difficult to cover with the decline in her productivity after her depressive state makes her lose her steady income. As Forney writes in the front of a dollar bill shown in fig. 2.13, “[i]ronically, this is not a disease for an artist’s budget” (230). Below the dollar bill, Forney employs the shape of a coin to depict each of the expenses caused by her treatment: “health insurance: but even then, mine didn’t cover mental health (many plans don’t),” “[a] psychiatrist is often \$200 or more per visit,” “health care for side effects (e.g. acne),” “labs for blood work,” “yoga classes,” “possible hospital stay,” “swimming pool,” “acupuncture and alternative medicine,” “vitamins and supplements,” and the “lower rate of productivity in an acute episode.” On the right side of the page, a ticket itemizes the costs of a monthly supply of Forney’s medicines, which “are sometimes covered, sometimes not, and they can be pricey.” For instance, a monthly supply of lamictal costs \$490, and xypreza, \$660. Forney concludes that “[t]reatment can easily cost thousands per month,” a cost that she would not have been able to cover without her mother’s financial support (230).



Fig. 2.13. The costs of a treatment plan for bipolar disorder (Forney 230).

These high costs further disrupt her already precarious financial situation, and thus she is placed into a never-ending cycle: she needs to work steady to be able to cover her

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medicines and therapy sessions, but she is unable to hold a job without a treatment that helps her control her symptoms and manage her disorder. As she peers through job adds, desperate to gain any sort of income, Ellen wonders if she can sell her eggs: “Wow, \$5000—I wonder how hard it would be emotionally to sell my eggs?” However, she soon realizes: “Wait—no one would want my eggs! I am broken and tainted! Judgmental infertile couples!” (Forney 149). The rest of the scene, displayed in fig. 2.14, illustrates Ellen’s worries about her future as a disabled woman, manifested in her internal debate about the idea of reproduction. The first panel starts with Ellen wearing a robe and looking disheveled, sitting in front of a table with a classified job listing open before her and a cup of coffee on her side. She agrees with her previous imagery of a “judgmental infertile couple” that would reject her “bipolar eggs”: “Well, I wouldn’t want my eggs either, if I were those people. Chick with a serious hereditary disease with no cure. Next, please.” The whole sequence depicts a worried, confused Ellen pondering about the idea of having children while being a medicated, disabled woman. In the last panel, she stops drinking from her cup while she questions the implications of finding a “bipolar gene.” Question marks pop up around her: “stigma? abortions? babies left on mountaintops? better and earlier treatment? cure?” (149).



Fig. 2.14. “I’m glad I never wanted kids myself” (Forney 149).

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Apart from visualizing Ellen’s desperation to cover the financial costs of her treatment, the previous scene also engages with the ableist ideas about the future of disabled individuals as examined in the third chapter of this Thesis. To recall Kafer’s arguments, futurity “has often been framed in curative terms, a time frame that casts disabled people (as) out of time, or as obstacles to the arc of progress” (*Feminist* 28). The future is used to impose and reinforce compulsory able-bodiedness/mindedness through technologies such as prenatal testing, “much of which presumes that all positive diagnoses will be ‘solved’ through selective abortion” (Kafer, *Feminist* 29). In this manner, “pregnant women with disabilities and pregnant women whose fetuses have tested ‘positive’ for various conditions are understood as threats to the future” (29).

Rooted in eugenics beliefs, these ableist ideals disregard the very own existence of disabled individuals like Ellen in the present while simultaneously rendering them as obstacles to the able-bodied, able-minded future. As shown in the previous panels, Ellen falls victim of these beliefs—“I probably wouldn’t want my eggs either” (Forney 149)—and feels relieved because she does not want to have biological children. While she mulls over the consequences of scientific research finding a bipolar gene, she is incapable of imagining a future that does not include the elimination of her condition. Her unanswered questions in the last panel—would this discovery lead to a better treatment or a possible cure for bipolar patients? Or would it translate into abortions and abandonments of babies that test positive for that gene?—formulate the two possible futures where eugenics places disabled people: either a path to a better treatment and a possible cure that inserts them back into a system of capitalist productivity, or death and elimination. Completely distraught by her current situation, Ellen is incapable of imagining a better future that does not entail the eradication of bipolarity. At the end of the scene, she does not reach a definitive answer to her questions, and the issue is not mentioned again in *Marbles*. Still, just like the visual itemization of the costs of her treatment in fig. 2.13, the previous sequence informs Forney’s text with some of the most negative aspects that Ellen endures while learning to live with her disorder. Under a neoliberal system that values ability and normalcy, her pervading anxieties about the future and about the costs of the treatment she needs to keep working become thus part of her experience of BI-D, as much as the blankness provoked by depression or the powerful energy of mania.

The long trial-and-error process that Ellen undergoes to find the exact dosage of medication to manage BI-D offers a compelling analysis of medication culture. As Forney

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notes at the beginning of the seventh chapter, “[b]ipolar disorder is difficult to treat. Finding the right medications can take a long time, so bipolars may list our med histories proudly, like merit badges” (181). She then depicts her younger self with a medication bottle cap on her head and a long list of badges on her hands—as a sort of “med scout,” as she humorously calls herself—which highlight the long process of receiving medical treatment over the years: there is, for instance, a badge for “capsules,” another for “tablets,” and another one for “pill box purchase” (see Forney 181). But the most interesting visual evidence is found in the three pages that Forney dedicates to detail the different side effects that each of her medications have produced on her bodymind since her diagnosis in January 1998 until March 2002. Fig. 2.15 introduces the first of the three spreads, divided in three rectangular panels that encapsulate detailed descriptions and schematic drawings—each dedicated to three of the many different drugs that Ellen has tried over the years. In the second panel, for example, Forney delves into her lithium intake and depicts her sullen, schematized face and arm while a phlebotomist—depicted as a small, black leech with sharp teeth—draws her blood. Lithium keeps Ellen “from getting manic,” but does not help with her depression and forces her to take “lots of blood draws.” Among the many side effects caused by this treatment are “memory problems,” “skin breakouts,” and “weight gain.” Lithium also hinders her ability to work as a cartoonist, which Forney represents in the shivers of Ellen’s right hand as she attempts to hold a pencil.

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Fig. 2.15. Forney's detailed description of her medicines (Forney 182).

The long description continues over the course of the next two pages, which illustrate Ellen's experiences with different medicines, such as celexa or neurontin, and a return to lithium which caused her skin to break out and led her to get on side effect meds for her side effect meds (Forney 183-84). It is interesting to observe that Ellen is reduced to a schematic, unrecognizable figure—barely a head with eyes, nose, and arms—that stands still while the different treatments and mood stabilizers work on her. As her distinctive visual characteristics—her facial features, her clothes, and even her black hair—disappear, the previous panel further reinforces Ellen's role as a patient subjected to—and dependent on—the workings of the medicaments she takes.

This dependence on medication is also present when Ellen questions the connection between mood disorders and creativity. As noted in the previous section of this chapter, Ellen's first decision when she gets diagnosed with BI-D is to avoid medication, because she believes it would destroy her capacity to think creatively—and therefore she would lose her job as a cartoonist. But her stance completely changes after

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experiencing the full swings of her condition, and her self-surveillance notebook quickly becomes witness of all her thorough attempts to avoid acute episodes:

“Keeping track” had become so familiar. In my daily journal entries, I’d take particular note of possibly-symptomatic behaviors, was I spending money more easily? Was I working? Not enough? Too much? What was I wearing? Was I eating? Interrupting people? Napping? Crying? I’d keep my charts on the back pages of my journal—date, meds, sleep, mood, notes. (Forney 188)

Under these procedures, every symptom of her disorder must be covered or kept under control in order to fit in society, and taking medication becomes a step towards maintaining the level of productivity that allows her to keep working as a cartoonist. Her internal debates about the usage of medicine to treat BI-D conclude that it is beneficial for her creative job: “I guess [medicines] help my creativity, because it’s when I’m balanced that I can really focus and get my work done” (Forney 216; emphasis in original). In this sense, Ellen’s beliefs are guided by neoliberal ideas about work and productivity, which are visualized in her constant worries to maintain her creativity and her ability to work at all costs. As observed at the end of the seventh chapter of *Marbles*, this idea is supported by the fact that her concept of “balance” depends on a finely tuned combination of medicines after going through multiple combinations and measures over the years: “Finally, after four years,” Forney writes above a drawing of Ellen quietly practicing yoga, “[o]n precise measures of lamictal and lithium, and with klonopin and zyprexa at the ready... I found balance” (197).

But far from hiding or minimizing her troubling relationship with medication and the costs of achieving that “balance,” Ellen’s self-surveillance notebook shows all these tensions as well as her worries about managing a disorder that has completely interrupted her life. Just like her stress about money and her questions about a possible cure for bipolarity, the most adverse facets of living with BI-D are displayed through her detailed notes and itemized lists, and through her comprehensive descriptions of drugs and their side effects. In doing so, her decision to accept medication in order to mask her symptoms and maintain her ability to work becomes part of the *crip* archive. And by engaging with these worries, the reader becomes a witness to the difficult choices that Ellen must make to manage her disorder while simultaneously enduring the extreme distress that it causes.

Forney does not only detail the physical and psychological side effects produced by her medication over the years, but also accounts for the emotional costs of planning, surveying herself, and adapting to each new treatment. “It should get easier,” Karen

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reassures the young woman, “once we find the right meds and dosages, they should keep you pretty even, and you won’t have to be so vigilant about everything. We’re not there yet” (Forney 168). When Karen adjusts her medication dosage once again, Ellen gives her best to get used to it, her mind still quickly racing with thoughts of everything she needs to keep supervising. A compelling visual example of this struggle to find balance while supervising herself is found once again in her self-surveillance notebook (see fig. 2.16). Drawn in a huge, exaggerated shape, the insides of Ellen’s head are divided into several compartments belonging to different aspects of her life: “WORK LIFE,” “SOCIAL LIFE,” “FAMILY/MOM,” “YOGA,” and “I AM BIPOLAR.” Inside each life category, Forney lists all the aspects that she needs to attend to and creates a bullet point for each idea. For instance, inside the category “FAMILY/MOM,” she writes: “How my being bp affects her. Must remember to thank her for paying for KAREN, I keep FORGETTING. Stay in touch/out of touch. Call Dad. Card to Grandma. Email Matt” (Forney 172). The bottom right of the panel shows Ellen’s overwhelmed expression as she furrows her brows.

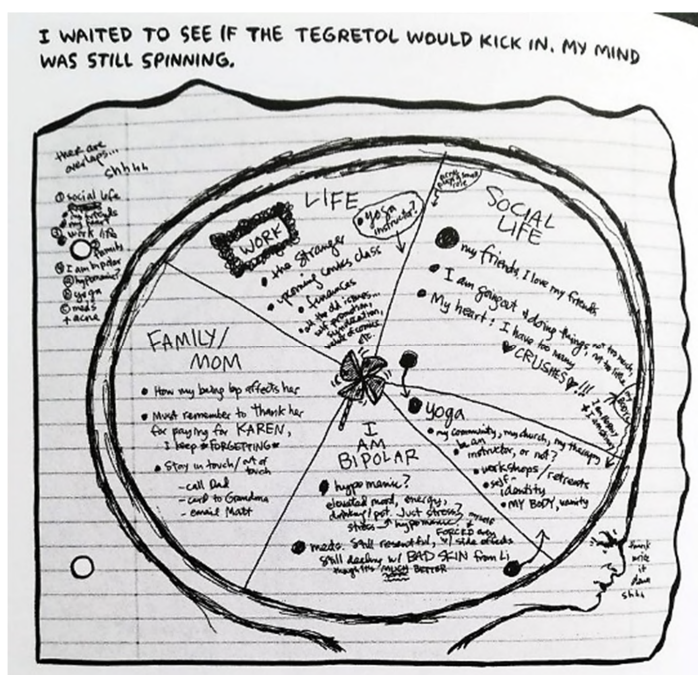


Fig. 2.16. Ellen’s mind spins as she tries to categorize her life and moods (Forney 172).

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This self-portrait bears witness to Ellen’s struggles to keep track of every single aspect of her life while undergoing the symptoms of a disorder that overwhelms her in all its forms. While the clearly delimited compartments visualize Ellen’s efforts to categorize her life into crammed lists with bullet points, the small, spinning pinwheel depicted at the center of her head—which recalls the spinning eyes from fig. 2.13—suggests the difficulty of keeping a balanced focus with a racing mind on the verge of triggering a manic episode. Unable to stay grounded, Ellen’s mind resembles a roulette that cannot stop turning and turning over each aspect, category, and data to be managed and surveyed.

As months of treatment and monitoring pass by, Ellen starts to feel better, but “definitely all over the place emotionally,” which induces her psychiatrist to adjust her medication once again. The scene is shown in the four rectangular framed panels depicted in fig. 2.17: first, Karen suggests that Ellen should go back to lithium, which she vehemently refuses. Then, in the next panel, the psychiatrist continues with her explanation: “Lamictal is good for holding off depression but not so good for holding off mania, and lithium is the opposite. They might work well together. We’ll keep the dosage very low” (Forney 190). In the third panel, Ellen collapses in her chair, attempting to reassure herself while her psychiatrist convinces her to get on the new treatment: “We can taper you on very slowly.” However, Ellen finally breaks down and cries in the last panel as Karen acknowledges that getting back on lithium is hard. Hiding her face behind her hands, Ellen cries: “It’s **hard!**” (189; emphasis in original).

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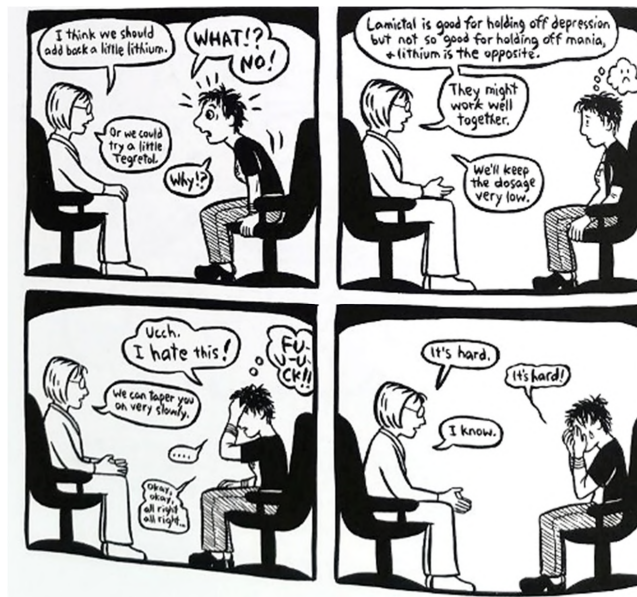


Fig. 2.17. In her psychiatrist's office, Ellen struggles with the idea of being put back on lithium (Forney 190).

Even though the previous sequence manifests Ellen's frustration at having to return to problematic drug, it also serves to articulate her active role when managing BI-D. Eugene observes that Ellen is not "a passive recipient of medical care," as she "seems to actively orchestrate treatment, initiate intermissions, and persuade her therapist" (240). In fact, she does not limit herself to go through the physical and emotional changes caused by her disorder and the side effects of her medication, but instead actively negotiates Karen's suggestions and seeks other treatments, options, and dosages, while also acknowledging the harshness of the whole process. Her struggles with medication, the challenging conversations with her psychiatrist, and the difficulty of managing and keeping track of her mood—which she openly shares with the reader as well—show that she is extremely proactive and autonomous.

Watching herself proves to be an arduous endeavor, not only because of the exhaustion caused by monitoring each bodily and mental symptom, activity, and data, but also because of the distress of not having a clear understanding of her manic and depressive phases. Furthermore, years of treatment have masked and dulled some of the most distinctive, tell-tale signs of mania and depression, which complicates the task of distinguishing between them to prevent acute episodes. This idea is exhibited in fig. 2.18,

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where Forney includes a self-portrait taken from the self-surveillance notebook that depicts Ellen's schematized figure with round black holes for head, eyes, nostrils, mouth, and heart. Each of these holes is crossed by thick lines that intertwine and contort themselves all over the bodily surface. A small, frail word balloon contains the verbal expression of Ellen's emotions: "I feel distracted" (Forney 154). Above and below the image, Forney narrates the frustration that comes with Ellen's attempts at classifying her complex emotions: "It was strange not knowing if I was up or down. How could that not be clear? I was sideways, I was upside-down. Too energetic to be depressed, too anxious and sad to be manic" (154).

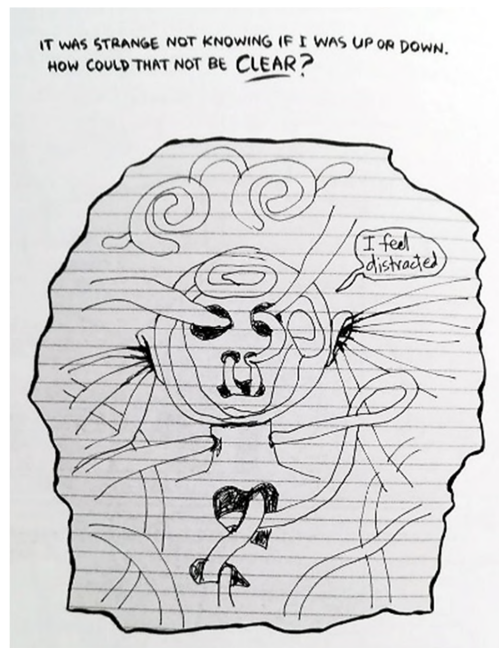


Fig. 2.18. "It was strange not knowing if I was up or down" (Forney 154).

For Ellen, BI-D "brings an intense questioning of self and a troubling dissociation between her two extreme ways of inhabiting her identity" (Mannon 146). While mania and depression are articulated as opposites of a medically established binary that she must learn to navigate, her actual emotions overflow the clearly delineated symptoms of each state. I would further argue that, by engaging with this disruption, the previous figure resists the clinical definition of "Bipolar I Disorder 296.4" and its symptoms as stated by the *DSM* (see fig. 2.2). Far from the neat, easily identifiable descriptions that belong to

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either a manic or a depressive episode, her actual experience of BI-D cannot be always assimilated into one side of the binary: just like Ellen’s sketched body is crossed by thick, curling lines that move inside and outside the holes in her chest and head, the actual experiences of her fluctuating, troubling moods “cross” her bodymind at all times, disturbing the wide distance between the two extremes of mania and depression.

Even when Ellen’s shifts in mood become more manageable due to her treatment, she is still deeply affected by BI-D: “My moods were less extreme, but still unpredictable, precarious. In turns I’d be okay, or in a suspiciously good mood for days, or under the blanket on my couch for long stretches of time” (Forney 146). As noted earlier in this section, feelings of happiness prove to be extremely challenging for her due to their linkage to upcoming manic episodes. An engaging scene that illustrates her struggle around positive feelings is found in the sixth chapter, where a depressive Ellen goes out for a walk in the arboretum. Forney draws herself as a small, crestfallen figure with her hands on her pocket, while in front of her lies a “happy couple,” a “happy dog owner,” and a “happy dog,” all happy figures drawn with schematic yet smiling faces that she finds hard to confront in her current state. Exhausted of the joy around her, she decides to avoid the main route and follow a “half-hidden path” that guides her away from the happy people (Forney 148). Following that hidden path leads Ellen to a “very strong and quiet,” even “maternal” tree that she feels inclined to hug, as she feels “hypersensitive and in need of comfort” (148). The rest of the sequence is shown in the first panel of fig. 2.19, where Ellen sobs as she hugs the enormous tree in the first panel. The caption above the picture reads: “So I took off my shoes and stood on the mossy roots. Immediately upon wrapping my arms around the trunk, my chest tightened and I sobbed and sobbed.” In the next panel, Ellen rests her head on the trunk, looks at the branches, and thanks the tree for the moment of relief it provided in the midst of her depression. As Forney continues in the caption box below the picture, “I left without anyone coming by—or if they did, they quietly left the crazy woman alone” (148).

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Fig. 2.19. Crying in the hidden path (Forney 148).

McDonald observes that “[w]ithin medicalized discourses, the turn away from ‘happy objects’ is one of depression’s key indicators. Anhedonia, defined as ‘the loss of interest in things once found pleasurable,’ is even listed as one of DSM-5’s criteria for Major Depressive Disorder” (100). Drawing on Sara Ahmed’s work, McDonald further argues that depression mimics queerness in that it can also be seen as “an outright rejection of ‘the good life’ insofar as it constitutes a turn toward objects of ‘unhappiness’ that threaten capitalist productivity and the social imperative to optimism that sustains the flow of that productivity” (98). Ellen’s depression orients her away from the straight, able, conceptions of normativity where she is supposed to lead a happy life: “[a] queer woman herself, Forney’s need to avoid the “happy” heterosexual couple . . . in order to avoid causing herself undue pain illustrates Ahmed’s assertion that we become alienated when we do not experience pleasure from objects that are supposed to make us happy” (McDonald 98). As Ellen refuses to navigate the same path of the happy, abled straight couple, the “maternal” tree is the only object that manages to leave “a tangible imprint on Forney’s body and mood, and provides her with queer connection even as she appears to others as a ‘crazy woman alone’” (98).

While McDonald reads Ellen’s choice as a practice of disorienting herself from normative ideas of happiness, I am particularly interested in seeing how this sequence articulates Jack Halberstam’s productive and subversive idea of failure, where getting lost allows Forney to find other unexpected meanings. To evoke Halberstam’s ideas, the practice of failure “prompts us to discover our inner dweeb, to be underachievers, to fall short, to get distracted, to take a detour, to find a limit, to lose our way, to forget, to avoid mastery” (*Queer Art* 120-121). Ellen’s deliberate act of taking a deviation from the main

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path in the arboretum goes beyond her avoidance of the happiness she cannot endure while depressed: it is an act of exploring, mapping, and allowing herself to “stay” lost. Her detour leads her to find relief and solace in an atypical manner—in the form of hugging a tree, alone, away from judging eyes. In a way, this conforms another form of treatment—one that has not been prescribed by her psychiatrist, and that is not extensively described and annotated in her self-surveillance notebook. Just like failure, depression has many negative aspects, but can offer different rewards to those who live with it. And it is that act of following the path of failing, of getting up and trying again, that finally leads Ellen towards acceptance, as will be shown in the last section of this chapter.

5.3. Repurposing Archives

Having analyzed Ellen’s self-surveillance notebook in the previous pages, this section turns to the critical examination of the other fruitful levels that compose Forney’s archive, namely autobiographies, indexes, reading materials, Ellen’s sketchbook, and photographs. Since the beginning of *Marbles*, the act of reading allows Ellen to trace and map the various sources of knowledge that she gathers to obtain information about her diagnoses. In fact, Forney includes many depictions of her younger self reading different books and materials that detail the lives and work of famous writers and artists who, like her, have struggled with mental disability. Thus, some of the first sources that Ellen encounters are the autobiographical works of two famous writers with mood disorders.

Soon after her diagnosis, and following Karen’s recommendation, Ellen begins to read “Macarthur genius psychologist/researcher Kay Redfield Jamison’s autobiography about being bipolar, *An Unquiet Mind*” (Forney 28), but ends up dismissing it, unable to see herself reflected in Jamison’s narration of her manic episode: “Simultaneously seeking and pushing away reflections of myself, I dismissed her story as not pertaining to me at all” (28). At this point, Ellen has not yet experienced the depths of depression, and considers her manic self to be her most valuable, productive self. Consequently, Jamison’s description of her manic hallucination—“awful phantasmagoria... black centrifuge inside my head...” —does not resonate with Ellen at all, who believes that the writer is “psychotic” (Forney 28). Much later, when she faces her first major depressive episode, Ellen picks the book again, and this time she does not attempt to find an exact parallel with her own experience of BI-D, but instead accepts Jamison’s autobiography as “company”: “This time, I didn’t push her story away just because it didn’t line up exactly with mine. We were different, but we shared something important—important

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enough for her to write a book about. She was company” (Forney 90). In this way, and after learning about the dangers of her own extreme ups and downs, a different experience of bipolarity becomes a valuable source of knowledge and understanding for Ellen.

The second autobiography that Ellen reads is *Darkness Visible: A Memoir of Madness* by William Styron, who describes “the pain of his own experience of depression so eloquently, and so vividly” (90). In a spread that occupies an entire page, Forney writes down unconnected phrases and words taken from Styron’s memoir that resonate with her deepest depressive episodes. “It was stunning to see my own demons nailed so effectively,” she narrates in the caption box above the disconnected balloons filled with Styron’s words: “self-hatred... fragility... dank joylessness... unrelenting... loss...” (91). Just like Jamison, Styron is also a source of company for Ellen: both books guide her through the muddy, untrodden waters of depression, providing her with valuable, verbalized feelings connected to her disorder when she is still learning to navigate it—and therefore needs it the most.

It is worth mentioning that this engagement with the works of famous writers and artists takes place since the very beginning of *Marbles*, when Ellen is sitting in Karen’s office, receiving her diagnosis. Immediately after hearing the label “Bipolar I Disorder 296.4,” she identifies herself with the famous, tortured, “crazy” artists that have gone down in history as geniuses as shown in the caption from fig. 2.20: “I was officially a crazy artist.” In a frameless panel, Forney depicts her younger, manic self sitting on a chair with her arms crossed, staring blankly at the reader. She is accompanied by the overly simplified silhouettes of the famous “crazy artists” that preceded her, such as Virginia Woolf, Vincent van Gogh, or Sylvia Plath, but also the anonymous ones, unrewarded by history—“some street artist” and “some classical composer” (22). Next to Ellen, uncaptioned comments containing stereotypes about these artists float in the white, empty background: “destroying paintings! writing a brilliant novel in one sleepless week! smack back of hand to forehead, and fall backwards onto shabby canopy bed, distraught!” (Forney 22).

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Fig. 2.20. “I was officially a crazy artist” (Forney 22).

According to Mannon, “Ellen’s affinity for other crazy artists, whom she encounters through their writing and visual art, helps her to find meaning in her illness” (146). I would further suggest that Forney’s deliberate and ironic act of graphically placing her manic self in between world-famous artists and writers points out to one of the most defining symptoms of BI-D as listed by the *DSM*: “inflated self-esteem or grandiosity” (Forney 16). By doing so, the previous panel introduces a medical reading of Ellen’s condition: just like Ellen is assembling—and literally sitting in the middle of—a genealogy of famous mentally disabled artists, the reader is left to observe and trace the symptoms of her illness and to reassess her membership in that group of “crazy artists.”

Ellen’s genealogy of artists with mood disorders is informed by her meticulous practice of searching and examining lists and indexes. Following her psychiatrist’s recommendation of reading materials about BI-D, Ellen discovers a second book by Jamison, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993), which contains “a list of bipolar artists through history” (Forney 39) depicted in the compelling double spread shown in fig. 2.21. Here, Forney reproduces Ellen’s hands holding the book open on the page that shows an appendix full of the names of famous writers and artists that dealt with bipolar disorder throughout their lives. At the top of the page, the description of the list reads “Appendix B. Writers and Artists with Probable Manic-Depressive Illness or Major Depression” (Forney 40). Divided in “artists,” “poets,” and “writers,” the list extends over the course of two pages and includes a key at the bottom of the second page that indicates whether they were admitted to an asylum or to a psychiatric hospital, and whether they committed suicide or had a suicide attempt.

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The sparse captions scattered across the pages contain Forney’s thoughts: “Reading the list felt voyeuristic. Were these people being outed? Did they know, themselves?” (40-41).



Fig. 2.21. Appendix B (Forney 40-41).

By reproducing the pages of one of her post-diagnosis reading materials, Forney includes the reader in her reading practices and in the process that she follows to understand BIPOLAR DISORDER. The position of Ellen’s hands holding the book open invite the reader to stare at the appendix and to participate in the voyeuristic process of uncovering and exposing the traces of mental illness in those who attempted to commit suicide or were admitted to asylums. The last question—“Did they know, themselves?” (Forney 41)—signals the potential dehumanizing effect of lists: the lives and experiences of illness and disability of many different individuals are grouped together, laid bare for Ellen and the reader to see and stare at, just like the clinical label “Bipolar I Disorder 296.4” encloses Ellen in a boxed medical identity that deprives her of her individuality.

This careful examination of Appendix B prompts Ellen’s questioning of her own identity as a bipolar cartoonist—a process that Forney covers by drawing her past self actively investigating the lives and artistic production of three famous artists with known mood disorders. The first one is the famous Vincent van Gogh, “the ultimate crazy

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tortured genius artist” (Forney 118). While Ellen goes through one of the many art books that her father had sent her over the years, she examines van Gogh’s prolific number of pieces—“840 paintings and over 1000 drawings” in 10 years working as an artist. These numbers lead Ellen to question his outcome: “Was it his demons that gave his art so much life? Or did he work in spite of them? What if he’d been stabilized on meds?” (118). The next two pages contain a rich spread of hand-traced reproductions of van Gogh’s famous self-portraits, produced in the last four years of his life, when he was “in and out of mental institutions”: “Was he trying to pin down the confusing swirls inside his head, to bring them outside? Painting his self-portraits, did he find a sense of calm? Focus? Relief... like I did? I hope so” (Forney 119-20). Even though Ellen does not have a definitive answer to these questions, her examination of van Gogh’s self-portraits favors a process of identification with the Dutch painter: she wonders if this man felt the same relief when painting his own face, just like she does when she draws her self-portraits in her sketchbook.

The works of a second famous painter, Edvard Munch, allow Ellen to investigate the contested relationship between suffering and art. Munch valued his misery and pain as sources of artistic creativity, and even drew a cartoon “about staying in a psychiatric hospital!” (Forney 122). Forney depicts her past self holding an art book about Munch’s work on her hands. Several word balloons spring directly from its pages, as if Munch himself was talking to Ellen: “My sufferings are a part of my self and my art,” states the Norwegian artist. “They are indistinguishable from me, and their destruction would destroy my art. I want to keep those sufferings. Without anxiety and illness, I am a ship without a rudder” (122). Ellen cannot help but stare at the book she is holding with a confused expression on her face: while she sees herself reflected in Munch’s words—“God... [losing inspiration] has been my fear about taking meds” (122)—she ultimately decides that she does no longer want to link her creativity to her suffering. Pain, she realizes, is often an idealized source of inspiration in art: “Sometimes it seems like ‘pain’ is too obvious a place to turn for inspiration. Pain isn’t always deep, anyway. Sometimes it’s awful and that’s it. Or boring” (Forney 123). Unlike van Gogh, Munch does not prove to be a source of comfort and identification for Ellen, but his artistic work and his commentaries lead her to acknowledge the most arduous facets of her disorder and to question the idealized linkage between pain and creativity.

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The third author that Ellen inspects is the writer and poet Sylvia Plath, who was also bipolar. When she reads her poems, Ellen soon learns that Plath received electroshock therapy her whole life, an experience that “seems to color a lot of her work. The themes of electricity and fire come up over and over” (Forney 169). Forney includes fragments of Plath’s poems, novel, and journals that reproduce this connection with electricity: “I sizzled in his blue volts,” “radiation,” “I have been flickering, off, on, off, on,” “ash” (170) and so on. Then, depicting a light bulb shattering above her manic head, surrounded by ashes, Forney narrates:

It occurred to me that a sense of electrical current was part of my own experience of being manic. The sensation that my mind was spinning and overheating would sometimes build to a sensation like an electrical short—a burst of light, a melting, or dissipating—and I’d get a metallic taste in my mouth, like when you lick a battery. (171)

Although Ellen does not notice this close resemblance until she reads Plath’s poems, the imagery of lightning and lightbulbs exploding accompanies her manias since the beginning. In fact, Plath’s description recalls the opening pages of *Marbles*, when Ellen is getting her back tattoo done and Forney describes the sensation of the needle on her skin as “a bright white light, an electrical charge” (3). Besides, the fact that Ellen describes her experience of being manic by mentioning the taste that it leaves in her mouth—“like when you lick a battery” (Forney 171)—gestures to the physicality of her embodied experience of mania, as analyzed in the first section of this chapter. Ultimately, Ellen finds a powerful connection with Plath’s descriptions of mania, in such a manner that it helps her to understand her own manic episodes.

Forney’s archive is also composed of unconnected research, personal files, and scientific and medical explanations of bipolar disorder that seek to clarify psychiatric information to the reader. This idea is clearly exemplified in the consecutive pages presented in figs. 2.23 and 2.24. In the first image, Forney presents a makeshift family tree on her mother’s side of the family, the one “with the mood disorders” (58). Upon Karen’s request, Ellen’s mother compiles a list of family members that have suffered from depression, bipolarity, or committed suicide. The cartoonish, stylized faces of several family members are depicted along with a description of the troubles they faced. Thus, under her great-grandmother, the text reads: “[h]ospitalized multiple times for nervous breakdown.” While her great-uncle and second cousin were “hospitalized for depression,” her first cousin once removed was “hospitalized, bipolar, suicide,” and her aunt was “medicalized for depression.” Finally, under the label “mom,” Ellen’s mother is

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described as “possibly cyclothymic (self-diagnosed)” (58). All the figures are linked by the leafy branches of a family tree that binds them together in their shared trait of living with mood disorders. Then, in the second figure, Forney depicts a circus carousel to provide a clinical explanation of the main types of mood disorders and the mood states they refer to. Under the caption “What is a ‘MOOD DISORDER’ anyway?” she provides a key definition of the term and lists the clinical labels and descriptions of its main types, named Bipolar I, Bipolar II, Cyclothymia, Unipolar Depression, and Dysthymia (59; emphasis in original). After this medical explanation, the carousel displays a cartoonish figure that, depending on the mood state being described, balances itself up or down the ride with varying intensity.

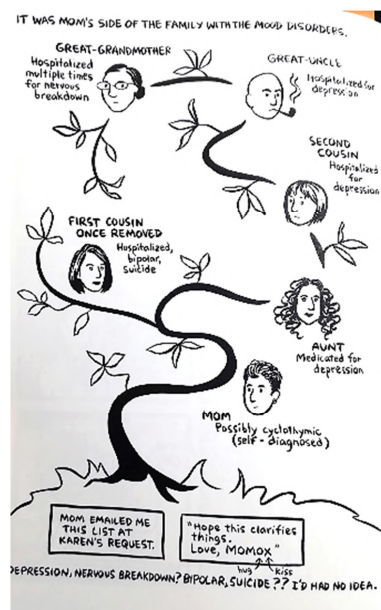


Fig. 2.22. Forney’s family tree of mood disorders on her mother’s side (Forney 58).



Fig. 2.23. Medical terms and explanations about the main types of mood disorders (Forney 59).

These pages are placed next to each other, with no guiding transition or explanation provided, which succeeds in echoing and recreating the disconcerting task of living with a mood disorder and its unpredictable, swift changes. As archiving practices, both pictures serve to guide the reader through Ellen’s own learning process: she first uncovers the history of mood disorders in her family, which her mother reveals only after Ellen is diagnosed, and then she presents an infographic of their main types. In addition,

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by exposing the real stories of suicides, hospitalizations, and mental illnesses in her mother's side of the family, she reproduces the same voyeuristic effects of the list of famous artists from Appendix B. Once again, the reader is left to follow and retrace the symptoms and accounts that label Ellen as mentally ill—this time, through the examination of antecedents in her family, which constructs an alternative medical history that counteracts the official psychiatric diagnosis provided by the *DSM*. I would further suggest that, in doing so, Ellen engages with a specific practice of crippling that subverts the ableist expectation that psychiatric information and medical histories exclusively belong to the medical realm. By asking the reader to momentarily become a medical expert and consult clinical definitions and examine her family tree, Forney subverts the power exerted in the medical model, where only doctors and medical personnel have the capacity to make diagnoses through the usage of “specialised languages” or “expert-ese,” to recall Couser's ideas (*Recovering Bodies* 19).

A crucial part of the archive is composed of Ellen's striking preparatory sketches, created in her deepest depressive episodes. Even when words prove to be a comforting safe place where she can feel understood by others who share her condition, it is the graphic quality of her artistic sketchbook that allows Ellen to fully engage with her mental illness: “But it was really my sketchbook where I could face my emotional demons in a wholly personal way” (Forney 92). Forney decides to include the actual reproductions of the drawings she produced while deeply depressed, scanning and incorporating them into the space of the graphic narrative. She even shows the patterned cover of the sketchbook, the spiral that binds its pages together, and the marks on the surfaces of the pages (see Forney 93). This act of presenting self-portraits drawn in moments of intense suffering connects the sketchbook to the voyeuristic impact shown in other instances of the book, such as Appendix B or her family tree of mood disorders: in this case, Forney is exhibiting her darkest “demons,” rendering them visible and accessible for the reader. Two instances are shown in figs. 2.24 and 2.25, the first depicting one of Forney's most realistic self-portraits, titled “crying in the bathroom.” Her head and neck are drawn with thick, trembling lines, and her puffy eyes stare back at the reader, almost defiantly. Then, the next self-portrait illustrates Ellen's contorting body bent over itself and squeezed in a dark nest of spiky branches.

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Fig. 2.24. Self-portrait: “Crying in the bathroom” (Forney 100).



Fig. 2.25. Self-portrait: a body’s nest (Forney 97).

According to Horstkotte and Pedri, “[a]lthough the exact meaning of these sketchbook self-portraits is uncertain, they speak to her effort to imagine her bipolar self across the body,” as Ellen attempts “to understand her mind through images of her body” (81). I read these images as a grounding practice, since the act of drawing provides Ellen with the tools to calm herself in a time of crisis: “In my sketchbook, I’d trace the familiar lines of my face, and I’d calm down and come back into myself” (Forney 98). Observing her crying, startled face in a mirror and then capturing the image by hand becomes an exercise that allows Ellen to calm down during a depressive phase. The physical space, the immediacy, and the intimacy of the sketchbook propel her to visualize her troubling moods and, by drawing with pens and pencils, her racing mind can focus on the task at hand. “Inert on a piece of paper,” Forney writes, “the demons were more handeable” (98).

Moreover, the sudden, unannounced inclusion of these sketches halts the pace of the narrative: the conventional graphic devices—panels, captions, word balloons—disappear to force the reader to look at different self-portraits produced in moments of extreme anguish. In these sketches, Forney either resorts to a more realistic, detailed style, or to sparse, feeble lines, and quick scribbles—both forms distant from the stylized, cartoonish style she employs in the majority of *Marbles*. The great detail of the self-

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portrait shown in fig. 2.24 gestures to Ellen’s need to retrace her sense of subjectivity amidst her troubling, painful feelings. As Gay remarks, “[t]he specificity with which Forney captures her emotional state by emphasizing the uniqueness of her own face allows her to retain a sense of herself in the distressing experience of being diagnosed as bipolar” (178). Drawing her face after crying inconsolably for hours, or portraying her crooked body enclosed in a space that leaves her no room to stretch or breathe, become graphic strategies that allow her to engage with her altered bodymind.

As can be seen in figs. 2.26 and 2.27, Ellen’s body contorting over itself and hiding from view is a recurrent theme in her sketchbook. The first image contains a drawing of her body, reduced to a set of round lines as she hides her head between her legs, disappearing completely. Similarly, the sketch presented in the next figure, drawn in a promotional flyer of “Girlie Press,” shows Ellen’s body completely covered—this time by a ghost-like blanket. Three big, dark holes represent her eyes and nose, and a straight line forms her mouth.



Fig. 2.26. Self-portrait: hiding
(Forney 103).



Fig. 2.27. Self-portrait: “Girlie Press”
(Forney 106).

While her sense of individuality and her identity as a creative cartoonist has been challenged by the medical label “Bipolar I Disorder 296.4,” it is the exceptional space of the sketchbook that allows Ellen to reconnect with her changing identity in her own terms. Thus, these sketches allow Forney to draw and archive her embodied, localized

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experience of bipolar disorder away from the objective, medical descriptions of symptoms imposed by the authority of the *DSM*. She is able to inscribe her experience of illness away from “the medical model of illness whereby the medical practitioner externally observes the ‘patient’ and draws a conclusion with the aid of numerical and literal data” (Velentzas). If the *DSM* introduces order, containment, and depersonalized clinical descriptions, Ellen’s sketchbook is an unruly, personalized space that contests the medical model of disability and its default pathologization of disabled bodyminds. In this manner, Forney legitimates her own experience of the symptoms of depression. Furthermore, she “presents her self-portraits as another treatment,” as the act of drawing, “first during her illness and again when she creates *Marbles*, is central to Ellen Forney’s ability to negotiate disruptions to her sense of self” (Mannon 146). Complementing her therapy sessions, her medication, and her yoga practices, the act of drawing provides her with the best means to access—and to vent—her innermost feelings, emotions, and fears, away from medical eyes.

Another enthralling quality of the sketchbook lies in its unpolished nature. Forney’s preparatory sketches speak back “to the artificially-polished, final product of other images such as the photograph or cartoon avatar” (Velentzas). There is a stark difference between the framed, ordered, encapsulated panels where Forney talks to her psychiatrist (see fig. 2.16), and the artistic production of the sketchbook, which, in its rawness and lack of refinement, offers an unedited visualization of Ellen’s depression in non-chronological order. The reader is thus able to observe depression unbridled, with all the ugly feelings it provokes—worthlessness, numbness, self-depreciation—laid bare on the page. I would further suggest that in some instances these preparatory drawings creep their way into the other—final, polished—parts of *Marbles*. In the fifth chapter of this graphic narrative, Forney includes what she terms a “depression drawing,” an ink illustration done in her sketchbook that depicts a solitary, small figure standing in a desolate mountain, below huge stormy clouds that represent “floating, rumbling anxieties” (Forney 124). Then, on the next page, she reproduces the structure of that image, with its lines and shades that represent stormy clouds in a framed, regular panel where Ellen is about to cry in one of her yoga classes (see Forney 125). As Forney reveals, “[u]sing the drawing felt strange, like I was secretly revealing my insides, but crying quietly in yoga class felt that way, too” (125). I consider that there is yet another compelling repetition of this “depression drawing” in the very own cover of *Marbles*:

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amidst a bright blue background, Ellen stands alone below these curved forms that resemble the shape of the clouds. Interestingly, the row of clouds at the forefront appears in bright colors—which signals her manic phase, where everything is bright and full of energy—while the clouds in the background are dull and gray, representing the depression that lurks behind any high wave. In this way, Ellen’s sketchbook “leaks” into other parts of the book, refusing to be contained in its scanned pages.

Throughout *Marbles*, Forney makes extensive use of the medium of photography, which provides an interesting counterpoint to Ellen’s sketchbook. An early example is located at the beginning of the book, when Ellen first decides to plan her work on comics during her unmedicated mania by organizing photo shoots to gather reference materials for future comics. With this scheme in mind, Ellen convinces her group of “morning swimmers” to take pictures of their bodies after a swimming session. Forney then includes the reproductions of the reference photographs that Ellen takes alongside her friends—radiant images of naked women, smiling and confidently posing in the showers—next to the self-documentary snapshots that a photographer takes of Ellen getting her back tattoo (see Forney 31-32). But the widest collection of reference photographs in *Marbles* is presented right after, when Ellen is preparing her work on an upcoming porn comic book that she roughed out “in one sitting” (Forney 34). Amidst her high energy levels, Ellen poses with another group of close friends, this time undressing, kissing, touching, and playing with each other (see fig. 2.28). Their suggestive poses are contained in different photographs scattered through the page, and in the captions interspersed among the photographs, Forney writes: “My brain was sizzling and Anita was right with me. ‘I’m going to kiss you full-on on the mouth now.’ ‘Okay.’ Where did the comic book storyline go? She tucked the end of a bicycle pump into the waistband of my thong and pretended to blow me up. It was exhilarating!” (37).

The depictions of these photographs, taken while Ellen was manic, seem to challenge the contents of her sketchbook, drawn in the depths of her depression. I would like to explore this contrast by placing the sketch shown in fig. 2.29 next to Ellen’s erotic photo shoot: in her self-portrait, Ellen is drawn as a ghostly figure that emerges from the shell of her own decaying body, which lies inert on the floor. Shell-Ellen’s body is contained by a sash that reads “1998,” tight around her left arm and waist, simulating a straitjacket. A puddle of vomit is close to her open mouth, and an open box of spilled pills is next to her feet. Above her, ghost-Ellen is naked, wearing a “1999” sash and diapers.

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The caption at the top of the sketchbook gives a title to this drawing: “Phoenixlike Ellen 1999 rises from the ashes of Ellen 1998...?” (Forney 109). The question mark at the end of the caption engages with the irony implicit in the drawing: unlike the powerful mythical bird that is born anew stronger from its own ashes, Ellen resurfaces from the ashes of her previous self in exactly the same deranged, untidy shape. As the sketch was made in the first year after diagnosis, it illustrates Ellen’s feelings of hopelessness—getting out of her first major depression seemed like an impossible task at the time.



Fig. 2.28. Reference photographs (Forney 37).



Fig. 2.29. Self-portrait: “Phoenixlike Ellen 1999” (Forney 109).

Forney does not paste real-life photographs next to her comic panels, but instead reproduces these photographs by hand, tracing over their lines and employing the same ink that delineates the rest of the pages.¹⁶ By doing so, this intimate process mimics the procedures of tracing her own face in the self-portraits of the sketchbook. Cressman points out the inside-outside tensions between the drawn photographs—whose

¹⁶ Cressman observes that Forney is not the first cartoonist “to incorporate photographs and other forms of ‘documentary evidence’ in ways that disrupt the narrative sequence and provoke questions about the intersection of personal and public artefact” (9). In the widely acclaimed *Fun Home: A Family Tragicomic* (2006), Alison Bechdel employs a detailed reproduction of family photographs to examine the “authority of photos as ‘official histories’ . . . and open them up to subjective interpretation” (Watson 133; qtd. in Cressman 9). For a detailed account of the usage of photographic images in graphic narratives and their relation to truthfulness, see Nancy Pedri’s 2012 article “Cartooning Ex-Posing Photography in Graphic Memoir.”

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“reproduction by hand brings them ‘inside’ the text, and yet they are realistic enough to assert the sensual presence of an outside, material object”—and the scans of the sketchbook pages, which “seem to go the other direction, as they were private drawings exposed to the public and reproduced in the text as distinct material objects” (9). There is yet another tension between Forney’s grotesque rendition of her own body in the sketch, which intensifies all its imperfections, and the raw sensuality of the referenced photo shoot, where her attractive, voluptuous body image enacts different playful poses with other equally appealing women. Through that stark visual clash, Ellen’s bodily differences further accentuate the distinct embodied experiences of mania and depression as analyzed in the first section of this chapter.

The inspection of Ellen’s photographs offers another engaging level of analysis: as Ellen is undergoing a manic episode in the erotic photo shoot, the scene it portrays “is not just sexual, but medical: here is her illness on full display” (Cressman 11). Just like the self-portraits or the family tree of mood disorders, the inclusion of these photographic images allows the reader to trace the symptoms and the distinct embodied manifestations of Ellen’s illness, becoming thus another visual repository of BI-D. In a similar vein, Ellen reenacts this process of scanning for signs of BI-D in the lives and works of these famous artists that she takes as reference. This idea can be examined by drawing a connection between the retraced photographs from fig. 2.28 and a scene where Ellen comes across the paintings of Georgia O’Keeffe in one of her research trips to the library (see Forney 140-41). While she picks one of her art books from a shelf, she questions the traceability of bipolar disorder both in O’Keeffe’s work as well as in her own: “She was on the list of bipolar artists. I wonder if it shows at all in her work? ... I wonder if it shows in mine?” (Forney 140; emphasis in original). She also observes the many photographic portraits of O’Keeffe that her ex-husband took throughout her life, some of which “were startlingly erotic, with her in varying states of undress” (Forney 141). At this point, Ellen pours over these images while imagining a relation between her manic involvement in planning and taking erotic photo shoots and O’Keeffe’s own experience in front of the camera: “I was manic for my sexier photo shoots. Could she have been, too?” (141). Through these unanswered questions, Ellen is enacting the procedures of diagnosis in O’Keeffe’s paintings and photographs, attempting to find hints and visual proof that BI-D translates into one’s work and image. Even though the only thing she knows about O’Keeffe’s illness is that she appears in Appendix B, that is enough for her to look for a

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shared experience—a source of company that clarifies the experience of her symptoms. At the same time, Forney extends the process that Ellen follows to the reader of *Marbles*, by including the retraced reproduction of her manic photo shoot and inviting them to find traces of mania in her own work.

After her intensive research on the thorny relationship between mood disorders and creativity, Forney ends the eighth chapter of *Marbles* by surrounding her past self once again with the faces and names of all these artists, writers, and creatives that appear throughout the graphic narrative: as can be seen in fig. 2.30, Ellen appears in the bottom center of the page, with her eyes closed and a content expression on her face. The portraits of famous personalities—such as Anne Sexton, Jackson Pollock, Mark Twain, or Emily Dickinson—surround her and occupy the rest of the space of the page, each figure contained in superimposed panels, with their frames shaped as thought balloons.



Fig. 2.30. Ellen finds company (Forney 222).

Drawn in the same cartoonish style in which Forney depicts herself, the visual style of these portraits connects these creators to Ellen. The words written above her head reinforce this idea: “connection, context, perspective, inspiration, company.” In addition, the short descriptions located next to each portrait indicate the name, profession, and date of birth and death of each famous individual. Far from a mere list of names on an index,

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these individuals become a source of inspiration and validation for Ellen, who chooses to remember them not for their medical labels, but for what they did with their lives—writer, painter, poet. What matters to Forney is the fact that history is populated by people who, like her, had to face a mental disability that in one way or another affected their ability to think imaginatively and to create artistic works. Thus, she devices an archive of bipolar disorder by connecting these names, professions, dates of birth and death with her own personal, private experience of mania and depression.

Forney’s archival criptistemology becomes a collective enterprise, made up with the myriad of lists, charts, data, statistic textbooks, studies, and the many reproductions of portraits, paintings, poems, and novels done by artists who may have faced any form of mental disability. As she builds on external sources as well as on her own experience to contest the official, medical discourse, Forney engages in what Mannon terms “a counter narrative” where “the patient becomes an expert on bipolar disorder” (147). In doing so, Forney is the graphic memoirist that resists “universalizing medical discourse by telling situated and specific first-person stories” and presents instead “patients as experts who credibly speak back to dominant discourses about illness” (Mannon 148). This resistance is also cleverly demarcated in the subtitle of *Marbles*, which does not mention the clinical name “bipolar” nor “Bipolar I,” but instead includes the words “mania” and “depression,” which are the actual embodied and emotional states that Forney deeply experiences and steadily draws and documents. Furthermore, *Marbles*’ subtitle points out that her archive is also about those famous figures that accompany her—“Michelangelo”—and that it is ultimately about her own disabled self—“me.”

The last pages of *Marbles* offer an interesting rendering of time in the space of the page: Forney recreates Karen’s office, where the psychiatrist sits on one side and Ellen sits on the other to carry out their therapy sessions, but this time it is Ellen who counsels her past self, becoming “both therapist and patient” in the boxed encounter of the dialogic therapy (Smith and Watson, “Contrapuntal” 39). Fig. 2.31 illustrates four rectangular, framed panels that are part of this sequence, where present-Ellen informs her past self that her diagnosis is going to place her in a hard journey. In the first panel, past-Ellen listens attentively as present-Ellen reassures her: “You’re going to like getting off the emotional roller coaster. Don’t worry, you’ll still be emotional, and you’ll still have ups and downs. You’ll be an even better listener because of all that therapy.” She continues to list the positive aspects that her disorder will bring to her past version of herself:

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“You’ll do more work than when you were manic because you won’t keep wanting to, like, rearrange your bookshelves. People won’t freak out when they find out you’re bipolar. Your life is shifting. You can handle it” (Forney 235; emphasis in original). Lastly, past-Ellen, who has been listening attentively, asks present-Ellen what her current life is like, to which present-Ellen responds: “It’s different, but it’s not really that different. I’m still you” (235).



Fig. 2.31. Ellen counsels her younger self (Forney 235).

Mannon acknowledges that this scene legitimizes both selves, “past and present, manic and depressed,” as their layering on the page “is Forney’s strategy for honoring the disruption to her identity that bipolar disorder brought about” (152). I consider that this disruption is also cleverly manifested in the graphic depiction of both present and past “Ellens.” While fig. 2.31 only presents four panels of the total twelve that compose the scene, the complete sequence, which extends over the course of two pages, shows past-Ellen slowly shifting from her embodiment of mania—curly, combed hair, comfortable posture as she sits down—to that of her depression—unruly hair, sullen expression, arms embracing herself. These changes take place while past-Ellen sits on her chair, overwhelmed by the crushing arguments that present-Ellen is laying before her: that she will need medication which will compromise her artistic capabilities, that she will take years to figure everything out, and that everything will be okay in the end (see Forney 234-35). Forney thus employs the formal devices of the medium of comics to depict not

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only a scene in which she counsels her own self, but also a whole transformation of her mood and her physical appearance within the framed, encapsulated space of the panel. As McCloud notes, contrary to other forms of narrative where “past, present, and future are not shown simultaneously” because “the future is something you can anticipate, and the past is something you can remember,” comics is the only medium “in which past, present, and future are visible simultaneously” (“Interview”). This is crucial to graphic narratives that deal with disability and illness: according to Venkatesan and Saji (2016), “this juxtaposition of past, present and future in a single frame facilitates the diseased subjects to visually construct their lived body experience while mapping their traumatic progression from past to present” (“Rhetorics” 222). Thus, present-Ellen observes her younger self engaging with her mania and moving into a depressive state in the same fashion in which Forney spreads, narrates, and orchestrates her experience of bipolar disorder, watching and engaging with the past versions of herself as they fail, cry, try many different things, and finally move towards acceptance.

On the very last page of *Marbles*, the 2012 version of Ellen watches her reflection on the bathroom mirror while washing her teeth. Her hair is a big longer and two-toned now, to differentiate this version of Ellen from the past selves that appear throughout the graphic narrative. A content smile greets her in her reflection as she realizes “I’m okay!” (see fig. 2.32).



Fig. 2.32. “I’m okay!” (Forney 237).

This panel reinforces the idea that there is no ultimate “overcoming” of disability in *Marbles*: at the end of her long journey, Ellen is not cured of bipolar disorder, but instead

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learns to live with it in a manner that balances her manias and depressions while allowing her to continue creating. This sense of acceptance includes a lifelong dependence on medicines and a treatment plan that consists of attending her now monthly appointments with Karen, practicing yoga, swimming, journaling, monitoring her mood, keeping up with her emotional support system (friends and family), and getting blood draws every few months (Forney 229). I would further argue that by choosing medication and therapy but not submitting herself to a pathologized view of her disorder, Forney resists the medical model of disability. In doing so, she engages with Kafer's political/relational model, which does not oppose nor privileges medical intervention in disabled bodyminds, but instead questions medical practices (*Feminist* 6). Ellen relies on her psychiatrist and trusts her guidance, takes her medications, and fights through their side effects. But she never lets that be the whole part of the story, as she actively (re)arranges changes in her treatment plan while questioning the stereotypical, pathologized view of the "crazy artist."

Besides, Kafer's model understands disability as a continuous set of questions, not as fixed answers contained within definitions (*Feminist* 10-11), and this is precisely what Forney steadily does throughout *Marbles*: while refusing to be wholly defined by the fixed label "Bipolar I," she enunciates the experience of her mood disorder through the many different questions she poses at each step of the winding road that is her journey—"what if I couldn't even think creatively?" (Forney 24), "how could I work with 'cognitive dulling'?" (Forney 72), "When is 'happy' TOO happy??" (Forney 173), "Isn't 'crazy artist' just a stereotype, anyway?" (Forney 42). These endless questions and the different answers and interpretations that she finds take part in the documentation and the creation of her crip archive, as they motivate her to question herself, the medical information she has received, and the stereotypical vision of those mentally disabled artists that came before her. All in all, this inquiry leads Forney to visualize her disability not as a single medical label but as a complex lived experience that comprises different parts of her identity. At times she fails at receiving adequate, fulfilling answers to her many questions, but the rewards of failing, taking the hidden path, and getting lost are reaped in her self-acceptance.

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6. Entangling Disintegration and Crip Potentiality in Sarah Leavitt's *Tangles: A Story about Alzheimer's, My Mother and Me*

Sarah Leavitt begins her acclaimed graphic narrative *Tangles: A Story about Alzheimer's, My Mother, and Me* (2010) with a confession: "I've always had a bad memory." This revelation opens the single-page introduction that precedes the visual and textual account of a family that is about to be transformed forever. "So when my mother got Alzheimer's disease," Leavitt continues, "I knew I had to record what was happening to her and to our family. I wanted to be able to look back over my notes and remember all the moments of craziness, beauty, and tragedy—and not lose any of them" (7). *Tangles* is based on Leavitt's own experience during the six years that she took care of her mother Midge, diagnosed with Alzheimer's disease in 1998 at only 54 years old. During that time, Leavitt's need to preserve the memory of her mother prompted her to keep a private archive of "notes and sketches, some careful and considered, some dashed of in the middle of a crisis and barely legible or blotched with dried tears" (7). Divided in three parts, the text covers Midge's deterioration, her family's crisis, and Sarah's shifting roles as a daughter and as her mother's caregiver—and all the pain, frustrations, and rewards that come with this experience.

Kathleen Venema (2016) delves into the entangled relationship between mother and daughter and the processes of witnessing, remembering, and rendering Alzheimer's disease on the page. She locates *Tangles* within the subgenre of daughters' stories about their mothers' experiences with Alzheimer's. These stories reveal deep narrative concerns, such as the disconcerting procedures of diagnosis, the devastating progress of the disease, and the visualizations of the mother's past health and vitality (Venema 46). They also account for the extreme anguish experienced by the daughter when faced with the forthcoming loss of her mother, as well as the changes in the protagonist's identity in the midst of her mother's deterioration (Venema 46-47). Leavitt's work proves to fit in this subgenre owing to its detailed articulation of the multiple physical and mental changes that Midge experiences after dementia transforms her life. The text also explores Sarah's shifting identity as an emancipated, lesbian artist that returns home to become her mother's caretaker. While grieving Midge's upcoming death, Sarah has to learn how to wash, feed, and care for her, thus giving up her role as a daughter in order to parent her own mother.

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Due to its textured depictions and its enthralling storytelling, *Tangles* has received wide critical attention. Its rich, ambivalent portrayal of caregiving has been the focus of scholars such as Sathyaraj Venkatesan and Anu Mary Peter (2015) and Sethurathinam Pushpanathan (2018). A similar approach is followed by Amelia DeFalco (2016), who draws on ethics of care philosophy to investigate how graphic narratives about illness and disability complicate the act of caregiving by presenting its struggles and rewards as well as the conflicting feelings that spring from it. Then, in her study of illness narratives authored by women, Neeraja Sundaram (2017) explores Leavitt's usage of the graphic form to visualize the pathologized feminine and the effects of Alzheimer's disease on gender roles in the family home. The portrayal of the disabled body in this text has been studied by Renata Lucena Dalmaso (2015), who examines the many different visual metaphors of disability that Leavitt utilizes to depict her mother's experience of dementia.

Other scholars have praised *Tangles*' capacity to turn inwards by providing an intimate, private account of the illness of a loved one without relying on objective medical information. For instance, MK Czerwec and Michelle N. Huang (2017) argue that comics about caregiving move away from the traditional, individualistic medical discourse where patients are diagnosed according to evidence-based medicine and instead show patients' lives in relation to their personal environment and the medical system (96). If texts like Ellen Forney's *Marbles* are explicitly concerned with the acquisition and the portrayal of information about illness and/or disability through the inclusion of scientific and medical data, *Tangles* functions in the opposite way: medical information about Alzheimer's disease is very sparse, only included in key moments of the story, such as Midge's first visit to her neurologist. For Venema, the main concern of *Tangles* lies in "the wracking emotional cost" suffered by the Alzheimer's patient and her family, which uncovers "the irreversible deterioration of one's capacity to be oneself" (49). Certainly, one of the defining characteristics of *Tangles* is its position as a personal account of a family disrupted by illness. Leavitt's singular visual style—her minimalist drawings, her panels packed with text and framed within spare, white space, and her dense layout compositions—prepares the reader for the tragic events that unfold. As cartoonist Brian Fies notes in his back cover praise, Leavitt "brings a good eye for the telling detail—the small observations that reveal larger truths—to her memoir of a family in crisis." Precisely, Leavitt's capacity to disclose these "small observations" and "larger truths" produced amidst the relentless progress of her mother's illness allows me to argue that

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Tangles is uniquely positioned to engage with crip potentiality: as Leavitt negotiates Midge’s past normalcy, her present disintegration, and her future death, she also accounts for the beautiful, gripping moments that mother and daughter shared together, both before and after Alzheimer’s. By examining Leavitt’s productive archival project, the analysis that follows offers a critical discussion of Leavitt’s usage of the fragmentation of the graphic form to construct a crip project that resists normative coherence and ableist understandings of time.

The first section of this chapter will study the graphic strategies employed by Leavitt to document the past normalcy of her mother and the current damages caused by dementia. Drawing on the works of Venema and Sundaram, I will analyze how Leavitt articulates Alzheimer’s disease on the page by representing the visual and textual disintegration that the disease forges on Midge’s bodymind. Then, *Tangles*’ particular concerns with time and futurity will become the focus of the second section, as Sarah engages with alternate temporalities and constructs “an alternative imaginative world in which her mother lives on, intact and healthy” (Venema 68). Building on the negative aspects of crip time developed by Ellen Samuels (2017), I will suggest that this juxtaposition of alternate temporalities with looming death gestures to Sarah’s struggles to cope with the merciless progress of the illness and the upcoming loss of her mother. Her urgent need to remember every living moment of Midge—both before and after her diagnosis—prompts her to record and trace her words, actions, and feelings in her journal, which becomes a crucial archival tool to cope with her family’s crisis. My last section will examine the three different levels that compose the archive constructed by Leavitt to reminisce her mother: Midge’s scattered notes, Sarah’s journal entries, and the different interludes placed between episodes. While Midge’s notes offer glimpses of the woman’s past normalcy and the destruction caused by the illness, Sarah’s journal manifests her conflicting, ambivalent feelings towards her mother’s decay. The analysis will also suggest that *Tangles*’ interludes engage with the notion of crip de-composition as articulated by Robert McRuer (2006), as they offer intimate, unconnected moments that drift away from the coherent continuity of the narrative, managing to weave together grief and desperation, but also happiness and solace. This chapter will end with an exploration of Sarah’s forms of grieving Midge, as she turns towards her Jewish heritage to find a safe space to mourn the loss of her mother.

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6.1. The Disintegrating Bodymind

The earlier signs of Alzheimer’s disease manifest themselves while Midge is still working as an educator. After a decade of success designing the kindergarten curriculum for the province of New Brunswick, Midge returns to the classroom to teach young children, but she is soon forced to quit her job over numerous parents’ complaints: she would often find herself unable to control her students, it would take her hours “to clean up her classroom,” and she would also spend “so long on lesson planning that she was working over 60 hours a week” (Leavitt 19). Losing her hard-earned job is only the first hint that Sarah receives about her mother’s new condition—a hint that is soon followed by other worrying signs that the family perceives at home, such as Midge’s newly acquired inability to open the bathroom door at Sarah’s apartment: “She’d struggle with it until Dad or I came to help,” Leavitt writes. “She never got the hang of it” (19). The swift changes in Midge’s mood are also significant: soon after the incident with the bathroom door, Hannah, Sarah’s sister, informs Sarah that their mother is “sad and angry all the time.” While Sarah notices that something is wrong with Midge, she dismisses her worries and attributes her mother’s forgetfulness and her angry demeanor to her age: “Maybe she was depressed about losing her job. Maybe it was menopause. Maybe she was having a midlife crisis or something” (19).

Forced to stay at home after quitting her job, Midge’s deterioration is easily observable in her new struggle to carry out her usual daily activities. Her steady decline is illustrated through a series of domestic scenes in which she fails to perform the simplest household chores (see fig. 3.1). “One afternoon I found the iron on, blazing hot,” Leavitt writes in the first panel, alongside a picture of a forgotten ironing board, still plugged in. “Lots of people forget things like that. It happens all the time,” she continues in the second panel, which contains a close-up of the iron (22). The third panel depicts Midge working in the garden while Sarah attempts to confront her about her tendency to forget items everywhere. “More things kept happening. Small things,” reads a caption that introduces two panels where Midge is unable to open the front door of the house and stands in place, angry and rejecting the help of those who surround her. In the eighth panel, Sarah, suspecting that something wrong is definitely happening to her mother, begs her to go to the doctor—a petition that Midge receives with annoyance: “I don’t need to go to the doctor!” she yells at her daughter. “The little twit is barely older than you are!” (22). The last panel manifests Sarah’s worries as she sits alone in her bed, unable to focus on the

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open book that lies on her lap: “I didn’t understand what was happening to my mother,”
 Leavitt writes in the white, nearly empty background (22).

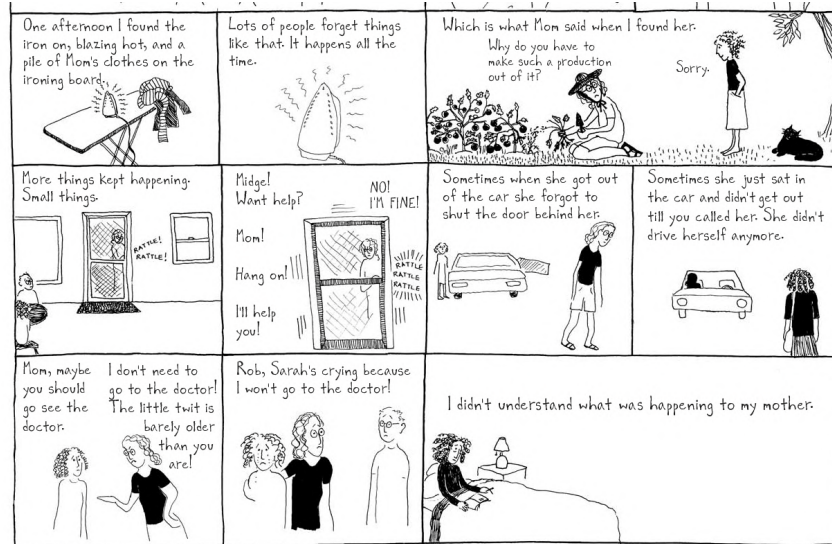


Fig. 3.1. The warning signs of Alzheimer’s disease (Leavitt 22).

The previous sequence advances the early stages of the transformation that Alzheimer’s brings to Midge. Crucial to the representation of these first warning signs is her depiction as an aimless, lonely figure that stands next to the car, and as a dark shadow stuck in the passenger seat. Alzheimer’s removes Midge from her routines and habits, and from her family relations as well: her sweet, firm personality is slowly being replaced with anger, and she becomes unable to communicate her needs when her brain starts to forget how to work and go through her daily tasks. The loving mother that used to tend to Sarah’s childhood nightmares and the tireless educator that designed brilliant, innovative school curricula are fading before Sarah’s—and the reader’s—eyes. I read this act of fading as a disintegration of Midge’s personality, which will be then replicated in her body in the later stages of her illness.

This disintegration is also visually conveyed through Leavitt’s distinctive usage of the formal aspects of comics. As Dalmaso observes, her style “is very minimalistic, with an abundance of empty space in the frames” and with a “lack of balloons in her dialogues” (79). This visual lack that disrupts the most common elements of the comics medium replicates the implacable symptoms of Alzheimer’s—a disease that, as Sarah

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soon learns, creates a “lack” in those who live with it, prompting them to forget words, events, loved ones, and even themselves. In contrast to this visual lack, Leavitt devises heavily packed layout compositions punctuated by framed panels stacked together, with no gutter that provides a separation between them. This absence of space between panels disturbs the reading process, complicating the task of comprehending the information provided within the frames. Venema notes that “*Tangles* implacably stacks one, often text-saturated, panel up against the next and the next, apparently uninterested in giving its readers time or space to breathe or think. Or feel” (51). As illustrated in the previous example, one panel follows another, leading to an implacable sequence that reproduces the ruthless advance of the disease, with no space in between for the reader to process Midge’s changes and Sarah’s worries.

It takes a lot of effort for the family to approach an increasingly bitter, detached Midge. After a family gathering in which she is particularly moody and irritated, Sarah and Rob manage to get her to sit down in the living room so the three of them can talk. “Dad and I are worried about you. We just wanted to talk about some things we’ve noticed,” Sarah earnestly tells her mother, who is frowning with her arms crossed (see Leavitt 24). Soon after, Midge breaks down crying. The resulting family talk is included in the three wide panels displayed in fig. 3.2: in the first one, Leavitt draws her mother crying and blowing her nose. Two unconnected close-ups of her strong “Mom hands” appear next to her figure: first, her veiny hand holding the napkin, and then her extended hand, sporting a ring on her ring finger. The next panel depicts both parents and daughter sitting on the couch—Sarah, visibly concerned, occupies the left side of the panel as she tries to start the uncomfortable conversation. The last panel abruptly changes the dynamics of the sequence by removing Midge from the family’s living room and enclosing her in a dark, rectangular space that disrupts the shape of the layout. Her blank expression and her unfocused eyes emphasize her desolating, overwhelming announcement: “I have Alzheimer’s” (Leavitt 25).

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Fig. 3.2. "I have Alzheimer's" (Leavitt 25).

This image of Midge enclosed in a black rectangle confined within the whiteness of the panel symbolizes her increasing isolation from her family and advances the beginning of her slow yet progressive removal from the able-bodied and able-minded world. The somberness of this last panel is not unfounded, as Alzheimer's is an extremely debilitating degenerative disease of the brain that can affect individuals who have not reached old age.¹⁷ In her exhaustive study of Alzheimer's disease life-writing, Martina Zimmermann (2017) states that even though "Alzheimer's disease is the most common neurodegenerative disorder among the elderly," patients can be "as young as forty-five" when they are first diagnosed with the early-onset of the illness (3). People who suffer from Alzheimer's "face memory loss, an impaired ability to understand or produce speech and an inability to recognise things or people." Perhaps the most troubling, painful symptom is that "their perception of themselves as individual persons disappears in a relentless process of brain atrophy." This process extends itself through time and is divided into different stages, "with early stages still allowing for the patient's

¹⁷ I place Alzheimer's disease within the category of disability following Kafer's understanding of disability not as a monolithic, fixed category, but as a "collective affinity." To refresh Kafer's words, collective affinities regarding disability offer the potential of including "everyone from people with learning disabilities to those with chronic illness, from people with sensory impairments to those with mental illness" (*Feminist* 11).

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articulation,” and later stages which “strongly limit intellectual performance, making the patient dependent on caregiving in almost all activities of daily life” (Zimmermann 3). Thus, Midge is both physically and graphically isolated with a condition that entails one loss after another and is left with a bleak future that metaphorically—and literally, in the space of the page—encloses her in darkness.

Rob and Sarah finally manage to convince Midge “to go to some appointments to try to figure out what [is] wrong” (Leavitt 26). After a visit to a psychiatrist that leaves her baffled and angry and an appointment with a naturopath that gives no answer to her ailments, Midge sees a neurologist. “Ok. So. Midge Leavitt. Let’s see here,” the doctor begins, addressing his patient. “What day is it today, Midge?” (Leavitt 36). Fig. 3.3 introduces the medical scrutiny that Midge is forced to face inside the doctor’s office as she sits on her chair, with her hands clasped before her and a worried expression on her face. The questions asked by the doctor surround her, written in big, bold letters that contrast with the white, empty background: “What year is it? Where do you live? Where do you work? How old are you? What did you eat for breakfast?” Midge is not able to provide a reply to any of the questions, and instead addresses the doctor to explain that she only wants to know the origin of her constant headaches, but the doctor completely ignores her and turns to interrogate her husband instead: “So Robert, has Midge exhibited any inappropriate behaviour?” The fifth panel depicts a worried Rob surrounded by medical questions about his wife’s condition and abilities: “Confusion? Mood swings? Outbursts?” The inquiry continues in the last panel as the family is reduced to three dark silhouettes, lost in the bold assessment that hangs above them: “Can she dress herself? Drive? Feed herself? Bathe? Clean? Read?” (36).

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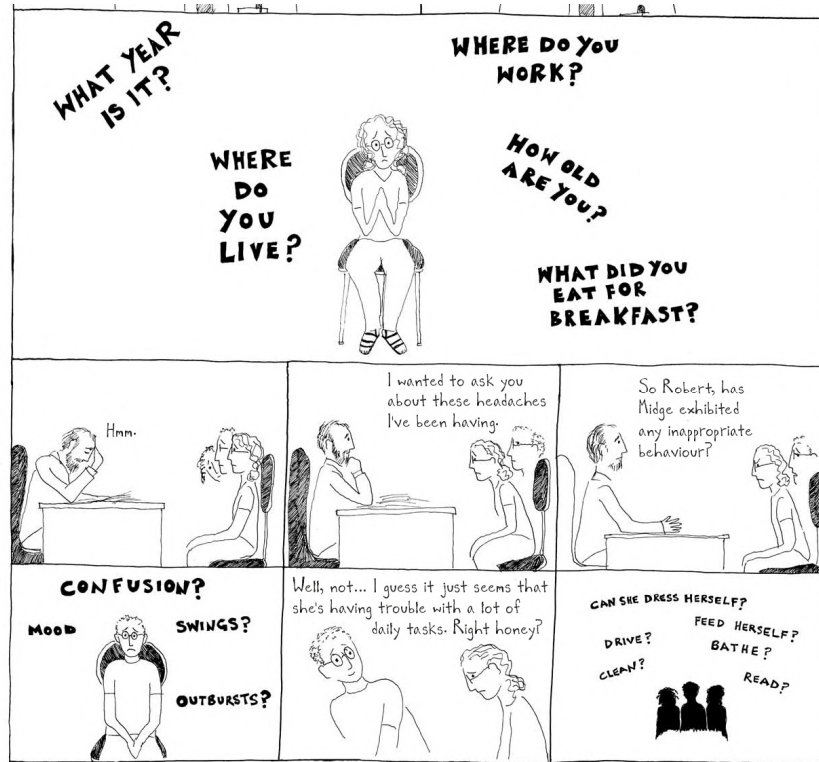


Fig. 3.3. Midge faces the medical scrutiny of the neurologist (Leavitt 36).

The previous sequence provides one of the scarce insights into the medical setting in *Tangles*. As Zimmermann points out, the doctor “is distant from both patient and caregivers, behind his barrier-like desk” (121). This separation between the neurologist and Midge is widely reflected in the second row of panels, where it conforms a visual division that categorizes each character into their respective fixed roles—doctor and patient. The neurologist’s inquiry is particularly exhausting for both Midge and her family, as it reduces her to a list of actions that she is not able to perform—working, driving, cleaning herself—and to several data—date, age, mood changes—that she is not able to provide. In this manner, the doctor’s invasive assessment recalls Withers’s conceptualization of the medical gaze, which is embodied in the questions that surround Midge and that she is unable to answer. These relentless questions become “the filter” applied to Midge’s life and experiences (Withers 39). Furthermore, the confusion and the exhaustion caused by the medical examination is also rendered in the visual similarities

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between the three members of the family: while Midge is surrounded by questions in the first panel, Rob appears in an almost identical posture in the fifth one, wearing the same disoriented look on his face. Then, in the last panel, the dark silhouettes of Midge, Rob, and Sarah appear together as the medical questions hang above the three of them. I would further argue that this repetition of the placement of the characters in three panels, overwhelmed by the medical inquiry, evokes Groensteen's notion of restricted arthrology, which signals the relationship between the panels that compose a single sequence (22). Through its visual repetition of the expression and bodily posture of the three family members, this arthrological connection displays the relational aspect of Midge's illness: Sarah and Rob are as baffled as Midge when the doctor asks them to report Midge's behaviour, because in the face of a diagnosis as devastating as Alzheimer's, feelings of anguish and confusion are shared by the whole family, not just by the disabled person.

Additionally, Leavitt remarks the damaging way in which Midge is blatantly ignored during the medical assessment and disregarded as a patient when she mentions her headaches. According to Couser, "[s]ince the birth of the clinic, diagnosis has depended less and less on face-to-face dialogue between patient and physician; physicians can and do make their diagnoses in consultation with specialists on the basis of evidence supplied by their patients' bodies—in the absence of patient themselves" (*Recovering Bodies* 22). While Midge may be physically present in the doctor's office, she is absent from this "face-to-face dialogue" about her own issues. She is the topic of the conversation of a doctor that talks about her as if she were not present in the room, and specific concerns as a patient—her headaches—are completely disregarded. In fact, the detached doctor gives up on her and turns to address her husband instead. This demeaning action towards Midge is not missed by Sarah, who addresses this matter on the next page as she barely holds back her tears: "Could you please address my mother directly?" (Leavitt 37). At the end of the appointment, the neurologist reveals Midge's potential diagnosis to her distressed husband and daughter: "I think we're probably looking at some sort of dementia. Probably Alzheimer's" (37).¹⁸ These results, along with other scans,

¹⁸ The educational website *Alzheimer's Association* makes a clear distinction between dementia and Alzheimer's disease: "[d]ementia is a general term for a decline in mental ability severe enough to interfere with daily life. Alzheimer's is the most common cause of dementia. Alzheimer's is a specific disease. Dementia is not." In addition, even though it is a term still widely used by the general public, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* has replaced "dementia" with "major neurocognitive disorder" and "mild neurocognitive disorder" (591).

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blood tests, and consultations to other neurologists give a name and a medical label to Midge's condition—a label that in the space of the episode is never communicated to her.

Once the crushing diagnosis is disclosed to both Sarah and the reader, Leavitt narrates the multiple changes that Alzheimer's disease causes in her mother through a series of juxtapositions in which she contrasts her mother's healthy, pre-disabled past self to her present disabled self. As Sundaram states, “[m]ost of the panels that depict [Midge's] bodily transformation by illness are preceded by a brief visualising of past normalcy.” This normalcy entails a visualization of Midge's everyday life and routines “prior to her illness” through acts such as “grooming herself, caring for her children,” and “being physically appealing to Leavitt's father” (254). This past normalcy, I argue, engages in a process of disintegration that not only affects Midge's bodymind, but also her habits, hobbies, activities, and routines—as well as her loved ones who take care of her.

Some of the first observable changes occur in two places that belong to the daily life of Midge's past self: the kitchen and the garden, which Leavitt explores in the episode titled “Food.” Alzheimer's disease turns Midge from an enthusiast of gardening and a lover of the healthy, homemade food that she would often cook from scratch into a person unable to kneel or hold a kitchen utensil. Leavitt begins by remembering the caring mother that always tried to feed healthy food to her children: “When Hanna and I were growing up, Mom did her best to feed us healthy food. Like soup made from vegetables she'd grown from seed, and homemade bread” (51). But this practice ends when Midge gets sick and becomes unable to handle utensils: “And she couldn't cook. Tools became weapons. Things got ruined. Sometimes we'd give her a carrot and a dull knife and let her ‘help’” (51). The mother who took pride in feeding her children healthy food from vegetables she grew herself is gone. A similar fate awaits her love of gardening: “Mom helped with weeding and harvesting. But she couldn't manage to squat or kneel. Even when she only meant to pull weeds, she pulled up lots of other plants too.” This description is accompanied of depictions of Midge clasping her hands before her, unable to bend down and tend to her plants (see Leavitt 51).

Another crucial change in Midge's bodymind takes place when the disease disrupts her senses and her way of relating to the world: “One of the first things that happened to Mom when she got sick was that she lost her sense of smell,” Leavitt states. “This can be a sign of Alzheimer's. But that was before we even suspected that she had

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something serious. She just couldn't smell" (59). The cramped sequence of twelve panels shown in fig. 3.4 visually reinforces Midge's separation from the outside world and from her own self. The first row presents Midge's body enclosed in a black rectangular shape that confines her within the space of the panel, preventing her from reaching the rich smells of the outside world, such as the "smell garlic or apples or tomatoes that had warmed in the sun" (59). Then, the text turns to the past to reveal that Midge used to be a very strict mother that would not allow her children to eat sugar, nor eat sugar herself—a habit that changes when she gets sick. Leavitt first draws a younger Midge offering a bowl of fruit to Sarah and Hannah, who scrunch their noses in disgust, and then returns to the present Midge, who sticks out her tongue and extending her arms to grab candy canes, cookies, and ice-cream. Sarah, who has a sweet tooth and used to gorge on sugar behind Midge's back, is now forced to take away the sweets from her ill mother: "She didn't know that she thought sugar was evil. She only knew it tasted good. I used to hide candy so I wouldn't get in trouble. Now I hid it so she wouldn't eat it all" (59). Midge's disintegrating bodymind is widely exposed in the last two panels of the sequence, where Leavitt draws her head and body separated and encapsulated within two different boxes. This severed, fragmented bodymind, which drifts away in the vast empty space of the panels, underlines the caption that alludes to one of the most devastating symptoms of Alzheimer's: "Mom forgot more and more of herself" (59).

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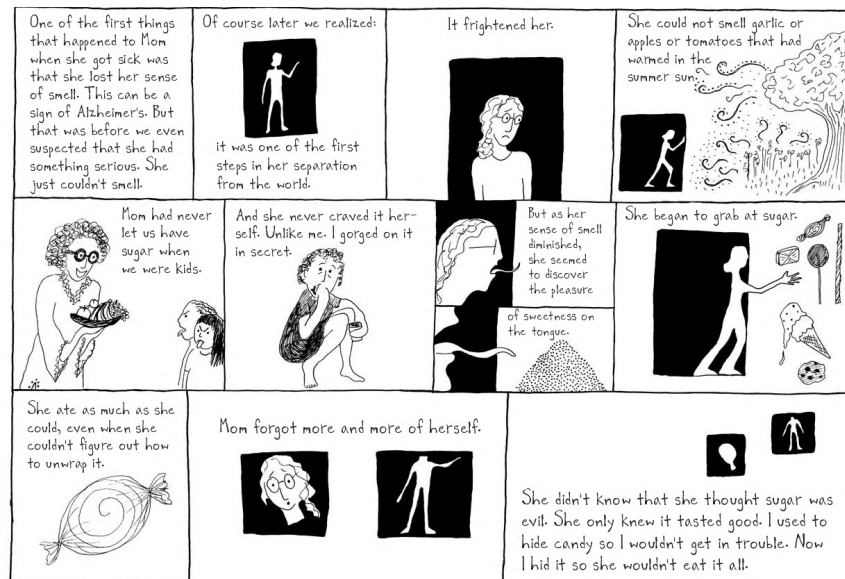


Fig. 3.4. "Mom forgot more and more of herself" (Leavitt 59).

The previous sequence recalls Chute's ideas about the nature of comics, which move "forward in time through the space of the page, through its progressive counterpoint of presence and absence: packed panels . . . alternating with gutters (empty space)" ("Comics" 452). This interplay between absence and presence that lies at the heart of comics is also found in the lived experience of Alzheimer's disease. Building on Chute's work on the graphic representation of memory, Venema argues that "with its peculiar deployment of punctuation, pause, absence, space, and gap," Leavitt's narrative "memorializes a mother who is increasingly unable to enact, or even mimic, the 'procedures of memory'" (49). Here, the disintegrating nature of dementia is conveyed through the text-filled panels that alternate with the white, empty background, along with the two widely separated boxes that contain Midge's head and body. Leavitt's decision to place her mother's pre-disabled and disabled selves together in the same row reinforces the severity of the symptoms that the older woman experiences: nothing of the young, strict mother that forbade her children to eat sugar remains in the shapeless, white figure that extends an unknowing hand to grab a candy cane. Midge cannot remember that she previously believed that sugar was bad for her own health and for the development of her children. As a result, she is separated both from the outside world—from smells, tastes,

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and even from her interactions with her own family—and from her own vanishing memory.

Sarah’s actions and thorough efforts are intended to mask, resist, and compensate for the unforgiving losses caused by Alzheimer’s. As Alzheimer’s removes Midge from her status as a mother, worker, and caretaker of others, Sarah gives up her role as a daughter and receiver of care in order to parent her own mother. Her routinized practices of caregiving prompt her to learn how to bathe, handle, and feed Midge. In this manner, illness imposes a cruel mirror in the family unit—a mirror where Sarah is forced to become her mother: as shown in the previous figure, she needs to run after Midge to prevent her from eating too many sweets, just like Midge used to reprimand Sarah and control her sugar intake when she was a kid. These parenting duties, which take a physical and emotional toll on Sarah, also unearth conflicting feelings of embarrassment and shame. In the second part of *Tangles*, Leavitt describes how her mother “dressed herself in odd collections of garments from different seasons and occasions,” wearing winter clothes during summer, which made her sweat a lot, and she “didn’t brush her teeth very well, so her breath stank” (59). Finding her mother in such an abandoned bodily state utterly affects and devastates Sarah: “I smelled my mother and I was filled with shame” (Leavitt 60). Whenever she takes care of her mother, this shame extends itself over other areas of Sarah’s life, as illustrated in the sequence from fig. 3.5: one evening at home, Sarah tries to bathe Midge, but she notices that the older woman has defecated in her own pants. The first panel illustrates Midge’s profile as she sits in the bathtub, holding a dirty cloth before her. The caption located above her small body describes what Sarah finds when she steps into the bathroom:

Mom’s clothes were piled on the floor. There was dried shit in her underwear. The bathwater was full of small disintegrating bits of it. She was dipping her washcloth in the water and rubbing it over her skin. She had no sense of smell, true. But she could see. She just couldn’t recognize. Couldn’t recognize shit, dirt, shame. Disintegration. (Leavitt 60)

The right side of the page presents a sequence of six smaller panels where Sarah cleans the bathroom, washes her mother, and helps her to get out of the bathtub. Above, the caption reads: “There are moments when you have a choice: fall apart, or take a deep breath, and just do what needs to be done” (60). Noticeably, Midge has a clear expression of pleasure on her face as she is rubbing a washcloth stained with her own defecations over her skin. Her content face, which extends to the panels where Sarah washes her clean, signals the advances of the symptoms of the disease: not only is Midge physically

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unable to clean her own body, but she is also unable to understand what “shame” or “filth” are.

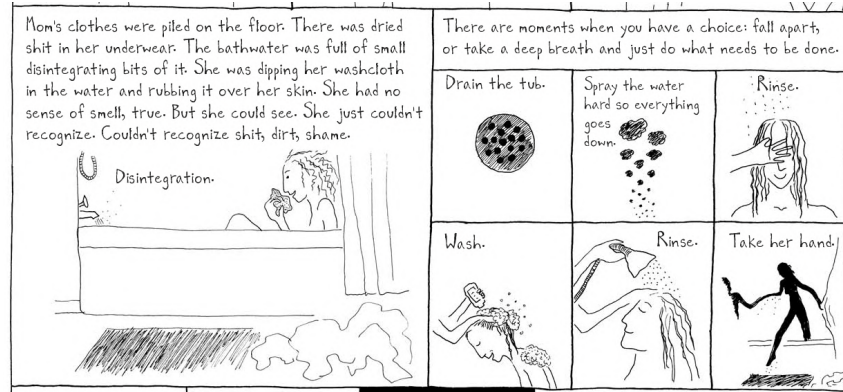


Fig. 3.5. Sarah bathes her mother after finding her covered in waste (Leavitt 60).

Leavitt's drawing style produces an interesting clash with the contents of the previous scene: her clean, thin lines depict a polished, minimalist rendition of a bathroom and a sanitized picture of feces, which contrast with the utter desperation and shame that Sarah feels when encountering her mother in disarray. Similarly, the decomposing waste spread over the bathroom, along with the dirty clothes piled on the floor are drawn with thin, tidy black lines against a spotless white background. These graphic choices suggest that the author seems to be more preoccupied with showing the raw emotions that Sarah feels as a daughter when encountering her mother in such a shameful state than in faithfully rendering the messiness embedded in some acts of caregiving. This idea is reinforced by the neat sequence on the right side of the page: the action of bathing Midge is distinctly divided into panels of the same size that narrate one step after the other—drain the tub, spray the water, rinse, wash, rinse. Thus, reducing caretaking to a list of steps to follow shows that Sarah overcomes the pain of this situation by distancing herself emotionally and focusing on the task at hand—by taking “a deep breath” and just doing “what needs to be done” (Leavitt 60).

Another compelling instance of disintegration takes place approximately three or four years after Midge's diagnosis, when she loses the ability to understand that she is sick—an event that Leavitt conveys in the episode titled “Lighter” (see fig. 3.6). The captioned text notes that Midge “rarely cried or got angry” and that “[s]he often seemed overwhelmed by the beauty of people or animals or flowers” (Leavitt 108). The first panel

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encapsulates the different activities that Midge likes to perform with the other members of the family, such as singing, laughing, and pulling on people’s clothes. After getting accustomed to this lighter, happier version of Midge, who does not notice that she is sick, her family starts talking about her “right in front of her all the time, since she didn’t seem to notice” (108). Unaware of the situation, Midge stands on the left side of the panel, with her hands clasped, singing happily.

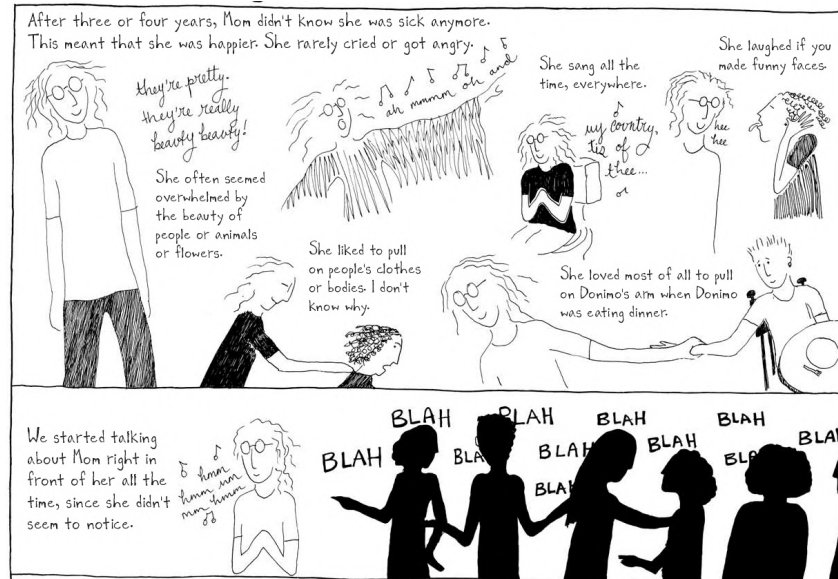


Fig. 3.6. Midge no longer understands that she is ill (Leavitt 108).

Previously a tireless educator and a hardworking mother and wife, Midge is now disconnected from her environment, and only interacts to sing, laugh, or touch others. The composition of the second panel signals Midge’s complete rupture with the outside world, her disintegration manifest in her physical separation from the other members of the family, drawn as dark shapes that talk incessantly about Midge as if she were not present. As her illness progresses, the attitudes that others have towards her change: Sarah and the rest of the family are now engaging in the behaviour that Sarah had previously reproached in the neurologist that diagnosed her mother in fig. 3.3. The progress of Alzheimer’s imposes a wide chasm between Midge and the rest of the world in the medical setting and now in the privacy of her own home—an idea that is supported by the fact that the scene of the second panel is portrayed from Midge’s perspective, as she is the only clearly distinguishable character amidst a series of unrecognizable silhouettes.

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Leavitt reproduces the progressive deterioration of her mother’s bodymind by depicting different physical changes that function as visual cues for the reader to follow the advances of her symptoms. The most noticeable cue is found in her eyes: when Midge is healthy, her eyes are shown, drawn as small dots that add to the expressiveness of her face. But in the later stages of Alzheimer’s a pair of glasses obscures them. Dalmaso points out that when Midge’s illness progresses, Leavitt “suggests that the character is distancing herself from her family through the depiction of a blank expression: Midge’s glasses are still on, but no discernable expression is seen on her face.” Drawing on Garland-Thomson’s seminal definition, she notes that the blank stare “is often used to characterize people with disabilities and, visually, it is employed as a marker of deviance” (85). In this manner, “Midge’s visual characterization is taken over by a sort of blank stare that dehumanizes her, stripping her of subjectivity” (Dalmaso 81). I would further argue that, just like the eyes obscured by glasses in David Small’s *Stitches* suggest detached, uncommunicative parents, Midge’s absent eyes gesture to her own loss of communication with her family and her rupture with the outside world.

Another engaging cue lies in Midge’s hands, which were previously praised as strong “Mom” hands, hardened by decades of work as a teacher and caretaker of her family (see fig. 3.2). But when the onset of illness affects Midge, her hands become still, always clenched together in front of her body. “Mom held her hands clenched in front of her like I’d noticed her doing in the summer,” Leavitt writes in the captions of the episode where Sarah visits her parents in their sabbatical stay in Mexico. “At last she unclasped them long enough to hug me” (28). These hands, veiny, hardened, and calloused, are no longer used for work or leisure, and cannot tend to the garden, teach young children, hold kitchen utensils, or hug her family. Midge’s new posture, with her hands clasped before her, becomes thus another visual sign of her bodily and mental decline.

Midge’s needs for intimate, physical care trouble Sarah’s identity as a lesbian and her role as a caretaker. “I could never have trimmed Mom’s pubic hair,” Leavitt confesses in the first panel shown in fig. 3.7. “I never touched her between the legs without toilet paper or a washcloth between us” (111). Her words are accompanied by two loving depictions of Sarah and her girlfriend Donimo lying together in bed, embracing each other, and followed by a small drawing of Sarah looking through a window. The confession continues in the uncaptioned text: “I believe this was partly because I had touched women’s bodies for sex, and because sometimes I feared being accused of

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perversion because of it. That all added to the weirdness of bathing and grooming my own mother in the first place” (111). The second panel shows Midge’s white shape—her features shapeless and undistinguishable—against a black, empty background. The white text next to her body reads: “You get sick and your body is no longer private. Even if none of your caretakers ever hurts you, some basic dignity is lost.” Just like the dark panels from figs. 3.2 and 3.3, this second panel visualizes Midge’s disintegrating bodymind: her white, featureless figure reveals both the emptying processes carried out by Alzheimer’s disease as well as her separation from the outside world. A final picture of Midge holding a sock in one hand and her daughter’s hand in the other occupies the last panel. Interestingly, Leavitt does not draw the fingers in Sarah’s and Midge’s entangled hands, but instead merges them into two connected arms. “Come on, Mom, let’s go to the bathroom,” Sarah says as she guides her mother (Leavitt 111).

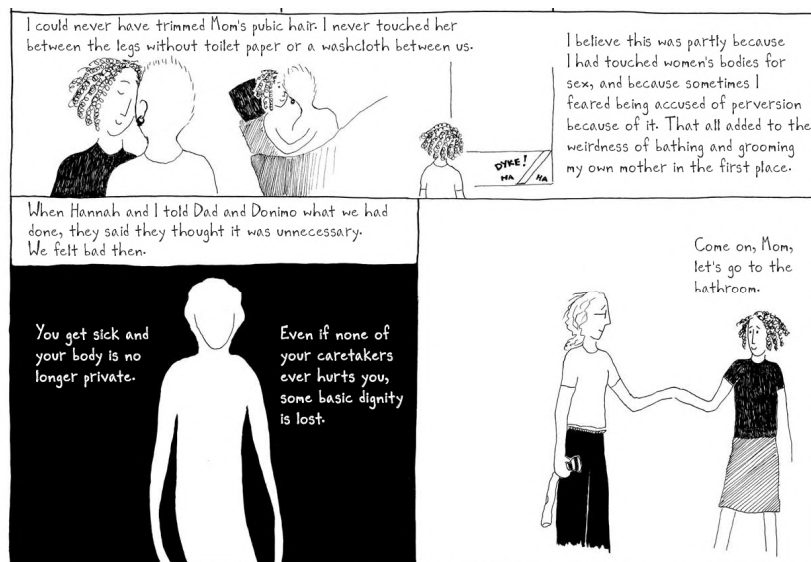


Fig. 3.7. “You get sick and your body is no longer private” (Leavitt 111).

Taking intimate care of Midge introduces a further layer of self-consciousness in Sarah’s identity as a lesbian who touches “women’s bodies for sex” (Leavitt 111) and who has suffered homophobic verbal harassment for holding her mother’s hand in public. The small drawing of Sarah looking through the window in the first panel evokes the scene shown in the episode titled “Finally,” where mother and daughter walk together in the street holding hands, only to be insulted by two teenage boys, who start yelling at

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them and calling them “dykes” (see Leavitt 77). After that incident, Sarah stops holding her mother’s hand in public: “I dropped Mom’s hand while we waited because I never held it anymore when it was just the two of us,” Leavitt writes in another episode where Midge and her two daughters go feed the deer in one of their visits to the local park (see Leavitt 78). Apart from showing Sarah’s worries about the abuse that her mother may be subjected to if the two of them are mistaken for a lesbian couple, the previous scene visualizes the extent to which Sarah’s duties as a caretaker affect her sexual identity: since Midge needs to be fed, bathed, cleaned, and even shaved by her, Sarah has to touch and handle her body, and because she has sex with women, she fears “being accused of perversion” (Leavitt 111). In addition, the naked bodies of Sarah and her girlfriend lying together in bed contrast with the empty, immobile shape that is Midge in the second panel, producing thus a counterpoint between healthy, sexual practices and the intimate procedures of caregiving that risk damaging the privacy of the ill person that receives it, as Leavitt observes in the captions—“some basic dignity is lost” (111).

Central to the previous sequence is also the emotional and physical entanglement between mother and daughter produced over the course of the three panels, which engages with the relational aspect of disability. As demonstrated in the third chapter of this Thesis, disability and illness are complex lived experiences that actively inform and affect both the individual that lives with it as well as their family, relationships, and environment. Kafer incorporates this reality in her formulation of the political/relational model, observing that “disability is experienced in and through relationships; it does not occur in isolation” (*Feminist* 7-8). These ideas are reflected in the last panel, which ends with the visual, metaphorical, and literal entanglement of Sarah and Midge, represented in their conjoined hands. As a lesbian and as a daughter-turned-caretaker, Sarah is forced to face the frustrations, shame, and difficult feelings that arise when taking intimate care of her mother, but the experience does not end there. By rendering mother and daughter side by side, touching each other, Leavitt constructs an interconnected experience of disability that does not take place in isolation, thus countering the dark panel that features Midge’s blank body and isolates her from the outside. Whenever Midge needs to step out of the bathtub, or go for her walk, Sarah is there to hold her hand.

6.2. “The real Mom lived somewhere else”: Inhabiting Strange Temporalities

Tangles presents a compelling engagement with time through Sarah’s negotiation of the imminent loss of her mother, a crisis that fills her with dread and fear. Taking full

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advantage of her minimal yet sometimes packed graphic style, Leavitt presents a diverse arrangement of interrupted conversations, uncomfortable pauses, and revelatory silences to convey Sarah’s increasing uneasiness about the near future. Feeling lost and not knowing how to face Midge’s predicament, Sarah consults the reading materials provided by Alzheimer’s Society, which encourage her to talk to her mother about the future—a task that proves to be difficult, as everyone in the family is “scared and silent” (Leavitt 57). “In the first years of her illness, it often seemed like Mom didn’t understand that her condition was terminal,” Leavitt writes above two close-ups of Midge’s crying face. Her mother believes that the medications and the doctors will help her to get better and overcome her illness: “The Aricept is helping me, right Rob?” a teary Midge asks her desolate husband. “Please can we call the neurologist right now and ask her if I’ll get better?” (57). Even so, Sarah decides to follow the indications of the medical materials and sits down to talk to her mother one day over breakfast, since “[a]ll the brochures said you should talk to patients while they could still understand and express their wishes” (57).

Composed of fifteen panels divided in three identical rows, the crammed sequence shown in fig. 3.8 visualizes Sarah’s struggles when addressing a mother that has no capacity to understand that she is going to die. It displays different close-ups of Sarah’s and Midge’s faces against an empty background. Sarah’s attempt at approaching the difficult topic—“I want to see you as much as I can before... before you die” (57)—is abruptly cut short by her unresponsive mother, who continues to eat while staring at her daughter in annoyance, her mouth dirty with food stains. “Everybody dies,” she sentences, and refuses to participate in the conversation any further (57).

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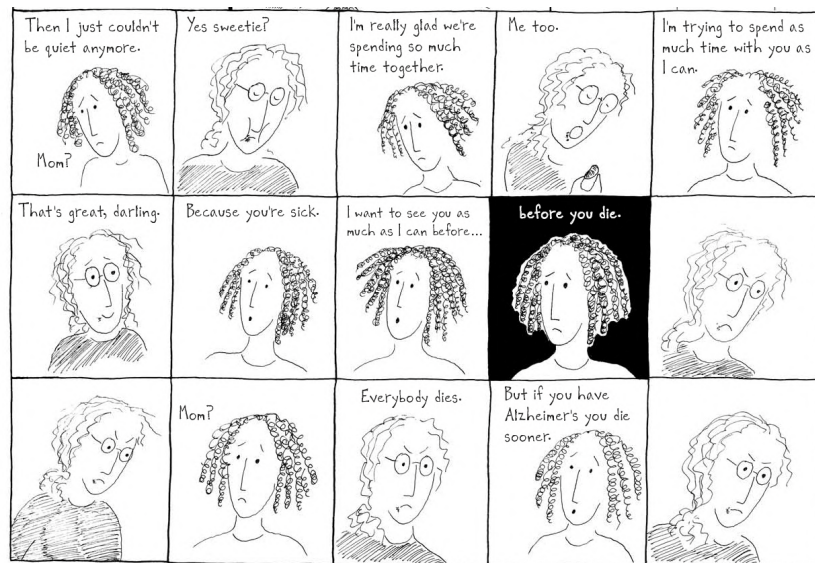


Fig. 3.8. Sarah tries to have a conversation with Midge about death (Leavitt 57).

Both the layout and the spare, monotonous background seem to keep each character within their own respective, confining panel. This graphic feature—Sarah and Midge not appearing together in any of the fifteen panels—suggests that their communication has been broken beyond repair: the symptoms of dementia have advanced, and it is too late for an honest, challenging conversation about upcoming death. I would further argue that the visual quality of this scene engages with the most negative aspects of crip time, as Leavitt employs the repetition of the rows of panels to replicate a halted dialogue that goes nowhere. This formal device directly addresses a particular feature of crip time, which “forces us to take breaks, even when we don’t want to, even when we want to keep going, to move ahead” (Samuels). The repetition requires constantly turning back and forth between the barely altered faces of mother and daughter and intentionally slows down the reading rhythm. In this manner, the shape of the layout represents Midge’s entrapment within the unwanted slowness of crip time: unable to move forward, to participate in the conversation, or even to think about the near future. This monotony is also reinforced by the fact that the only time in which the white, empty background turns to black is when Sarah utters the sentence “before you die” (Leavitt 57) in the third panel of the second row—a change that conveys the anguish that the younger woman feels. Soon after their failed conversation, Sarah loses all hope of getting her

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mother to understand her predicament: “I got up and started on the dishes. Maybe I could wait a bit and she’d just forget” (Leavitt 58). But when it seems that Midge has forgotten about her efforts, she suddenly gets up with the intention to write a letter of apology to Rob, feeling that she is behaving horribly with her husband. Still, Midge never manages to fulfil her task: “She never wrote to him. Because she couldn’t write anymore. And I never tried to have another talk like that with her. Neither did anyone else. It was too late” (58).

The terminal nature of her mother’s disease leads Sarah to turn to her vivid, creative imagination to cope with her emotional pain. Leavitt dedicates an entire episode to portray a detailed, thorough fantasy—involving doctors, funds, and research teams—in which Midge remains healthy: as shown in fig. 3.9, Sarah imagines that her mother would be faking her ailments in order to help a team of doctors and researchers develop a “top secret project” that studies the impact of dementia in families. “This is what really happened to my mother,” Leavitt begins. “She wasn’t really sick at all. One day she was watering her flowers. Dad wasn’t home” (112). In the first row of panels, Leavitt draws a pair of researchers that approach Midge to ask for her collaboration in their project: “We’re trying to help people with dementia,” the two men explain. Leavitt visualizes her kind, compassionate mother accepting the offer so she can help other families and donate her payment to charity. The fourth row turns to depict Midge attending an acting class to learn how to “look” like a person with dementia: she learns to wear mismatched clothing items, and she perfects her slouch, her blank expression, and her characteristic pose with her hands clasped before her. In addition, she visits nursing homes to study how people with dementia act and meets once a week with her team comprised of a doctor, an acting coach, a researcher, and a therapist. Then, in the first panel of the last row, Leavitt envisions her mother suffering after seeing her family members cry because of her “fictional” illness, “[b]ut she would remember the people she was helping and the money and it all seemed worth it” (112). Finally, the last panel returns to reality by presenting Sarah talking to her therapist about her fantasies of a healthy mother.

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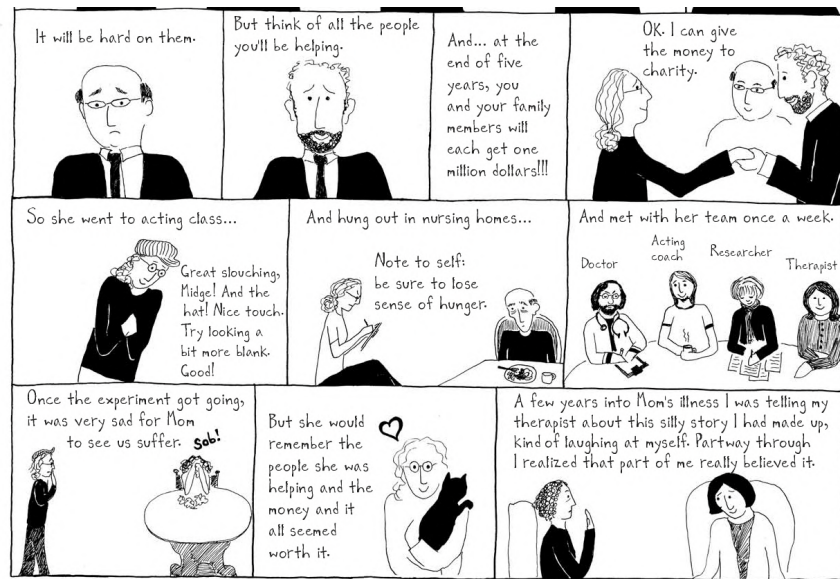


Fig. 3.9. Sarah imagines an alternate reality where Midge is healthy (Leavitt 112).

For the daughter, the immensity of the pain caused by the mother’s incurable disease can only be ameliorated by extracting her mother from the reality in which she is disabled and placing her in an alternate, fictional timeline where she is abled, healthy, and continues to live. Leavitt recreates this extraction in the visual, by depicting the previous scene with the same graphic elements employed in any other part of *Tangles*: the distinctive layout, with its usual lack of gutter and its stacked panels, is identical to the sequences that portray Midge’s disintegrating bodymind, her visit to the neurologist, or the new dangers that appear at home when she cannot cook or tend to the garden, just to name a few examples. Midge is thus encapsulated within the same visual elements that narrate the decay caused by Alzheimer’s, except that this time her bodymind and her kind, compassionate personality are intact. Moreover, the fact that the sequence is visually indistinguishable from these other scenes signals the value that Sarah is placing in this alternate temporality: she needs these daydreams to cope with the close future from which her mother is absent. As she confesses to her therapist in the last panel, part of her really believed her “silly story” to be true (Leavitt 112).

Another prime example of the text’s fruitful engagement with time is found in the episode “Nature Lover,” which Leavitt begins by returning to Midge’s past normalcy, presenting her as a caring individual, extremely respectful and mindful of the natural

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world: “Mom loved all of nature: plants, worms, rocks, soil. She did not seem to feel as separate from it as most people did” (93). A memory of Leavitt’s childhood follows these words: a small Sarah and a younger Midge drink from the sugar maple tree that the family kept at their old farmhouse. As this scene denotes, this younger Midge felt a particular kinship with nature, especially with trees: “My mother used to say that she wanted her ashes spread under the sugar maple tree beside the old farmhouse where we lived in Maine,” Leavitt writes in the captions. “She used to say that she wanted to be reincarnated as a maple tree. She felt a strong kinship with trees, especially maples” (93).

The scene continues in fig. 3.10, which moves forward in time to the moment where Midge is already facing Alzheimer’s. Leavitt graphically marks a juxtaposition between Midge’s pre-disabled and disabled selves by dividing them into two distinct temporalities, each belonging to a row of panels. The first row begins with disabled-Midge stepping on a wasp that she finds on the front door, a motion that she repeats in the second panel, refusing to stop “until the wasp was a black smear” (Leavitt 94). The third panel focuses on Midge’s distant expression, with her eyes obscured behind her glasses. Then, immediately after this close-up, Leavitt introduces the second row with a depiction of Midge’s pre-disabled self with a surprised, worried expression on her face as a thought balloon pops from her head, reproducing the dark silhouette of her disabled self and the wasp smeared on the ground. Her extravagant hat and her absent eyes are now gone, since they are part of disabled-Midge’s defining physical characteristics. The last panel turns to Sarah, who stares at her unresponsive, ill mother while she imagines what her mother’s previous self—a lover of nature and animals of every shape and size—would think of her current actions. “I caught myself wondering what Mom thought of herself,” Leavitt writes. “I realized that part of me believed the real Mom lived somewhere else, unchanging, immortal, observing the new Mom” (94).

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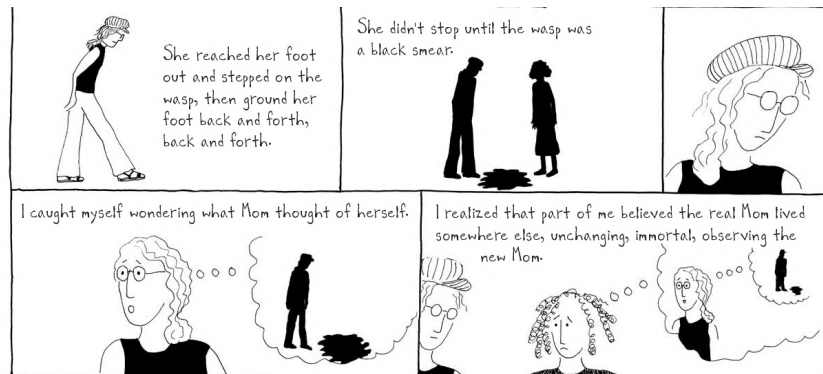


Fig. 3.10. “[T]he real Mom lived somewhere else, unchanging” (Leavitt 94).

The previous sequence reminds us of the contents examined in the first section of this chapter, as Leavitt visualizes the progress of dementia through a division between her mother’s disabled and pre-disabled selves. But the juxtaposition between the older woman’s selves goes one step further in this example, as Leavitt draws Sarah actively imagining how these two “versions” of her mother would interact: pre-disabled Midge would be horrified at the thought of her own self killing an insect, but disabled Midge does not move or respond to her abled self in this fantasy—thus mimicking her lack of interaction in “real” life. This scene also evokes Samuel’s ideas about crip time and the toll that some experiences of illness and disability take on the bodymind: “*Crip time is grief time*. It is a time of loss, and of the crushing undertow that accompanies loss . . . With each new symptom, each new impairment, I grieve again for the lost time, the lost years that are now not yet to come.” By presenting these two distinct temporalities, Leavitt shows that grieving begins while Midge is still alive, and the reader witnesses Sarah’s difficulty to live in the present and come to terms with the most painful aspects of the disabled reality of her mother.

I would like to end this second section by examining a connection between Sarah and Midge and their relation to normative ideals about the future. At the beginning of *Tangles*, Leavitt describes the life that Sarah leads in Vancouver, where she moved after graduating from university. There, she begins to date women and gets highly involved in feminist activism (see Leavitt 17). When Midge becomes disabled, she travels back and forth between Fredericton and her home in Vancouver, refusing to settle in her parents’ city. “Fredericton never felt like home,” Leavitt writes in the first panel shown in fig. 3.11. “I couldn’t imagine staying there. As far as I could see, there was only one possible

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future there, and I didn't want it" (15). The text is accompanied by a picture of a heteronormative marriage composed of a husband, wife, daughter, and son, all of them smiling as if they were posing for a family portrait. Then, the next two panels depict the two Leavitt sisters as adults: Sarah, with an angry frown, and Hannah, with a big smile on her face. The captions uncover the two different lives that the sisters followed: "I left as soon as I could, right after high school graduation. Hannah went away to university but moved back in with Mom and Dad when she graduated" (15).



Fig. 3.11. "[T]here was only one possible future there" (Leavitt 15).

Sarah's rejection of a future life in Fredericton recalls Halberstam's concept of queer time, which exists outside "the paradigmatic markers of life experience—namely, birth, marriage, reproduction, and death" (*Queer Time* 2). As an independent, unmarried woman and a lesbian artist that moved away from home as fast as she could, Sarah is estranged from her family unit and the gendered roles imposed on her. This separation means freedom to the young woman, who cannot fathom a life for herself in her parents' city: "In my mind, there was me and then the rest of my family," Leavitt states at the end of the episode, "who I missed and felt liberated from at the same time" (15). Thus, her life project exists outside the normative markers that have regulated the lives of her parents and her sister and that are embodied in the happy family portrait recreated in the first panel. Connected to this idea is the visual contrast between Sarah and Hannah, which evokes Ahmed's ideas about queer unhappiness. As a lesbian, Sarah exists outside heteronormative modes of affection and reproduction, and thus becomes the queer child who is "a cause of unhappiness in [her] failure to reproduce the family" (Ahmed, *Promise* 95). Depicted with an angry frown, she runs away from the family structure to take her own queer detour. By contrast, Hannah, who marries a man, has a child, and stays in her family's house, is depicted with a warm smile and a calm demeanor. She is content,

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smiling just like the fictional people in the family portrait—all of them are oriented towards the happy family and the happy future.

In a similar vein, individuals with altered bodyminds do not always follow the linear development that is expected of an adult in a neoliberal society. I read the silent panel that contains Midge’s close-up in fig. 3.11, with her eyes absent behind her glasses, as a sign that shows her estrangement from the future that would have been hers should she had not been affected by dementia. As Samuels notes, “[d]isability and illness have the power to extract us from linear, progressive time with its normative life stages and cast us into a wormhole of backward and forward acceleration, jerky stops and starts, tedious intervals and abrupt endings.” Midge has been extracted not only from her passion for animals and nature, but also from her possibilities of working as an educator, from her hobbies, and from the meaningful relationships that she shared with her family—which Leavitt reflects when narrating how her mother complains about not being present in Hannah’s wedding, when in fact she was invited and present for the whole ceremony and the party afterwards (see Leavitt 75), or when Hannah gives birth to her baby and Midge, in the later stages of Alzheimer’s, is unable to respond to the new life in the family (see Leavitt 114). Just like Sarah’s lesbian identity orients her away from obtaining happiness grounded in heteronormative concepts of marriage and reproduction, Midge’s illness leads her to exist out of normative time. Thus, I would further argue that both Sarah and Midge inhabit “strange temporalities,” to employ Halberstam’s term (*Queer Time* 1): Sarah, as an independent, lesbian artist, and Midge, as a person living with Alzheimer’s who is removed from her previous familial and work-related routines and placed into crip time. In this way, both mother and daughter are connected through their existence outside paradigmatic life markers.

6.3. “Tangled, but with spots of brightness”: Archiving Grief and Potential

An essential part of Sarah’s childhood is her penchant for writing and reading, two hobbies promoted by her well-educated parents. Leavitt soon introduces the reader to the “life of books and creativity” (38) that Rob and Midge built for their two daughters, which fostered a deep love and respect for language: “Our parents taught us, as very young children, that language, words, and books belonged to us, that they were exciting and powerful, and that being smart and good with words was one of the most important things to strive for” (Leavitt 39). As illustrated by the many panels filled with lengthy descriptions and extensive dialogue, language becomes a crucial element in *Tangles*, not

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only because of its prominence in Sarah’s family home, but also because it becomes another archival tool that allows the daughter to preserve and retrace the memory of her mother. As I will demonstrate in the next pages, the presence of the different panels that depict Sarah writing in her journal and annotating Midge’s journey—from the earliest signs of illness until death—denotes her preoccupation with preserving every single detail of her deteriorating mother. This preoccupation is already stated in the written introduction, when Leavitt confesses her obsession with keeping every single line written by Midge: “Sometimes she would pull on the page or grab my pen as I tried to write. The pen would skid and make a mark and I’d label the mark: ‘Mom moved my pen.’ I wanted to keep every trace of her” (7). This desperate need to keep “every trace” of a mother that she is losing before her eyes motivates Leavitt to create three main archival spaces to commemorate Midge and to verbalize the manifold experiences of her family’s crisis: Midge’s scattered handwritten notes and letters, Sarah’s journal practices, and the one-page interludes that appear between each thematic episode.

I would like to begin this section by examining Midge’s scattered handwritten notes—reminders, diaries, and letters to her daughter—that populate the pages of *Tangles*. If Sarah is a productive writer and artist who finds her outlet in her extensive, detailed artistic production, so is the woman that encouraged her special relationship with words from a young age. Before Alzheimer’s disease halted her life, Midge was a creative, artistic person who found her passion in writing: “Mom wrote and drew all the time. When I was away at university, she used to send me notes and doodles from the endless work meetings that drove her crazy” (Leavitt 39). A particularly engaging example of Midge’s writing practices is found in the isolated panel shown in fig. 3.12, which depicts her journal of headaches, discovered by Sarah before her mother’s diagnosis. Presented in a single panel that occupies most of the page, Leavitt draws the many scattered notes that her mother writes “in a tiny journal with a purple cover that had two flies on it” in order to keep track of her “blankety-blank headaches” (34). Midge’s handwriting is disordered but still legible, and she is able to describe the different types of headaches she feels. As shown in one of the notes located at the bottom of the page, she also uses this journal to write down reminders for the medical tests and scans she needs to get.

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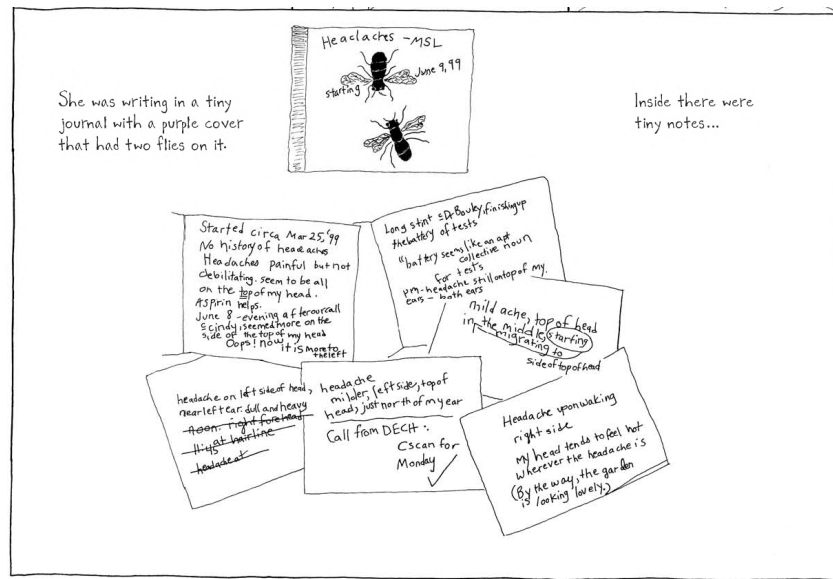


Fig. 3.12. Midge's journal of headaches (Leavitt 34).

Midge's concerns about her blinding headaches—which were blatantly ignored by the neurologist that first diagnosed her, as examined in fig. 3.3—are now kept and held in a big panel that faithfully reproduces her descriptions, her worries about her pain, and even her reminders for future tests. Couser states that “[o]ne of the most fundamental functions of illness narrative . . . is to validate the experience of illness—to put in on record, to exemplify living with bodily dysfunction, to offer lasting testimony” (*Recovering Bodies* 293). Following Couser, I read the previous panel as an act of validation towards Midge's personal experience of illness: if the neurologist does not pay proper attention to these pains, Leavitt makes sure to reproduce and give space to her mother's worries, thus validating her specific, localized knowledge of her illness and her own experience as a patient.

Even though at first she is able to keep track of her numbing pain in great detail, Midge soon forgets her attempts at documenting migraines. Her steady decline becomes evident in the set of handwritten notes shown in fig. 3.13: she had promised Sarah that she would compile several lists with facts about Sarah's childhood, “since her long-term memory was still good” (Leavitt 40), but she only manages to complete a few sentences. The second panel portrays Sarah's profile while she sits at her desk, staring at the barely completed list with a gloomy expression on her face: she cannot avoid noticing that her

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mother's handwriting becomes messier and more illegible as dementia advances. In this manner, both Midge's handwriting and her unconnected, unfinished sentences signal the irreversible changes in her bodymind. Below, the next row of panels turns to the medical setting: the first panel depicts a minimalist rendition of the insides of a head, with the shape of the brain clearly delineated. In the captioned text, Leavitt delves into the problematic of diagnosing Alzheimer's: "There is no blood test or anything that can definitively diagnose someone with Alzheimer's disease" (40). In the second panel, a group of doctors meet to discuss Midge's diagnosis, surrounded by medical terms such as "case," "test," or "rare infection" (40). Meanwhile, a worried Midge and her husband stand in the top right corner of the panel, observing the conversation from a distance, as if not daring to interrupt the experts.

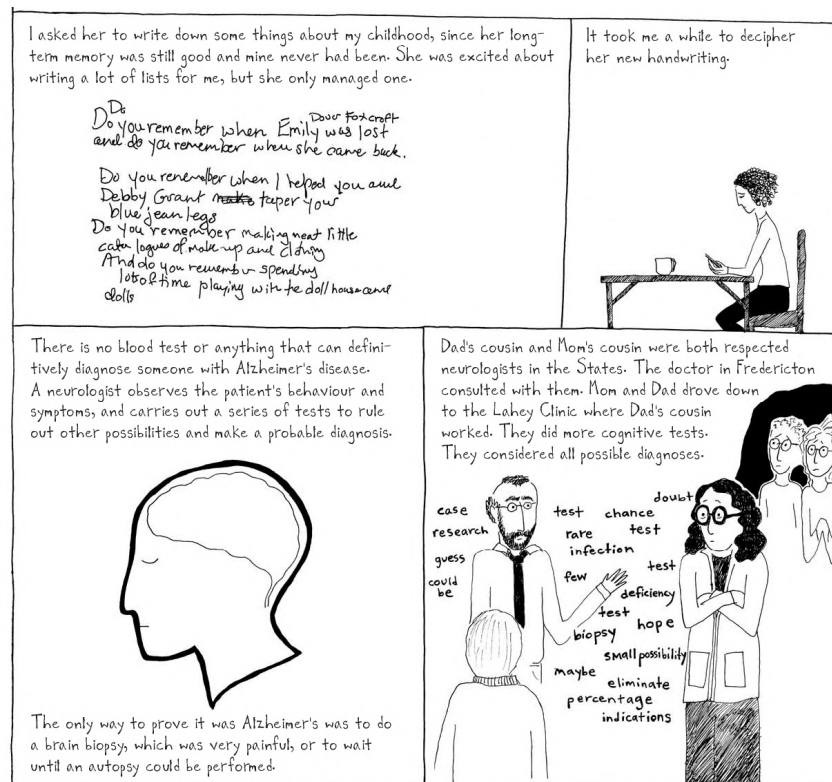


Fig. 3.13. Midge's handwriting and the difficulties of diagnosing Alzheimer's (Leavitt 40).

The previous sequence manifests the tension between the medical and the personal experiences of illness: the intimacy of a sick mother's handwritten notes that her

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daughter attempts to decipher is immediately followed by the bleak, minimalist visualization of the insides of a human head and the three doctors that discuss Midge's condition with a medical jargon comprised of labels, biopsies, and tests. In the right corner of the last panel, Leavitt represents the confusion, disorientation, and even fear that her parents must have felt in such a challenging medical encounter. In addition, the depiction of the human head with its minimalist brain produces a remarkable interplay with the nature of Alzheimer's disease. As Anthony Holland notes in *Encyclopedia of Disability* (2006), this condition "was named after Alois Alzheimer, who in 1906 described the clinical features and postmortem findings of the brain from an elderly person who had suffered from particular mental experiences prior to her death." The research that resulted from these findings demonstrated that this patient "had a significant loss of brain tissue and many microscopic *plaques* and *tangles* in her brain," establishing that there is "a relationship between the severity of the symptoms of dementia prior to death and the extent to which these plaques and tangles were present in the brain at postmortem" (91). Tellingly, no plaques or "tangles" are visible in the minimal drawings of the second panel, as the outlines of an empty brain gesture to the loss of the sense of self that Alzheimer's disease carries out in its patients.

Sarah complements her mother's inclination for the written word by extensively recording and writing in her personal journal about the crisis taking place in the family. Her journal entries "are juxtaposed concurrently with events . . . to indicate that they were being created at the time of actual events" (Sundaram 259). Throughout *Tangles*, there are several instances of Sarah writing down and recording the actions taking place before her eyes—her hands holding writing tools or touching the ink-filled pages of her notebook. Fig. 3.14 presents a compelling example: it begins with one big, narrow panel where Sarah writes the alphabet in both uppercase and lowercase letters using her left hand, an exercise that she spends an entire summer practising to strengthen her brain. The second panel is divided into two distinct parts: on the left side, Leavitt draws her mother's hands—easily identified by her wedding ring and the "urgent" tag that she wears on her wrist—and on the right side, she reproduces Midge's left hand wiggling her finger at Sarah's journal, which contains lengthy, descriptive notes about the different actions that her mother performs when she cannot remember what she intends to communicate: "She wiggles her index finger at things or at you when she can't think of the right word and she wants you to know what she means..." (Leavitt 70).

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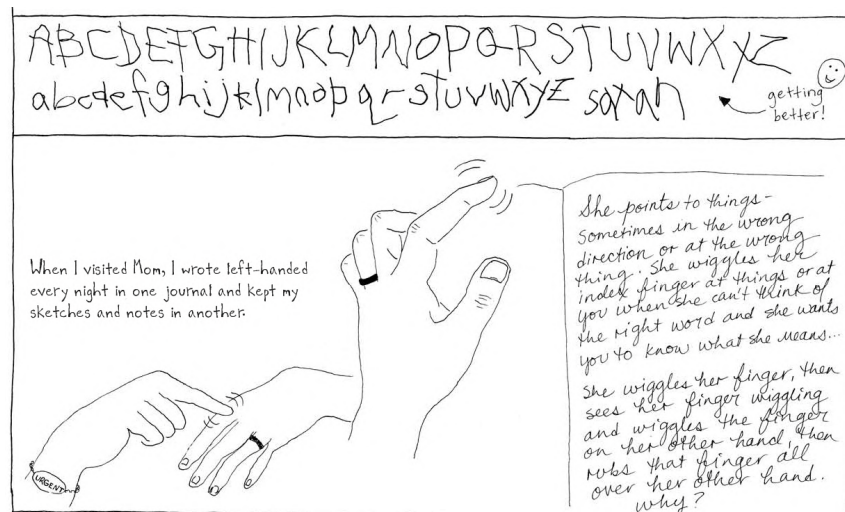


Fig. 3.14. “Gaps” (Leavitt 70).

The visual contrast between Sarah’s text-filled journal and Midge’s hands—who cannot remember enough words to communicate and reverts to touching, pointing, and wiggling her fingers—manifests the relentless loss of language caused by dementia, which creates blank spaces or “gaps” in Midge’s memory. This issue does not go unnoticed by her daughter: “Mom did not know what ‘tank top’ meant. She didn’t recognize pineapple weed, which we always called chamomile, and which we used to pick and eat together when I was a kid” (Leavitt 70). This enthralling scene also serves to account for the relational capacity of disability as manifested in *Tangles*, shown in the collaboration between mother and daughter: while Sarah is preoccupied with writing down her memory-strengthening exercises and annotating every action done by her mother, Midge’s wiggling fingers interrupt her daughter’s archival practice. As Rebecca Anna Bitenc (2017) points out, Midge sometimes resists “her daughter’s project, pulling the paper and pen away from her—whether to gain her daughter’s attention or out of an impulse expressing unease at being ‘recorded’ in this fashion remains open to interpretation” (185). Midge’s attempts to communicate in her own terms with her daughter become the focus of Sarah’s journal entry, and, in her interruptions, she is also participating and relaying her own voice to the text—whether it is through pauses or wiggling fingers. This collaboration is also observed in Sarah’s attempts to write the alphabet with her left hand, as her wobbly letters resemble Midge’s scribbles when dementia affects her ability to write clearly (see, for instance, Midge’s handwriting in fig.

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3.14). There is thus another mirroring process at work in this sequence, as the daughter briefly imitates and occupies the space of the mother.

In the episode titled “Cut My Life into Pieces,” Sarah’s journal delves into the most painful, grueling aspects of caregiving. Fig. 3.15 contains the first nine panels of the sequence, the first one illustrating the dark silhouette of Sarah’s profile writing in her bed while she waits for her mother to finish in the bathroom. Next, Leavitt draws her startled mother sitting in the bathtub, naked and not knowing how to get out. Filled with text, the third row of panels marks the start of Sarah’s confession about the arduous emotional cost of caring for a loved one with dementia: “It gets hard to see someone as a person when they’ve become a list of needs: BATH, CLOTHES, BRUSH TEETH, WALK, FOOD, ETC” (85). Then, the second panel of the third row shows Midge playfully pretending to be a monster while Sarah patiently feeds her: “If you just think about that list, then you’re not as sad... until one night you’re giving her pills and she starts pretending to be a monster... And she’s a person again and you don’t only love her, you like her” (85). A final drawing of a smiling Midge, with her hands clasped before her closes the scene.



Fig. 3.15. Sarah writes in her diary about her struggles with her mother’s care (Leavitt 85).

The daughter’s conflicting emotions towards her mother’s illness are supported and conveyed through a series of formal aspects: first, the unusual wavy frames indicate

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that this scene does not take place in “real” life, but in the space of Sarah’s diary entry from December 21, 2001. Then, the presence of handwritten, cursive text, very different from the usual lettering seen in the majority of *Tangles*—signals Sarah’s confession: that the demolishing routine of caregiving risks seeing a person as an exhaustive list of things to be done. Finally, her problematic feelings are reinforced through the placement of the panels, which alternate between encapsulating the young woman venting and writing on her journal, and then showing her mother, first unable to leave the bathtub on her own and then smiling and playing with her daughter.

Sarah’s journal entries are also present in the later stages of the disease to account for everything Midge cannot do anymore, such as talking or moving by herself. “Just like that. She never walked again,” Leavitt writes above a glimpse of a journal entry from July 22, 2004, which introduces one of the most painful confessions regarding Midge’s terminal state: “(I wish God would let her die.) Have you ever written that before?” (116). Rob’s decision to get his wife into a nursing home removes Sarah from her demanding caregiving duties while simultaneously overwhelming her with conflicting feelings, which Leavitt cleverly illustrates in the four-panel sequence shown in fig. 3.16. She begins by including two panels packed with text: while the first one, written in *Tangles*’ regular font, explains her father’s decision, the second panel turns abruptly to cursive handwriting to engage with Sarah’s journaled feelings: “July 26. It feels OK to think about Dad and be supportive and clear—but Mom—it feels like I’m mentally avoiding eye contact with her...” This confession is interrupted by a silent panel that depicts Sarah curling up in her couch, watching TV with an anxious, worried expression on her face, and returns in the last panel of the sequence with a final, unanswered question in her journal entry: “maybe because a small part of me feels a tiny bit of relief?” (Leavitt 116).

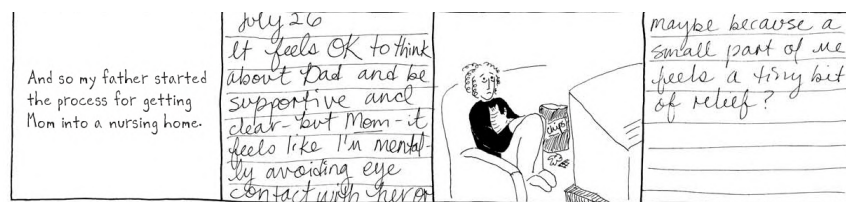


Fig. 3.16. Sarah journals her conflicting feelings of relief (Leavitt 116).

Sundaram states that Leavitt’s diary entries offer a two-fold functionality: first, they “provide a confessional sub-text of shame and guilt” and second, they display “a set of captions that report facts and events,” such as Sarah avoiding eye contact with her

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mother “and feeling ‘relief’ once she is institutionalized” (260). Thus, Sarah’s journal records her shame at wanting “to escape the burden” of caring for her mother: the fixed roles of motherhood and daughterliness—as well as caregiving itself—are “interrogated here by visualising selfish, non-traditional responses alongside normative modes of grieving, empathy and guilt” (Sundaram 260). I would like to extend Sundaram’s discussion by pointing out that Leavitt turns to her personal cursive handwriting instead of the usual typeface employed in *Tangles* to underscore Sarah’s ugliest, journaled emotions: since these entries are being recorded while the action takes place in front of Sarah, they embody the rawness of her emotions in “real time”—her relief while Midge is put into institutionalized care, or her disgust at having to take intimate care of her mother while she waits for her to finish in the bathroom. Sarah’s journal thus becomes an escape valve for the immediacy of her most negative emotions, those that cannot be conveyed in the polished, clean panels of Leavitt’s sequences and remain instead as messy as they are, spilled into the ruled pages.

As has been stated throughout this chapter, Sarah’s underlying anxiety about her own bad memory leads her to archive and record every single aspect of her mother—a practice that occasionally extends itself beyond journal entries or sketches of Midge’s face. A particularly revealing example takes place after a sick Midge accidentally falls out of bed and hits her face on the night table. “I kept taking photos of her face,” Leavitt writes in the long caption of the horizontal panel shown in fig. 3.17. “I couldn’t believe it. She looked so bad. I couldn’t tell if she noticed the injury. But she seemed sad” (107). Three different images of Midge’s face and hunched shoulders are included next to the text, showing her face progressively bruising after the injury. The varying shades of bruising in her swollen face act as indicators of the passage of time, as there are no gutter nor frames that divide the action. On the right side of the panel, a determined Sarah records and takes pictures of her mother with her camera.



Fig. 3.17. After a domestic accident, Sarah takes pictures of her mother’s bruised face (Leavitt 107).

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As Sundaram remarks, the previous panel acknowledges comics' capacity to fully represent "[t]he lived experience of illness," which is "characterised by visible, often sustained, periods of physical transformation." Graphic texts are able to "present the reader with a rich array of perpetually changing bodies—across panels, within a single page" (Sundaram 240). As her swollen face worsens after the impact, Midge's bruise dramatically alters its shape over the course of a single panel, but her obscured, unfocused eyes and her blank expression remain unaffected, thus reinforcing the separation between Midge's body and mind—which recalls her graphic disintegration in fig. 3.4. While Midge's swollen face gets progressively worse over the course of this sequence, her blank stare—a key signal of Alzheimer's—stays the same. This visual detail shows that small bodily damage such as bruises can alter the surface of Midge's body and then disappear over the course of several days, but the serious cognitive decline caused by dementia, which sometimes may not be as evident and tangible as a purple mark on the skin, remains intact.

Sarah's archival tendencies also entail a compilation of physical fragments of her mother, as seen in the six-panel sequence from fig. 3.18, which narrates her meticulous process of collecting little tangled balls of her mother's hair: "I never used a comb or brush on Mom's hair, just my fingers," Leavitt writes in the captions. "At some point I started putting little balls of her hair in my pocket instead of throwing them away" (63). Her words are illustrated by three little balls of Midge's hair, drifting away in the white, spare background. The third panel turns to Sarah's practice of collecting her own loose hairs—which some of her friends find "disturbing"—and the last two panels of the second row present the boxes filled with her own "dense, springy clumps of hair." In the last panel, Sarah sleeps in her bed with her cat by her feet and the boxes on the shelf on top of her. A curly scribble that resembles the curly hair stored in the boxes fills the bedroom's wall while the caption above reads: "I kept the boxes on shelves above the bed and it helped me sleep at night, just knowing they were there" (63).

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Fig. 3.18. “And then I started collecting my own hair” (Leavitt 63).

It should be noted that the boxes contain a collection of Sarah and Midge’s hair, since the young woman begins to assemble her own loose hairs soon after establishing the habit of collecting her mother’s. As Bitenc observes, “[i]nsofar as they include Sarah’s own hair, the boxes also hint at the ways their relationship has been incorporated into her own identity and will help her thrive even after her mother’s death” (184). I would further argue that the scribble that fills the background of the last panel suggests that the mother leaves her imprint on the daughter both physically—Sarah has inherited her curly hair from her mother’s side of the family—and emotionally. Moreover, brushing Midge’s tangled hair becomes a ritual that anchors Sarah to the real, physical presence of her mother—a ritual that becomes part of the daily routine when her mother can no longer tend to her own body. The act of labelling and collecting the different boxes of hair helps Sarah to feel connected to her mother, and their reassuring presence on the shelves of her room helps her to sleep at night. Amidst the relentless changes that Midge experiences on her bodymind, Sarah needs to keep a visible, concrete reminder of her mother that remains intact, unchanging, even years after her death. Thus, the curly hair becomes not only a symbol of the intricate, entangled relationship between mother and daughter, but also a concrete reminder that will always soothe and comfort Sarah.

A similar archival practice is shown in fig. 3.19, which engages with another remarkable aspect of Sarah’s journal: the reproductions of the sketches that she created next to her dying mother’s bed, following her desperate need to document Midge’s presence until her last moments. Upon news that her mother is dying, Rob urges Sarah to go back home as fast as possible, and so she quickly travels to Fredericton with her

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girlfriend. “Then, after six years of sickness and fear, there was nothing to do but wait,” Leavitt writes (119). After visiting her mother in the nursing home, Sarah returns home to spend the night with Donimo, but during the night she suddenly feels the immediate need to return to her mother’s side. Gathering her artistic tools, Sarah goes back to the nursing home to sit down next to Midge’s bed while Sukey—Midge’s older sister—prays and keeps them company. On the left side of the panel, Sukey sings to Midge, with a hand on her bedcovers. The tenderness of the scene is accentuated by the lyrics of her song—“a version of Pete Seeger’s *Quite Early Morning*” (Leavitt 121)—which fill the black background and surrounds the sick woman while she lies in bed. The two portraits of the sisters’ faces, drawn on ruled paper, are included on the right side of the panel: Midge’s face is turned to her left, while Sukey’s profile seems to be looking at her sister, with a look of adoration on her face. A final depiction of Sarah engaged in the act of drawing appears next to these portraits.



Fig. 3.19. In the nursing home, Sarah draws portraits next to her mother’s bed (Leavitt 121).

Even though the two blocks of captioned text indicate that there is a frame dividing two panels—one containing Sukey singing to Midge, and the other illustrating Sarah drawing in her journal—the vast darkness that engulfs the composition blends these two distinct scenes into a single panel. There is a visual tension between the clean lines of the scene where Midge lies in bed and the sister’s portraits, which are drawn in a more realistic style than the encapsulated, framed minimalist drawings that compose the majority of *Tangles*. In her portrait, Midge’s face is recreated with quick, messy lines that denote the hurriedness of Leavitt’s hand when creating this affectionate image of her mother. The inclusion of these portraits, taken straight from the ruled pages of Sarah’s

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journal, recalls Forney’s usage of her self-portraits in *Marbles*, which abruptly interrupt the flow of the narrative. In this case, however, Leavitt chooses to integrate these sketches within her structured, framed panel as a testimony of Sarah’s presence next to her dying mother’s bed. The sketches are shown in the same size as the rest of the visual elements that compose the panel, thus signaling that everything in this scene holds equal importance—Sukey singing, and her mother lying in bed, and Sarah’s drawing—as every action is essential to immortalize and remember Midge’s ending.

One of the most fruitful and enchanting features of *Tangles* is located in the unconnected, almost empty spaces between the thematic episodes that conform the ordered, coherent narrative. As Sundaram observes, the episodes in this graphic narrative “are always preceded and followed by interludes that depict a single scene, conversation, quote or song by Leavitt’s mother.” These interludes “are never explained or framed by commentary, even when they are exchanges that demonstrate very little narrative coherence” (259). These enclosed moments, purposely separated from the main body of the text and always surrounded by a white, vast empty background, offer an excellent opportunity to gaze into the most private aspects of Midge’s illness. Graphic narratives about illness and medical management “resist narrative closure and linearity, to present instead, a catalogue of diverse narrative ‘potentials’” (Sundaram 257). In *Tangles*, these narrative potentials are embodied in the presence of raw data such as “excerpts from diary entries, letters,” and also Sarah’s “failed alternate attempts at recording her mother’s illness.” Ultimately, these potentials become “alternate possibilities that are hinted at but never explored while simultaneously offering sufficient details to the reader to destabilise any coherent picture of the details of illness and its medical management” (Sundaram 257-58). I find Sundaram’s notion of narrative potentials extremely productive to delve into the crisp readings interwoven in *Tangles’* interludes, as they are ridden with meaning and allude to the many different facets of Midge as an individual with Alzheimer’s. The first interlude shown in this chapter (see fig. 3.20) exhibits one of the many handwritten letters that Midge addresses to Sarah and Donimo—her thick letters adorned with black smudges and scribbled hearts—while the second one (see fig. 3.21) illustrates Leavitt’s exhaustive list of the many different objects that her sick mother likes to carry around the house, such as a “cat brush,” “greeting cards,” “books I made her,” or even “*The Lord of the Rings, Book one: The Fellowship of the Ring*” (Leavitt 84).

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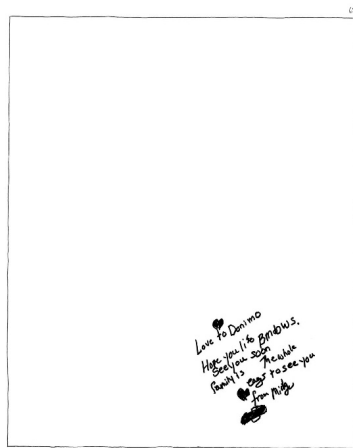


Fig. 3.20. Midge's letter (Leavitt 69).

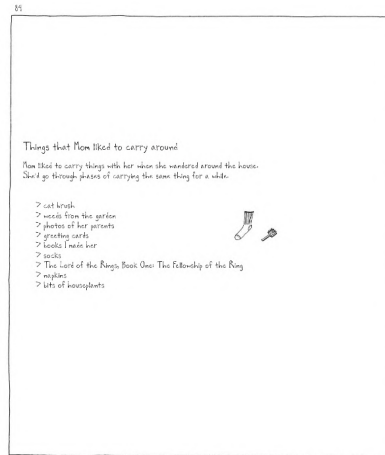


Fig. 3.21. "Things that Mom liked to carry around" (Leavitt 84).

Then, fig. 3.22 turns to depict a small, lonely Midge, with her back turned to the reader as she tries to walk with her pants down to her ankles. The small block of caption next to her reads: "Mom came out of the bathroom and started wandering off down the hall. 'I feel left out,' she murmured to herself" (Leavitt 81). Finally, fig. 3.23 reveals a worried Midge next to a shapeless, unrecognisable figure that seems to be extending an arm towards her. Both characters are placed in a box panel filled in black, with no other background elements around them. Out of the frame, Leavitt reproduces a short dialogue: "Mom: I'm always scared! / Dad: Even when I hug you?" (106).

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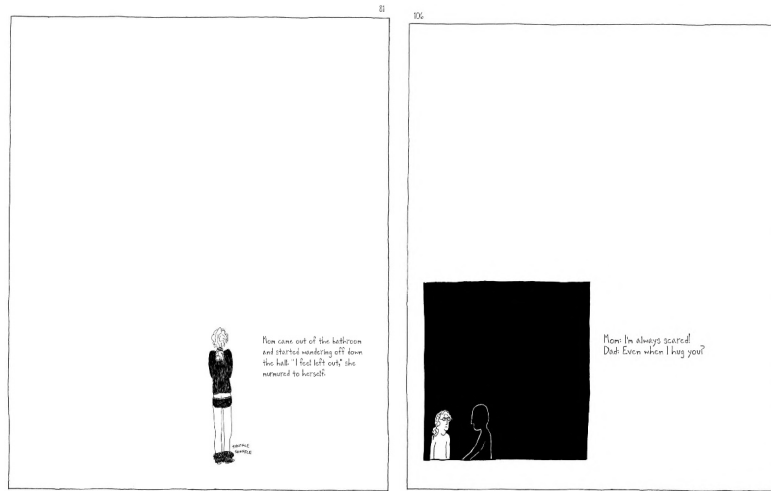


Fig. 3.22. “I feel left out” (Leavitt 81).

Fig. 3.23. “I’m always scared” (Leavitt 106).

These four figures lack a background setting that anchors the scene, a feature extended to the rest of the interludes shown in this text (see, for instance, Leavitt 61, 95, or 99). Midge’s frail body, her letters, and even the lists that her daughter compiles about her habits are located in a vast, empty space. If the lack of conventional gutter and the relentless succession of one packed panel after another replicate the swift advance of the illness, this vast white space is also charged with meaning. As Venema points out, “[m]ore effectively than any of its other visual techniques, *Tangles*’ many nearly empty pages powerfully replicate the identity evacuating effects of Alzheimer’s disease” (68). Specifically, the effects of the illness are expressed formally through the absence of panels, rows, or layout dividing the action. There is thus no visual guide for the reader, who is left with a minimal glimpse of the lives of Midge and Sarah. The interplay with the color black, which heavily contrasts with the vast whiteness of the page, is especially significant in the case of fig. 3.23, as it visually recreates the symptoms of Alzheimer’s: the darkness of the panel, which engulfs and dwarfs the figures of Midge and her unrecognizable husband, not only signals that Midge “disappears” for her family, but also that the rest of the world—Rob, in this case—becomes unrecognizable for her.

The interludes that inhabit the margins of the main narrative allow Leavitt to collect, recall, and offer the reader an assortment of the precious moments that she shared with her mother—both the devastation and the anguish that spring from the symptoms of the disease and the happier occasions, also shared with the other family members: “We

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laughed so hard, then, all four of us,” Leavitt writes in an interlude where the whole family laughs when Midge, ill, confesses in her “sweet little voice” that she has farted in the kitchen (99). I would further argue that these interludes articulate McRuer’s key notion of crip de-composition, which rejects the demand of finished products that springs from heteronormativity, and argues in favor of working, disrupting, and refusing to provide normative closure (155). As stated in the third chapter of this Thesis, “projects of resisting closure or containment and accessing other possibilities, are queer/crip projects” (McRuer 159). Leavitt’s use of visual and textual interludes to interrupt the narrative flow seems one such project: by deciding to separate these interludes from the main storyline, presenting them as nooks of time and space that allow her to preserve the memory of her mother, she crips abled understandings of linear, stable flow of time and chooses to inhabit fragmented, unassembled, disabled moments instead. In doing so, her text dwells in the love Midge manages to embed in her letters, even when Alzheimer’s leads her to forget more and more of herself and her family; in Midge’s feelings of loneliness, isolated from the world because of her symptoms; and in the amusing list of the objects that her mother likes to carry around while sick. Thus, *Tangles*’ interludes are embedded in crip potentiality: Leavitt rejects abled coherence and takes a crip detour to account for the negative, painful aspects of illness and disability while also presenting the intimate, happier moments she shared with her mother. Both are equally important to present her—and her mother’s—experiences.

Having analyzed the potentiality of the interludes, I now turn back to the episodic format employed by Leavitt to portray the final stages of Midge’s illness. Leavitt situates the reader in the spring of 2004, when Hannah gives birth to her son Zeb and calls Sarah to cry about not being able to share this joy with her own mother: “I miss Mom so much! She would have been happier than anyone else to have a new baby in the family!” (Leavitt 114). In the summer, Sarah and Donimo travel to Fredericton to meet the new family member and to offer support to the new mother. As shown in the first row of panels in fig. 3.24, they are quick to “fall in love with Zev,” despite not being particularly enthusiastic about children. The couple plays and enjoys their time with the new baby, who smiles and grabs them. But these joyful moments are abruptly interrupted by the next row of panels, which depict Midge lying in her bed, with the bedrails on, “soaked in urine, in spite of the diaper.” Midge is now experiencing the later stages of Alzheimer’s: “She didn’t speak much. Her glasses fell off or she pulled them off. Her dark eyes darted like a

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scared animal's" (114). The scene changes once again in the last row, which turns to portray Donimo feeding Midge a carrot as the older woman sticks out her tongue and reaches out for the food, with her hands clasped before her and her eyes completely obscured behind her glasses. A detailed image of a wild, untamed garden with overgrown plants and tall leaves illustrates Donimo's description of Midge's mind: "Your mom's mind is like the garden this summer," she tells Sarah. "Tangled, but with spots of brightness" (Leavitt 114). The last panel portrays Sarah smiling and holding baby Zev in her arms. Only half of Midge's body appears inside the panel, as she is not paying attention to her daughter and grandson. "Sometimes I craved my mother," Leavitt writes. "Other times I fled her illness and escaped to Zev's new life" (114).



Fig. 3.24. "Tangled, but with spots of brightness" (Leavitt 114).

The composition of this sequence posits the contrast between the joy and happiness brought by Zev and Midge's own decaying life, visualized in her bedrails, her body covered in urine, her inability to speak, and her scared eyes. The whole sequence intertwines life and death: the new, promising life, to which the family escapes for a moment of relief, and Midge's complete separation from the world. Midge now fully lives in the most negative aspects of crip time: she inhabits the sides of the page, lying down, standing on the side, or letting herself be fed—not being fully present, nor recognizing any of the important events that are taking place in her family. I would further suggest

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that Donimo’s description of Midge’s mind as a tangled garden with its own spots of brightness evokes the notion of crip potentiality as examined in the interludes: it recreates the entangled relationship between mother and daughter, which is at times a grueling, tangled mess, but that manages to offer moments of goodness and brightness.

The last pages of *Tangles* focus on the pain and grief that Sarah experiences after Midge’s passing. Back at the nursing home, the family surrounds Midge’s bed to bid her a final farewell: “We cried and cried and touched her and stroked her hand and talked to her.” Then, Sarah cuts a lock of her mother’s hair to keep as a last reminder of her presence and love (see Leavitt 122). When she returns home, the process of mourning begins, and the unbearable absence of her mother prompts her to embrace part of her Jewish roots. Even though Sarah’s Jewish parents were not very religious, nor participated in the Jewish community, they still provided her with extensive knowledge and teachings about her heritage, and so she finds relief and solace on Jewish teachings after her mother’s death. This is not the first time that Sarah approaches religion: when Midge got sick, she decided to attend a synagogue where she met a rabbi that taught her a prayer for her ill mother. “I liked the prayer even though there was no change of my mother ever being healed,” Leavitt writes above a picture of a smiling, healthy Midge. “I put the prayer beside her photo like a charm” (44). Years later, when the loss of her mother becomes final, Sarah turns to another prayer, which Leavitt explains in the long caption of a framed panel, packed with text:

In Jewish tradition, you say Kaddish every day for 11 months after the death of a parent. The prayer itself is not about death or mourning. It affirms the mourner’s faith in God. It shows that the mourner had good parents who instilled a strong faith that endures through great grief. I didn’t care what the words were. I wanted the ritual. (125)

Building on the mourner’s prayer, Sarah creates her own religious ritual at home: first, she covers herself in the starry blanket she had gifted to her mother, and then she sits on the floor with Donimo to say the words out loud. She even takes part of her ritual with her when she goes outside, as shown in the last framed panel of *Tangles*, where Sarah returns to nature (see fig. 3.25). Among the trees, on an open road with no beginning and no end, a lonely Sarah embraces herself, covered with her mother’s blanket. The trees that surround her are now bare and empty, witnesses to a desolated landscape—Midge’s flourishing summer garden is not there anymore. “It helped to think about saying Kaddish for 11 months,” Leavitt writes in the last caption of her story, “and to realize that some day I would say the prayer for my mother for the last time” (126).

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Fig. 3.25. “Every day I mourned the loss of her blazing, protective love” (Leavitt 126).

The fact that in the previous panel Sarah is placed on an open road with no end in sight gestures to the long process of grieving that she has ahead of her. But even if she is alone, her praying ritual becomes a means of finding consolation amidst the pain, as it gives a space and time to meet—and honour—the memory of her mother: “I made the Kaddish into my own prayer, my time spent with her every night. Every day I mourned the loss of her blazing, protective love” (Leavitt 126). I would further argue that Sarah’s Kaddish is a last connection between mother and daughter. In the episode titled “Please,” Leavitt recalls how Midge took great care in teaching her two daughters about the family’s Jewish heritage and how they celebrated Hanukkah. Her mother would always put great care in uttering the prayers, “even when Dad had to help her with the words” (Leavitt 44). Saying Kaddish again and again, during eleven months, not only ensures that Midge’s presence is remembered, but also that her teachings pervaded in Sarah. Prayer becomes thus a last relay of voice from mother to daughter, as part of her mother’s cultural legacy of Jewishness lives in the daughter, who respects and reenacts these traditions and beliefs. And just like collecting her mother’s loose hairs gives her a grounding sense of calm, these prayers provide Sarah with a structure and a routine to face the devastation of her loss.

In the midst of the chaos that Alzheimer’s imposes on the family, Sarah attempts to search for order in her Kaddish prayer—a process that is ultimately replicated in the production of *Tangles*. As Bitenc points out, “[c]aregivers’ memoirs are frequently born out of an impulse to memorialise the parent or spouse, as well as out of the need to make sense of the devastating experience of watching a loved person die with dementia” (160).

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The authors of these memoirs engage with “the therapeutic quality of writing, both during caregiving and after the family member’s death” (160). The act of creating *Tangles* becomes a process of catharsis for Leavitt, who alleviates her grief and her desolation by drawing and writing her narrative with the same love and care she put into saying Kaddish for almost a year.

The daughter’s love is extended to the very last page of this graphic narrative, which takes the form of an interlude that opens the text to a final potential. This time, a single panel that contains a picture of a smiling, weary Sarah occupies a place near the center of the page (see fig. 3.26). Against the black background, several flowers spring from her shoulders, and the contours of her neck and body contain a handwritten inscription: “A few days after Mom died, I had a dream that I felt something tickling my ear. When I looked to see what it was, I saw that Mom had planted seeds on our shoulders, and they were growing into paper flowers” (Leavitt 127).

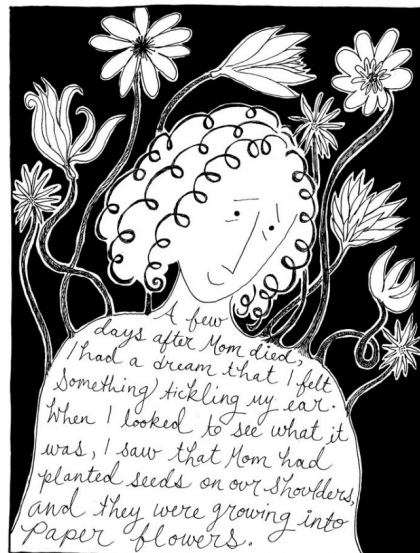


Fig. 3.26. “A few days after Mom died” (Leavitt 127).

The imagery of trees, nature, and flowers that permeates this narrative, along with this final inscription in beautiful italic letters, gesture to the imprint that Midge leaves on Sarah—a glimpse of the mother stays in the daughter’s body. Out of the coherent main

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body of the narrative, this final interlude connects Midge’s love of gardening and writing to her daughter, who receives these gifts—literally—on her body and then applies them to her work: while Leavitt builds on her mother’s teachings about the importance of words in the act of writing her graphic narrative, Midge’s connection to plants and animals becomes “real” in the space of the page, through the many panels in which the daughter draws her surrounded by nature (see, for instance, Leavitt 21, 93, or 102). Furthermore, by ending her story with an interlude and not with a framed, captioned panel, Leavitt seems to allude to the openness of the winding road Sarah has ahead of her, as shown in fig. 3.25. In this manner, this lack of a normative closure gestures to the long mourning process that would later propel her to create this graphic narrative.

But this last interlude offers a final twist, because the woman in the picture “might be, simultaneously, both Sarah and a young Midge” (Venema 69). The curly hair, which is a characteristic sign of the Leavitt family, along with the spare, minimal lines that form the figure help to visualize a woman that can simultaneously be both the mother in the past and the daughter in the present, thus signaling a long-lasting connection between the two of them. This entanglement also dates to the beginning of the text, as Leavitt confesses in the introduction:

I created this book to remember her as she was before she got sick, but also to remember her as she was during her illness, the ways in which she was transformed and the ways in which parts of her endured. As my mother changed, I changed too, forced to reconsider my own identity as a daughter and as an adult and to recreate my relationship with my mother. (7)

Leavitt is not only prompted to preserve both the pre-disabled and disabled selves of her mother, but also her relationship with her, and the shifting changes in her own identity as a daughter, threatened by her mother’s dementia and her need of caregiving. I read this alluring visual connection not only as a final entanglement between Sarah and Midge, but also as an affinity that links caregiver and care-receiver, past and present, pain and solace, and abled and disabled lives. While Alzheimer’s disease removes Midge from her family, her job, and even from her own bodymind, Leavitt’s archival project chooses to preserve each aspect of her existence. By tracking and displaying everything that happens to Midge, Leavitt becomes an archivist of her ill mother, and her detailed, affectional work turns into a compelling counterpoint to the self-erasure of Alzheimer’s. *Tangles*, then, is an homage to Midge and her memory.

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7. Conclusion

The purpose of this dissertation has been to critically examine the representations of disability and illness in *Stitches*, *Marbles*, and *Tangles* by employing an interdisciplinary framework that builds on comics theory, disability studies, and crip theory. Chapter 2 has explored the major formal elements of the medium of comics as well as its powerful capacity for sequential narration and storytelling. Cartoonists find plenty of creative freedom in the composition of the layout, which grants them the ability to “play” with the elements arranged on the surface of the page to alter traditional reading patterns. Close attention has been paid to the element of closure or the empty spaces between panels, which emphasizes the special relationship that comics shares with time and space: if Scott McCloud notes that panels offer a series of fragmented moments that the reader connects to construct a unified reality (*Understanding* 67), Hillary Chute puts that idea into motion by observing that the interaction between panels and gutter is what makes comics move “forward in time through the space of the page” (“Comics” 452). Thus, the sequentiality of the medium is born from an interaction between presence (panels) and absence (gutter). In addition, Thierry Groensteen’s notion of arthrology (2007) has been crucial to assess the manifold connections born from the network of relationships on the page. The art of comics combines fragmenting and assembling, as the process of encapsulation and the blending of verbal and visual elements disclose a particular meaning not found in other pictorial narratives. It is precisely this special quality that turns the graphic form into a productive space for the expression of bodily and mental matters.

This second chapter has also outlined the prolific production of comics in the United States and Canada, where the underground comics scene received a boost in the decades of 1980s and 1990s with the appearance of pioneering, experimental autobiographical works that dealt with feminist and queer topics. Building on this rich history, I have considered the power of graphic narratives to portray private, intimate stories. Elisabeth El Refaie’s key notion of pictorial embodiment (2012) has been central to conceptualize the ways in which autobiographical cartoonists produce multiple self-portraits while taking advantage of comics’ spatiotemporal concerns to envision disrupted, altered selves.

Chapter 3 has offered a critical reading of the theories of disability and illness following the frameworks of disability studies and crip theory. Drawing on the

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formulations of the eugenics and medical models, I have studied the pathologization of disability under the discourses that construct it as an individual fault that must be eliminated or cured with medical intervention. Michel Foucault's notions of biopower and surveillance (1963, 1975, 1976) are useful to examine the medical gaze and the neoliberal demands of high bodily and mental capacity that reject those bodyminds that fail to meet the norm. Against the pathologization and the devaluation of disability provided by medical, scientific, and evolutionary discourses, the social model has intended to remove the linkage of disability with weakness, pain, and suffering. "Normalcy" and "norm" are relevant terms for the analysis of the ideology of ability, which has been framed as the preference for an abled bodymind and aided by medical and scientific discourses. This chapter has also portrayed some of the most important controversies of the social model, as many scholars have criticized its inadequate emphasis on physical and environmental barriers and its lack of focus on the lived realities of impairment (Withers 91). Positioning a similar critique, Alison Kafer (2013) resorts to the creation of the political/relational model to encompass the manifold experiences of disability and illness, bridging the differences between these two categories and acknowledging that impairments sometimes entail pain, suffering, fatigue, trauma, and the need for medical treatments. Moreover, Kafer's understanding of disability as a collective affinity allows for the inclusion of individuals with sensory impairments, chronic illnesses, mental illnesses, or learning disabilities, just to name a few. I have further suggested that Jasbir Puar's theorization of disability in relation to assemblages of capacity and debility (2017) serves to acknowledge the fluid state of disability without conflating the manifold realities of disabled bodyminds.

The critical reading of crip theory deployed in this chapter has first explored the potential of the word "crip" and its alliances with queer theory as shown in the works of Carrie Sandahl (2003) and Robert McRuer (2006). Then, building on the ideas of Jack Halberstam (2011) and Sara Ahmed (2010), it has considered the linkage between crip bodyminds, failure, and unhappiness. And third, it has charted the subversive knowledges that depart from crip conceptualizations of failure, delving into the notion of cripistemology as theorized by Merri Lisa Johnson and Robert McRuer (2014). Within this framework, cripistemologies provide spaces for the creation of alternate, private archives that engage with the lived experiences of disabled bodyminds. The last section of this third chapter has turned towards crip understandings of time and futurity, where I

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have distinguished between two temporalities found in the discourses that approach disability: a first one born within medical and scientific discourses, which attempts to apprehend disability into purely measurable, homogenizing terms, and a second one belonging to activism and crip theory, which aims to destabilize these medical categorizations. The most negative aspects of crip time have been articulated through the work of Ellen Samuels (2017), who inspects the pain and the negativity embedded in missing time, work, and opportunities because of one's physical or mental impairment. Lastly, my reading of futurity has followed Kafer's notion of curative time: as an ableist belief that casts disabled people as hindrances to a normative development of life, curative time sees medication and cure as the only desirable future for disabled individuals. As a project of resistance against these ideas, crip theory seeks to create understandings of disability in which disability is seen as an integral part of human life.

Chapter 4 has probed the cripistemology of cancer and voicelessness that David Small devises in *Stitches*, representing and resituating his own reality of a disabled bodymind that faces pain, trauma, and exclusion. I used Foucault's conceptualizations of the Panopticon and disciplinary power to analyze the pervasive medical gaze exerted on David through the visualization techniques of the x-ray technology that caused the boy's cancer. Then, by exploring the arthrological connections between different page layouts, I have argued that whenever David has a source of light casted over his body—whether it is the x-ray technology, or the blinding light in his parent's living room—an external force is surveilling him. The oppressive silence that haunts the family home is thus paralleled by the fact that David loses his voice when one of his vocal cords is removed. In the cruellest way, David's emotional silence becomes physical.

My analysis has articulated Small's depictions of his own bodily interiors as crip potentiality, as he portrays his own experience of cancer and voicelessness away from the x-rays and the doctors that dissect his body. Through gaps and dark voids, David enters and walks through his own mouth and invites the reader to stare at the interiors of his ill body, thus showing, in his own terms, the site of his cancer. And as he is forced to adjust his life to an acquired disability without receiving any kind of guidance or support, David turns to his dreams to apprehend the most traumatic and painful aspects of his disability. Following Dale Jacobs and Jay Dolmage (2012), I have linked Small's skilled usage of arthrological connections as a reinscription of meaning: the medical abuse of his body is paralleled in the neglect he suffers at home at the hands of his parents. In this manner,

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both locations—his own mouth and his family home—are full of silence and betrayal. Forced to confront a lifetime of silence and withdrawn parents that dehumanize him, David turns to art, and it is art that saves him, providing him with an outlet to engage with the many silences that have plagued his life. One of these silences is his detached, closeted mother. In *Stitches*, queer and crip cues manifest an unexpected connection between mother and son, who are linked through connections of gender non-conformity and sexuality and (hidden) stories of illness. David’s accidental discovery of his mother’s lesbianism parallels the unexpected finding, years later and in a letter from his mother to his grandmother, that he actually suffered from cancer. Even though Betty’s experiences of illness are relegated to paratextual inclusions, Small constructs a polished network of graphic encounters between mother and son that never seem to converge, as the silence between them stays unbridgeable until her death. At the end of *Stitches*, David refuses to follow the footsteps of his mother and grandmother and through his therapy sessions and his artistic creativity, he decides to undo the repression that has been enacted on him.

My reading of *Marbles* has shown that Ellen Forney’s cripistemology of BI-D is a collective enterprise composed of external and internal sources through which she resists the medical label “Bipolar I Disorder 294.6.” This chapter has mapped and identified the different levels that assemble Forney’s crip archive; namely, Ellen’s self-surveillance notebook, autobiographies, medical texts, Ellen’s sketchbook, and retraced photographs. I began by examining the distinct ways in which Forney visualizes the contrary moods of mania and depression, arguing that as BI-D becomes an embodied experience as it leaves its trace on Ellen’s body. The visual analysis has revealed that Forney employs the formal properties of the medium to distinguish between her manic and depressive experiences: on the one hand, she characterizes her manic phases through visual excess and boundlessness, and, on the other hand, the bleakness and slowness of depression is conveyed through a lack of frames and minimal lines that hide Ellen’s body and convey her entrapment. By inspecting Ellen’s depression through Samuel’s articulation of the most negative aspects of crip time, I have examined how Ellen “wastes” productive time when depression renders her unable to move and work.

Crucial to the crip archive is Ellen’s self-surveillance notebook, where she records in great detail every single aspect of her life: medication intake, mood changes, daily activities, thoughts, and fears, and also the emotional costs of adjusting and planning her life around a fluctuating disorder that she does not fully understand. Another source of

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concern for Ellen lies in a “too muchness” of her feelings, which unearths the dangers of an elated sense of happiness, such as the one prompted by mania. *Marbles’* critique of medication culture is examined through the account of Ellen’s struggles to achieve the right dosage of medication to treat BI-D. After years of learning to manage her disorder, Ellen is afraid that being “stable” within bipolarity would flatten her uniqueness as a creative cartoonist, but at the same time, she covers and masks her symptoms with medication to continue working. While Forney does criticize the myth of the “crazy artist” and the belief that suffering produces better art, she is still guided by capitalist ideas about productivity, visualized in Ellen’s constant preoccupation to maintain her ability to keep working at all costs. But far from ignoring these struggles with medication, work, and productivity, Forney’s crip archive sheds light on her worries and contradictions and in the conflicts that arise when living with—and managing—disability. In doing so, Forney invites the reader to witness the difficulty of making decisions about one’s care when in distress. Following Nicole Eugene’s arguments (2017), I have argued that Ellen is an active participant of her own personal and medical care, as she orchestrates and arranges her treatment, seeking alternative options with her therapist while accounting for the many frustrations that come with the process.

The last section of this chapter has articulated an archival reading of the other levels that assemble Forney’s crip archive, such as the artistic and literary works of famous mentally disabled people, which lead Ellen to question her own identity as a bipolar cartoonist. In this way, Ellen obtains knowledge about her own condition, her worries, and her fears by questioning the works and the lives she inspects in detail. This is specially so in the appendix that she consults, which grants her the opportunity to question the dehumanizing, voyeuristic effects of lists and medical categorizations and the damaging idea that mental suffering is the only way to create good art. Forney’s crip archive is also composed of objective research and scientific and medical explanations about bipolar disorder that seek to clarify information to the reader, as well as Forney’s family tree of psychiatric disorders, which gives the reader the opportunity to trace Ellen’s history of mental disability in the same diagnostic fashion that she charts and records the lives of famous artists.

The analysis has also addressed Ellen’s preparatory sketches, which halt the pace of the narrative, diverting from conventional graphic devices to force the reader to stare at self-portraits produced in moments of deep suffering. Drawing these self-portraits

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guides Ellen to trace and retracing the “familiar lines” of her face, grounding her difficult feelings about a bodymind that she is not fully able to control. Thus, I have further suggested that the space of the sketchbook allows her to reconnect with her individuality and her changing identity in her own terms, contesting the objectivity of the medical label “Bipolar I Disorder 294.6.” Besides, the intimate self-portraits of the sketchbook contrast with the multiple redrawn photographs that show Ellen touching and kissing other women while manic. Taken during a manic episode, these photographs become diagnostic visual evidence of BI-D. In this manner, both the sketchbook—which turns to the ugliest part of Ellen’s depression and her feelings of worthlessness—and the photographs—charged with her manic energy exhibit Ellen’s subjective experience of bipolarity away from medical expectations, hence subverting the objective, sanitized descriptions of symptoms provided by the *DSM*. And just like *Stitches*, Forney’s text does not present an “overcoming” of disability, as Ellen is not cured of bipolar disorder, but instead she learns to live with it, balancing—with the help of her therapist, her treatment, and her support system—the shifting moods of manias and depressions and the troubling states in between

Chapter 6 investigates the cripp project that Sarah Leavitt builds in *Tangles*, which articulates crip potentiality by accounting for the painful decline caused by Alzheimer’s disease and the tender moments that Sarah shares with her mother. When Midge falls ill, Sarah is forced to negotiate a sudden change in her identity as a daughter, and her actions and caregiving practices intend to compensate for her mother’s Alzheimer’s. Illness thus foists a cruel reversal of roles in the family where the daughter is forced to become her own mother. The analysis has revealed that the process of disintegration that affects Midge is conveyed through her graphic isolation, which signals her removal from the able-minded and able-bodied world. *Tangles’* compelling engagement with the strange temporalities of Alzheimer’s has been crucial to my analysis. My focus has been on the ways in which Leavitt inscribes her mother in a timeline composed of before-and-after Alzheimer’s, visually distinguishing between Midge’s pre-disabled and disabled selves, and conveying her past normalcy through an account of the activities and routines that she was capable of doing while healthy. This juxtaposition of temporalities is translated to the graphic space of the page by separating pre-disabled and disabled Midge into two distinct rows of panels. Other graphic devices, such as monotonous layouts and panel repetitions, are used to portray the hopelessness and the gloominess of getting her sick mother to understand that she is going to die soon. Moreover, I have remarked that both

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queerness and disability are disruptions of normative futures: while Sarah refuses the happiness of the heteronormative family future in Fredericton and orients herself towards her life as a lesbian artist, Midge is removed from her future by her illness. In this way, mother and daughter exist outside of paradigmatic life markers—out of normative time.

My analysis has identified and examined three different levels that compose and inform Leavitt's archive: Midge's handwritten notes, Sarah's journal entries, and the interludes between episodes. The detailed reproductions of Midge's notes counter objective medical assessments and value her situated knowledge of her bodymind, whereas Sarah's journal entries convey her most ambivalent, conflicting emotions, such as the relief that comes when her mother is finally institutionalized. Sarah's archival practices are also extended to the eerie act of collecting her mother's loose hairs and storing them in boxes in her room, which stresses her desperate need to preserve and remember every aspect of her mother. The sketchbook in *Marbles* and the act of collecting hair in *Tangles* function as grounding practices, each with a different aim: while Ellen needs a safe, physical space to engage with the negativity of depression, Sarah constructs a small ritual, a practice that allows her to feel the physicality and the presence of a mother that she is losing before her very eyes. Thus, Sarah's exhaustive practices become a counterpoint to Alzheimer's: while Midge's illness leads her to forget herself and her world, her daughter desperately attempts to remember by writing—and drawing—everything that happens in her family. If through her extreme self-surveillance practices Ellen becomes an archivist of her own self, Sarah's exhaustive recording processes render her an archivist of her ill mother.

Finally, in the fruitful interludes between episodes, Leavitt reconciles with the loss of her loving mother by remembering both the traumatic, painful aspects of her illness and the beautiful moments that the family shared together. By refusing linearity and ableist coherence, these interludes illustrate McRuer's notion of de-composition: they resist closure and access other possibilities—other moments of Midge's disabled existence. During Midge's illness, Sarah retreats to alternate realities where her mother is still alive and healthy. But, when Midge's death is final, she turns to her Jewish heritage and the comforting routines of prayers in order to face and account for the reality that is taking place before her eyes. As a poignant homage from daughter to mother, *Tangles* operates as a scape valve for Leavitt, who revisits the past memory of her mother and her own present grief in the process of creating this story.

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The three graphic narratives that shape my corpus have proved to be archival spaces that question the pervasive, ableist discourse on the disabled body. I have argued that both the *DSM*'s description of bipolar disorder in *Marbles* and the technology of the x-rays in *Stitches* provide clear, objective visualizations of an individual's body and mind according to scientific and medical research. In their labelling and categorization, both remove the individuality of the patient. Visual and textual entrapments are also a common element in these three texts: whereas Ellen is trapped in the clear, objective definition of Bipolar I Disorder provided by the *DSM*, Midge is entrapped and enclosed in panels to showcase how her illness disconnects her from the outside world, and the arthrological connections of *Stitches* inscribe David entrapment in his family home and in the medical setting: if his childhood self is enclosed in the x-ray machinery that takes his radiographs and inspects every inch of his body—inside and outside—then his teenager self is trapped in a repressive home with parents who exert their control on him, having full access to his young, ill body, while remaining themselves inaccessible.

Yet, against the objective, medical images that impose a single, unified, stable view of their respective conditions, the three cartoonists turn to art to freely engage with their own selves. The case of David Small is perhaps the most notable: child David travels to a fantasy world by submerging himself into his drawings, where he meets his cartoonish imaginary friends, who, unlike his frowning, detached parents, smile upon his arrival and welcome him with open arms. Shaped as a stomach, this alternate world intertwines the physicality of the body with the graphic space of the page. While Forney tackles the issues of creativity and mental disability and devises a vivid, lived testimony of her passion towards her art, Leavitt repeatedly depicts her cartoonish self drawing and writing, documenting every single movement and action carried out by her ill mother. By doing so, the three of them chose the medium of comics to cover both fragmentation—their selves rendered bare in radiology tables and therapists' offices, or disintegrating in processes of mental atrophy—and assemblage—compiling each of the different aspects that inform their self-knowledge.

At some point in their stories, the three main characters are placed in a path with an unknown destination: at the end of *Stitches*, David refuses to follow the dark road to the mental asylum where his mother and grandmother wait for him, thus refusing a reenactment of the trauma that runs in his family. In *Marbles*, Ellen subscribes to Halberstam's concept of failure when she refuses to navigate the route of the happy,

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straight couple and instead gets lost in an alternate path. It is this action of deliberately taking a detour from the arboretum and getting lost, that guides Ellen to alternative forms of relief and acceptance. And the last framed panel of *Tangles* shows Sarah walking alone on a desolated path, bracing herself as she grieves the loss of her loving mother. Tellingly, these three autobiographical cartoonists situate their drawn selves in empty and solitary roads that orient them away from the futures that they are expected to follow. My task has been that of mapping these unexpected turns and connections in order to analyze crip archives—a task that, just like any other academic and archival work, can also entail a process of getting lost, taking other paths, and straying from linearity.

Although queer themes have been present in the visual and textual analysis of my selected texts, considerations about race have been absent from this dissertation. When I began my research and started studying works to compose my corpus, the vast majority of North American graphic narratives about illness and disability that I encountered were written and drawn by white authors. Still, I believe that future research should take this direction and investigate critical race issues in graphic narratives that depict disability and illness—Iasmin Omar Ata’s *Mis(h)adra* (2017) and Georgia Webber and Vivian Chong’s collaborative graphic memoir *Dancing After TEN* (2020), already mentioned in the introduction of this Thesis, are exceptional candidates to begin with this task. Scholars such as David T. Mitchell and Sharon Snyder (2003), Nirmala Erevelles (2011, 2015) or Jasbir Puar (2017), have sought to “connect critical race theory and transnational and postcolonial theory to disability studies scholarship” (Puar xx). Puar’s work, in particular, displays an understanding of disability in relation to assemblages of capacity and debility, all of them elements “of the biopolitical control of populations that foreground risk, prognosis, life chances, settler colonialism, war impairment, and capitalist exploitation” (xvii). The application of these ideas to the study of graphic narratives is opening a new and promising field.

This dissertation has been built upon an interplay with collective affinities that integrates the categories of disability and illness as well as the relationship of these experiences to the medium of comics and to archival spaces. In doing so, the analysis deployed here does not only demonstrate the dehumanizing discourses imposed on disabled bodyminds, but also attempts to inscribe disability and illness in potential, in that “otherwise” that Kafer mentions when talking about projecting new futures for disabled people that do not merely entail the threat of pathologization and elimination. It is my

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hope that this project has served to picture a glimpse of another future for disabled individuals, one that sees disability as an integral part of embodied existence.

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