The Representation of Mental Illness exhibited in selected works by Edgar Allan Poe

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1. Introduction

“I became insane, with long intervals of horrible sanity. During these fits of absolute unconsciousness, I drank – God only knows how often or how much. As a matter of course, my enemies referred the insanity to the drink, rather than the drink to the insanity.”¹ This quote, written by Edgar Allan Poe in a letter to an admirer, deals with one of the main topics in Poe’s literature: namely madness, insanity or – in today’s more politically correct terms – mental illness.

It must be noted that Poe lived in the first half of the 19th century, during a period in which psychiatric disorders had not yet been thoroughly studied and treatment of the mentally ill was inhumane and exceptionally cruel by 21st-century standards. Moreover, the way mentally disordered people were treated in past eras stands in stark contrast to our current approach. Both public and private asylums confined and restrained the “lunatics” for extended periods of time rather than actually treating their ailments. Unqualified staff in poorhouses, almshouses and asylums often caused further misery for the mentally ill. In the late 18th and early 19th centuries “the father of American psychiatry,” Dr. Benjamin Rush, pioneered a largely unexplored field. Even though his practices would be considered questionable or ethically incorrect today, Rush paved the way for a more advanced and – in the eyes of his contemporaries – revolutionary approach to care for the mentally ill. Meanwhile in France and England, Dr. Philippe Pinel and Dr. William Tuke established the “Moral Movement,” a practice that stressed kindness and focused on positive reinforcement and occupational therapy. Dorothea Lynn Dix made it her life mission to reform asylums and due to her commitment and dedication, the treatment of psychologically ill patients began to improve.

Poe, one of the most influential writers of the gothic and dark romance genre, had the skill to insinuate madness in his short stories’ characters without overtly stating that they might suffer from an actual mental illness. Despite his remarkable talent as a writer of both fiction and poetry, Poe’s literature was not fully appreciated until after his death. The author’s personal life was shaped by

¹ Online source: https://www.eapoe.org/works/letters/p4801040.htm
negative experiences and tragic losses. The death of his mother was a traumatic event for him, and he never found an appropriate way to deal with his loss. Poe also lost his beloved wife Virginia, which caused him tremendous emotional pain. He was suspected to have suffered from depression and mania – which is nowadays known as bipolar disorder – and alcohol addiction, although these assumptions were never officially confirmed. Nevertheless, Poe employed the topic of mental disturbances in his short stories as well as in some of his poetry.

Thus, this thesis aims to answer the following questions: Did Poe’s personal struggles with mental health have an influence on his literature? Which present-day diagnoses would the characters’ “abnormal” behavior fit? Are they even intended to be mentally ill, or does Poe merely insinuate and hint at behavior which may be explainable due to the circumstances the characters are in?

Firstly, the general understanding and treatment of the mentally ill as well as contemporary medical knowledge of mental illness in the 19th century will be discussed. A short biography of Poe and speculation about his own mental state will follow. A chapter on present day diagnoses (as sourced in the DSM-V) of mental illnesses exhibited in selected works by Poe (alcohol addiction, bipolar disorder, narcissistic personality disorder, claustrophobia, depression, schizophrenia and anti-social personality disorder) will conclude the first section.

In the second part of this thesis, five short stories and one poem (“The Black Cat,” “The Cask of Amontillado,” “The Fall of the House of Usher,” “The Pit and the Pendulum,” “The Tell-Tale Heart” and “The Raven”) will be analyzed – with a primary focus on the characters’ mental disorders. Each work will be discussed in a separate section with a short summary at the beginning, followed by a character analysis and an interpretation of the character’s thoughts, behavior and actions. It must be noted that one can only speculate about the characters’ possible mental disorders, as Poe himself never explicitly gave diagnoses to any of the protagonists in his stories. In addition, it has to be stressed that the diagnostic system as it exists today had not yet been established in Poe’s lifetime.
2. The understanding of mental illness in the 19th century

2.1 The revolution of psychiatric treatment in America – Dr. Benjamin Rush

Shortly before the beginning of the 19th century, physician and psychiatry expert Dr. Benjamin Rush (1746-1813) earned great fame by revolutionizing the field of psychiatry and advancing the treatment of the mentally ill. Thus, he was also called “the Father of American Psychiatry” (Deutsch 72). Rush practiced medicine at Pennsylvania Hospital and was known for his remarkable accomplishments in psychiatry. In addition, he was one of the most popular professors at Philadelphia college, “America’s first medical school” (Deutsch 73). Rush also supported and stressed the importance of higher education for women and argued in favor of free public schools for the poor.

Mental illnesses were his field of expertise, and he divided them into two separate groups: “general intellectual derangement, and partial intellectual derangement” (Deutsch 77). Diagnoses as we recognize them today did not exist at the time; however, Rush coined the term “Tristimania or the madness of sadness,” which he later substituted with “melancholia,” and which describes symptoms of what today’s psychiatrists would class as depression (Mills 8). Besides the rather vague two main categories and Rush’s “tristimania,” specific diagnoses had not been established by the start of the 19th century. Thus, patients were simply treated for their symptoms but did not receive a diagnosis.

With regard to the causes of mental illness, both Rush and his French contemporary Dr. Philippe Pinel\(^2\) argued that they were both biological and psychosocial. Especially when treating patients who would showed signs of depression – or, as Rush would have called it, “tristimania” – he noted that genetics probably had a major influence in developing symptoms of melancholic behavior, as his patients reported that their ancestors had suffered from similar symptoms (Colangelo 8).

\(^2\) More information on Dr. Pinel and his practice of “Moral Treatment” will follow in sub-section 2.3.
Dr. Rush’s preferred remedies included the practices of venesection and bloodletting. Venesection, in particular, was a popular treatment in the medical field during the 19th century. Besides venesection, which he reportedly used in excess, Rush stressed the importance of administering emetics and purgatives. His strong advocacy for bloodletting was due in part to his hypothesis that mental illness originated from a clogging or inflammation of arteries in the brain. According to him, the cause of madness was

a great morbid excitement or inflammation of the brains; that an unrestrained appetite caused the blood vessels to be overcharged with blood; and that it is important to relieve the brain before obstruction and disorganization takes place. (Deutsch quoting Rush 78)

In addition to his use of venesection, Rush invented two treatment devices intended to rid the mentally ill of their ailments. They were called the “tranquilizer” and the “gyrator” (Deutsch 79). The tranquilizer worked as follows: patients were strapped into a chair-like device with their limbs and head immobilized. This would, according to Rush, slow the patient’s heartbeat and blood pressure. Ultimately, it was used to relax the patient’s muscles and reduce their motor activity. Even though this treatment might seem torturous and cruel by today’s standards, Rush invented it “out of humane considerations” (Deutsch quoting Rush 79).

With regard to the gyrator, Rush further adapted the model of a circulating swing invented by British psychiatrist Dr. Joseph Mason Cox. Rush’s gyrator was meant to have the opposite effect of the tranquilizer: it would stimulate and instill fear as opposed to calming the patient’s body and mind. To receive a treatment on the gyrator, the patient would be strapped to a rotating

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4 Picture source: https://s-media-cache-ak0.pinimg.com/originals/a9/ab/fe/a9abfe725568112f5d7f2bf8609a2e35.gif/
board. The board would then be spun in circles at high speed, with the goal of activating the patient’s central nervous system and bringing a rush of blood to the brain.

Again, Rush invented this device with the intent to cure patients, rather than to terrorize them for no reason. Moreover, he stressed that patients needed to give their permission in order to receive treatment in the gyrator. Admittedly, during the 19th century, the ethics of medical treatment were interpreted much differently than they are today; by the standards of his time, Rush was in fact one of the most considerate and morally conscious physicians among his contemporaries (Deutsch 79-81). Interestingly, psychiatrists were actually referred to as “alienists” during that time due to the assumption that mentally disordered patients were alienated from themselves (Colangelo 8).

Although Rush worked to serve his patients’ best interests, he still believed in instilling terror and fear in mentally ill patients as long as they were willing to start treatment consensually and agreed without excessive coercion. Rush was also of the opinion that “if a patient knew that a physician could hold absolute power over a patient it would serve as some sort of role model on how to behave” (Colangelo 8). In his book The Mentally Ill in America – A History of Their Treatment From Colonial Times, Deutsch states, “[o]ne of the fundamental tenets in [Rush’s] therapy was to break the patient’s will by any means possible” (Deutsch 82). In addition, Rush treated his patients with violence and asserted that this was a normal and essential aspect of therapy.

One of his particularly extreme specialties was a practice called water therapy or “water-cure.” For this treatment, the patient was boxed into a coffin-like contraption with small holes, which was then put underwater. Rush’s intention was to wait until the air bubbles ceased and then free the patient in order to revive them. However, sometimes the

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resuscitation failed and the patient died as they had been without oxygen for too long (Deutsch 82).

Despite Rush’s seemingly cruel methods, he was an advocate for humane and kind treatment and harshly criticized the unclean conditions many mentally ill were forced to endure when treated in asylums and almshouses. Thus, his morals and attitude concerning the treatment of patients seem rather conflicting: on the one hand he supported “the use of terror as a therapeutic agent,” yet on the other hand, he was of the opinion that mentally ill people deserved to be treated with respect and should under no circumstances have to live in filth. Furthermore, he advocated professional personnel to treat the mentally ill and condemned the brutality and maltreatment many patients had to endure during their stay in mental facilities. In addition, Rush recommended “a well-qualified person as a friend and companion to the lunatics, whose business it shall be to attend to them” (Deutsch quoting Rush 85).

Rush was ahead of his time in several aspects and made revolutionary assumptions about how the human mind works. He was in favor of occupational therapy, a practice that also plays an essential role in Pinel’s “Moral Treatment.” In one of his writings, Medical Inquiries and Observations Upon the Diseases of the Mind, Rush stated:

> It has been remarked, that the maniacs of the male sex in all hospitals, who assist in cutting wood, making fires, and digging in a garden, and the females who are employed in washing, ironing, and scrubbing floors, often recover, while persons, whose rank exempts them from performing such services, languish away their lives within the walls of the hospital. (Rush 224)

Similar to a therapeutic agent that Sigmund Freud called “free association” almost a century later, Rush argued that patients should take note of their thoughts and write down everything that came to their minds. Then they should read their inner, most personal thoughts; this practice, according to Rush, would help them reclaim their sanity. Also, in regards to repressed emotions, Rush

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6 The topic of maltreatment in asylums will be elaborated in greater detail in sub-section 2.2.
was ahead of his time as he claimed that the effects of repressed thoughts have a negative influence on peoples’ mental wellbeing (Deutsch 85).

2.2 Asylums and (mal)treatment of the mentally ill

2.2.1 Workhouses, poorhouses and almshouses

In the early 19th century, poorhouses, almshouses and asylums were not yet particularly common. Generally, the state divided mentally ill people into two groups: “the dangerous and violent on the one hand, and the harmless and mild on the other” (Deutsch 116). Typically, those who were deemed dangerous and violent were locked away in public hospitals as they could not work as laborers or contribute to society. People belonging to the second category of the mentally ill, those who were not dangerously insane but often simply mentally slower than the average person, were seen as a burden for the state since they also required special treatment and needed to be cared for. They were grouped together with mentally healthy poor people and physically handicapped people and collectively received the name “paupers.” Oftentimes, they were auctioned off “to the lowest bidders, that is, to the person or persons willing to undertake their support at the lowest cost to the community” (Deutsch 117). This practice was comparable to the selling of slaves with the only difference that the paupers were not sold to the highest but the lowest bidder. Edward Field, a Rhode Island historian, commented on this system:

Practically it was offering a reward to the avarice and inhumanity of the man who would consent to neglect them more flagrantly and to inflict upon them worse abuse than any other man in town could be induced to practice. It was useless to resolve that only the bids of good men should be taken, [...] Then as now, a bad man was often a good politician…. (Deutsch quoting Field 120)

When farmers7 who had bought a pauper at auction realized that their pauper led to greater cost than benefit, they often passed them on to another farmer. This process sometimes repeated itself, causing the paupers tremendous physical as well as mental stress. In extreme cases, if deemed entirely useless, 

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7 These auctions exclusively took place in rural areas which is why the majority of bidders were farmers who used paupers as cheap laborers (Deutsch 118).
farmers tended to dispose of their paupers by taking them in the middle of the night and “dumping” them in another town. This practice happened almost exclusively to mentally ill paupers. Their previous owners hoped the pauper would be too mentally deranged and disturbed to tell townspeople who dumped them there and it would not be possible to find out who their original owner was (Deutsch 124).

Since the population began to rise drastically during that time, the state had to deal with more and more mentally ill people; this meant that poorhouses, workhouses and almshouses became a matter of greater demand in the 1820s. They were the precursors to asylums, and patients often experienced horribly cruel treatment. The conditions in which these patients had to live were exceptionally crude. Recalling a visit to one of these workhouses, Dr. William Perfect reported that he saw a man “secured to the floor by means of a staple and an iron ring, which was fastened to a pair of fetters about his legs, and he was handcuffed” (Colangelo quoting Dr. Perfect 5). Besides the restraining of mentally ill patients, their living space was also dirty, covered in filth and sometimes even feces. As mentioned earlier, the mentally ill were not the only people classed as “paupers”: prostitutes, criminals and the dependent physically ill also belonged to that category. Thus, inhabitants of almshouses were a mix of unfortunate souls who were usually sent off to those institutions due to the shame their families felt for being associated with the socially stigmatized (Colangelo 5). Another reason for the rise in the demand of institutionalization was taxpayers’ dissatisfaction with seeing an increasing number of societal outcasts – whether poor, mentally ill or criminal – on the streets (Deutsch 128-129).

The fact that the inhabitants of almshouses were such a mix of different people – both sane and mentally ill, physically healthy and disabled – caused substantial internal conflicts. Additionally, people from all social classes and levels of education lived together in these institutions. The staff were often incompetent and overwhelmed with the task of keeping all paupers under control. Thus, the early poorhouses did not work effectively and were doomed to fail (Deutsch 129).
2.2.2 The rise of asylums

Before the 19th century, state hospitals were few and far between. The first and most infamous psychiatric hospital in the world was Bethlem in London, which later received the telling name “Bedlam.” At first it housed both physically ill people and the insane, but during the 16th century it began to be used exclusively for psychiatric cases. This asylum was founded in the 13th century and housed mentally ill patients until 1948 (Shorter 5). Bedlam was notorious for its bad conditions and many horrible incidents were witnessed and reported by former staff and other insiders. Treatment must have been slightly better for private patients; however, all in all, the name of this institution still, to this day, “resonates as a synonym for chaotic madness” (Shorter 5). By the 18th century there were seven other asylums in England, but the great majority of mentally ill people were treated in private asylums later also known as “private nervous clinics” (Shorter 5).

One famous case concerning maltreatment of insane patients in Bedlam was former American seaman William Norris. He was admitted to Bedlam in 1800 and due to his aggressive behavior towards the staff, he was secured in an iron harness in 1804. A visitor named Edward Wakefield came to Bedlam ten years later and saw Norris still secured in the exact same way and spot. Wakefield recalled:

A stout iron ring was riveted round his neck, from which a short chain passed through a ring made to slide upwards and downwards on an upright massive iron bar, more than six feet high, inserted into the wall. Round his body a strong iron bar about 12 inches wide was riveted; on each side of the bar was a ring; which was fashioned to and enclosed each of his arms, pinioned them close to his sides. (Mellby)

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8 Picture source: https://upload.wikimedia.org/wikipedia/commons/0/07/William_Norris_confined_in_Bethlem_Hospital_for_12_years._Wellcome_L0010941.jpg
In America, Pennsylvania Hospital at Philadelphia was built in 1751. In 1769, the first actual asylum – meaning that it was a place exclusively reserved for mentally ill patients – was erected in Williamsburg, Virginia. This asylum had a telling name: “the Lunatic Hospital” (Deutsch 230). As mentioned earlier, due to the rise in population, the number of mentally ill continued to increased.

State hospitals and asylums were urgently needed and in 1833 the Worcester State Hospital 11 “marked the beginning of an extensive asylum-building throughout the country” (Deutsch 230). Interestingly, the general belief was that 90% of all mentally ill patients could be cured from their disorders – which was, of course, an unrealistic assumption. Due to this estimate, it was expected that every state would only need one institution in order to treat all mentally ill patients. However, authorities soon noted that the asylums were becoming overcrowded as a result of the “never-ending flow of patients” (Deutsch 231). They lacked both the space and the adequately educated personnel to accommodate the ever-increasing amount of patients. Facing overcrowding, those responsible for the asylums’ organization needed to carefully select patients in order to keep the number of inhabitants under control. Consequently, staff began to favor patients in acute mental stress as well as dangerous cases, and generally denied care for incurable, chronic cases. Patients presumed to be incurable were sent to poorhouses, state prisons or simply home to the care of their families. This morally questionable custom soon became an “unwritten law” (Deutsch 231). A side effect of the higher demand of asylums was that workhouses and almshouses fell from favor: families of mentally ill patients had a better feeling about putting them in asylums as opposed to almshouses (Colangelo 10).

The increase of patients was due in part to the rise in general population, but the number of people with mental illness grew disproportionally. It is unclear whether it was simply a matter of better accuracy in recognizing mental illness.

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10 This was the place where Dr. Benjamin Rush began his 30 yearlong career as a psychiatrist.
11 An image of the Worcester State Hospital, Massachusetts is shown to the left.
or if “this apparent acceleration in the rate of insanity is attributable to the actual spread of mental illness” (Deutsch 232).

As the situation in state asylums became progressively unbearable, the secretary of the New York Medical Society, Dr. Sylvester Willard, made it his mission to reform the system of mental institutions. He demanded the erecting of separate asylums for chronic cases as they were regularly denied psychiatric care in state hospitals. Thus, in 1865, the “Willard Act” was passed stating that an asylum should be built for the chronic mentally ill. Besides Willard’s personal dissatisfaction with the failing asylum system, another factor in the establishment of the “Willard Act” was the public uproar after details concerning the inhumane treatment of patients in asylums became common knowledge. Additionally, families and relatives of the mentally ill were not satisfied with having to care for them at home due to the lack of space in state hospitals (Deutsch 236-237).

The “Willard Act” also started discussions about the classification of mentally ill people as they now were also segregated into severe, acute cases and chronic cases. Soon critical voices who opposed to this newly created division emerged, arguing that this spatial separation caused discrimination and stigmatization. Dr. John B. Gray was among those who were radically opposed to the idea of separating treatment. He asserted that it was not possible to be absolutely certain whether a patient was truly incurable and that the division into two different institutions would cause lasting, negative consequences for patients and their relatives by extinguishing any hope for an eventual cure. Furthermore, he argued that all mentally ill people should be treated equally and were deserving of therapy, regardless of whether they were acute or chronic cases. Gray also stated that institutions for the chronically ill were designed in a way that prevented patients from possibly being cured. Interestingly enough, he was

12 “The difference between a hospital and an asylum might be stated thus: the former is an institution primarily for curative treatment, while the latter is primarily a place of custody. It must be remembered, however, that the terms have been used interchangeably and indiscriminately: asylums have been called hospitals, and vice versa” (Deutsch 233).

13 A patient was considered chronically insane if they had been mentally ill for more than 12 months or one year (Deutsch 237).

14 He was also a professional in the field of psychiatry – “superintendent of the Utica State Asylum of New York, and editor-in-chief of the American Journal of Insanity” (Deutsch 238).
also concerned about the lack of safety those institutions provided: he feared that personnel would treat patients unkindly or abuse them due to the fact that they were labeled as incurable. Admittedly, one could assume the possibility of unprofessional personnel as well as less than ideal living spaces because these institutions were meant to be financially cheaper alternatives to state hospitals (Deutsch 236-239).

Willard’s main intention was to provide treatment for all mentally ill individuals, regardless of whether they were acute or chronic cases – the kind of care and therapy previously unavailable to chronic patients due to overcrowded asylums. In addition, this would mean that the chronically mentally ill would no longer have to suffer from the horrendous conditions to which they were subjected in workhouses and poorhouses (Deutsch 236-238).

Besides the founding of institutions meant solely for the chronically insane, another topic that caused heated discussions in the field of psychiatry in the early 19th century was the restraint of mentally ill patients. This practice had the reputation of being horribly cruel and ethically and morally incorrect. Previously, in the 18th century, patients were sometimes secured with fetters or chains, leading to both physical and mental trauma. Over time, the manner in which patients were restrained had evolved to become more humane; however, some psychiatric experts were dissatisfied with the entire practice of restraining. This also led to public discussions on the usefulness of restraining and whether or not it should be abolished as a whole.

A tragic incident in 1829 sparked even more public uproar when a patient at Lincoln Asylum, England died as result of “being strapped in bed in a straight-jacket during the night” (Deutsch 214). Due to the patient's death, this institution determined that whenever patients were put in straight-jackets at night, one of their carers should stay with the patient and observe them. Moreover, as mechanical restraints were used more sparingly by this time, it became
apparent that the majority of patients would not even necessarily need to be restrained during the night (Deutsch 214).\textsuperscript{15}

One of the most influential professionals opposed to the restraining of psychiatric cases was Dr. John Conolly (1794-1867), who documented his ideas in \textit{The Treatment of the Insane Without Mechanical Restraints} in 1856. Conolly informed officials of his accomplishments in an annual report:

\begin{quote}
No form of straight-waistcoat, no hand-straps, no leg-locks, nor any contrivance confining the trunk or limbs, or any of the muscles, is now in use. The coercion chairs about forty in number, have been altogether removed from the wards. (Deutsch quoting Conolly 215)
\end{quote}

Nevertheless, the rise of the non-restraining practice caused difficulties professionals at psychiatric institutions neither expected nor knew how to manage. The manner in which professionals had to approach upset patients would need to change as they were not protected anymore and could face possible harm if patients attacked them. This proved to be difficult as it required a great amount of knowledge regarding patient treatment and could test professionals’ patients. Often, personnel were challenged physically, and in the absence of mechanical restraints, they needed to control patients by using their hands.\textsuperscript{16}

Thus, some psychiatrists began to doubt the usefulness of the non-restraining practice, with Dr. Isaac Ray being the most vocal about it. Ray asserted that the negative aspects and consequences of the non-restraining practice outweighed any positive ones, concluding that this way of patient treatment should be dismissed as a whole. Additionally, he claimed that the discipline in state hospitals was suffering due to the non-restraining practice and some sort of restraining techniques would always be necessary, at least when dealing with extreme cases. Ray also argued that some asylums that had attempted to

\textsuperscript{15} At Lincoln Asylum, mechanical restraints were banned entirely, “under the direction of Dr. Charlesworth and Mr. Gardiner Hill” in 1837 (Deutsch 214).

\textsuperscript{16} This was later proposed as one of Ray’s counterexamples; he stated that “manual restraint” was just as invasive as mechanical restraints (Deutsch 216).
adopt the non-restraining practice had failed horribly and reverted back to restraining their patients. Another disadvantage, according to Ray, was the financial strain on hospitals due to the increase in staff needed in order to deal with non-restrained patients (Deutsch 216-217).

Interestingly, even opponents of the restraining practice applied mechanical restraints in rare cases. Conolly – probably the most prominent advocate of non-restraining treatment – resorted to the use of mechanical restraints “in exceptional instances, such as in surgical operations” (Deutsch 218).

All in all, heated discussions regarding the preference of restraining or non-restraining treatment continued over the next decade. However, the rise of “Moral Treatment” in Europe completely objected to all kinds of restraining methods – whether manual or mechanical – and adopted an entirely new approach concerning the optimal treatment of psychiatric patients.

2.3 Moral Treatment – Dr. Philippe Pinel and Dr. William Duke

In contrast to their American contemporaries who still disagreed on the usefulness of restraining practices, Frenchman Dr. Philippe Pinel and Englishman Dr. William Tuke proposed the revolutionary idea of a therapeutic approach they referred to as “Moral Treatment.”

The basic point of view concerning moral treatment is the firm belief that in order to aid their cure, mentally ill people should not be treated like animals. Pinel was of the opinion that “the mentally ill were simply ordinary human beings who had been deprived of their reason by severe personal problems” (Colbert 5). Also, he stated that insane people deserve to be treated with respect and kindness, and that inhumane practices such as restraining techniques or mental torture17 should not be applied.

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17 This approach goes against the way in which Rush had treated his patients at Pennsylvania Hospital. As described in section 2.1., even though he also claimed to treat his patients with respect, Rush argued that instilling fear and terror in them would aid their cure. Additionally, he was in favor of restraining his patients.
Pinel viewed the insane as people whose internal, rational discipline had broken down and believed that “[t]heir moral and psychological faculties needed to be rekindled, so that external coercion could be supplanted by inner self-control” (Porter 105). Pinel had great success with his therapeutic approach of listening to his patients’ problems and talking to them in a non-condescending manner.

His English contemporary, Dr. William Tuke, had a more religious approach: he claimed that prayer, relaxation and quiet conversation would be the key to recovery of mental illness. However, Tuke was not a religious fanatic and besides spiritual activities, he – just as Pinel – stressed the importance of treating his patients in a humane way. Additionally, the English psychiatrist claimed that “walks through the countryside,” occupational therapy such as gardening and sufficient rest were essential tools in increasing the chance of cure (Colbert 5). He founded a mental institution called “York Retreat” where he attended to his patients according to the principles of moral treatment (Peloquin 40).

However, the term “moral” did not necessarily carry the same meaning as it does today. According to Bockoven, 19th-century psychiatrists used the word “moral” to express the terms “psychological” or “emotional” (Peloquin quoting Bockoven 40). Moral treatment was mainly concerned with focusing on the patient as a “moral human being capable of change” (Colbert 5). A comfortable and calm environment\textsuperscript{18} was seen as the optimal setting to treat mentally ill people. Also, the elimination of both physical and psychological cruelty was an important rule of the moral treatment. Essentially, patients were seen as human beings who deserved respect and caring attention. Thus, “[t]hrough moral treatment, the physician manipulated both the environment and the patient to help the patient overcome past associations and to create an atmosphere in which natural restorative elements could assert themselves” (Peloquin 40).

\textsuperscript{18} This stands in stark contrast to the reality many patients faced in asylums of the early 19th century. Oftentimes, the mentally ill had to live in filth and dirt, chained and restrained – a fate patients of moral treatment would not have to experience.
According to records from the 19th century, moral treatment was highly successful with regard to the recovery rate of patients. In both America and Europe, over 70% of hospitalized patients being treated with the moral approach were cured of their mental disorder and “another 5% - 8% improved” (Colbert 6).

One of the factors that led to the popularity of moral treatment was that over the course of the 19th century, people came to the realization that the mentally ill were indeed capable of reason. Prior to this awareness, they “had been considered subhuman because they were believed to be devoid of reason” (Peloquin quoting Deutsch 40). Thus, the fact that professionals started to have a better and more realistic picture of the mentally ill was necessary in order to change the way in which they treated them therapeutically.

However, moral treatment faced resistance, especially from the field of medicine. As psychiatry had previously been seen as a part of the medical field due to the belief that mental illness was caused by brain abnormalities, the new hypothesis of environmental circumstances being the cause of mental illness threatened traditional thinking (Colbert 8). Physicians were dissatisfied with the new approach as it rendered them redundant: the cure of mental illness was no longer realized by medical means (Colbert 8). Still, in the mid-19th century, most public asylums were under the control of physicians.

The theory of Moral Treatment, in which patients were seen not as biologically ill but simply as victims of their damaging environments, began to be challenged again around 1850. Now doctors tried to convince the public that mental diseases were in fact caused by physical abnormalities. The treatment of asylum inmates began to become increasingly medical once again (Colbert 8-9).

19 The term “psychiatry” was coined in 1808, by German physician Johann Christian Reil (Reil: 169).
20 Dr. Benjamin Rush, who has been dealt with extensively in sub-section 2.1, was of the opinion that clogged and inflamed arteries of the brain were the cause of mental illness.
21 In the very early 19th century, before the rise of Moral Treatment, Rush had already stressed that mental illness was caused by abnormalities in the brain and was thus biological.
2.4 Reforming the asylum system – Dorothea Lynn Dix

Dorothea Lynn Dix (1802-1887) was best known for her dedication to reforming the asylum system in the second half of the 19th century.

Dix was born in Maine, however her family moved to Worcester, Massachusetts when she was a young child. Her father was known to be a religious fanatic and an alcoholic, and Dix had few privileges and little freedom as she grew up (Deutsch 158). It was rumored that she did not attend school regularly (Parry 624). Due to the distressing situation at home, Dix, at the age of twelve, moved to Boston to live with her grandmother. However, her decision did not prove fruitful, as her grandmother did not treat her with the love and kindness the child desperately sought (Deutsch 158-160).

After two years, Dix moved back to Worchester and founded a school for young children. Her strict upbringing had a strong influence on her personality, and she was independent and strong-willed from an early age. Even in the 19th century, when teenagers began to work at a young age, it was unusual for a fourteen-year-old girl to be already a school teacher. Some of her students later recalled Dix as an assertive teacher and authoritative figure whom they respected a great, despite her young age (Deutsch 160-161). Dix was even known for scaring her students with her assertive demeanor; due to that fact, they dropped out “[o]ne by one, [so that] this first venture ended in dismal failure” (Deutsch 161).

Despite failing in her first try as a teacher, Dix published several books on teaching and education. The undertone of some of her books was the firm belief that women should have equal opportunity and access to education. At that time, women were at a massive disadvantage with regard to establishing a career, and discussions of gender equality were rare (Parry 624).

Nevertheless, Dorothea did not let this setback discourage her from her passion for education. She returned to Boston to live with her grandmother again, and several years later, opened another school. This time, Dix quickly became
known to offer excellent education. Still, the pressure soon proved to be too much for her and she “suffered a severe physical breakdown” (Deutsch 162). After several months off, Dix decided to step back and only teach as a hobby.

At the age of 40, Dix witnessed, due to a coincidence that led her to East Cambridge jail, the horrendous conditions the inmates had to suffer there. This made her wonder whether it was simply an unfortunate exception or if other institutions also were organized so poorly. Consequently, she wrote a letter to the state government in order to uncover the terrible event she had witnessed:

I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane and idiotic men and women…of beings wretched in our prisons, and more wretched in our Almshouses. I proceed, Gentlemen, briefly to call your attention to the state of Insane Persons confined within the Commonwealth, in cages, closets, cellars, stalls, pens: Chained, naked, beaten with rods, and lashed into obedience. (Hamilton 452)

The letter continued with a list of the inmates’ names and a brief description\(^\text{22}\) of the state Dix found them in. Furthermore, Dix tried to contact with some of the patients to ask them why they were, for example, in solitary confinement without any daylight. In her opinion, it was a shame that so many “harmless and insane persons” were locked away when they could instead contribute to the community. One example of the shocking maltreatment Dix witnessed was the case of a young woman who had to sleep naked on a bed of straw in a barn-like room. She was exposed to sexual abuse by passersby, who had permission to visit her whenever they wanted to. (Deutsch 166-167).

Although it may seem as if these incidents occurred due to evil guards and superintendents who took pleasure in the inmates’ misery, this was not the case. Instead, ignorance regarding treatment methods and the way mentally ill people

\(^{22}\) E.g.: “Lincoln. A woman caged. Medford. One idiotic subject chained, and one in a close stall for 17 years. Savoy. One man caged” (Dix quoted in Deutsch 166).
were viewed was to blame for this abusive environment. As much as the Moral Treatment approach was on the rise in Europe, attitudes and practices still differed greatly in the United States. In the first half of the 19th century, mentally ill people were seen as beasts who neither needed nor deserved kind treatment. It was a common assumption that “lunatics” would not suffer when living in cold and filthy environments as their bodies were not able to feel the sensation of cold and heat (Deutsch 167). Thus, the ill were often “chained in […] little shacks often poorly fed, left to the heat and cold of the elements for years and sometimes until they died” (Colangelo 5).

Since this inhumane treatment was due to lack of knowledge concerning adequate therapy, in addition to inappropriate living environments, Dix concluded that the solution would be to accommodate the mentally ill in state hospitals.23 Dix was relentless in her pursuit to reform the failing system and wrote elaborate letters to the state legislature, describing the horrible state of almshouses and prisons. This raised the public’s interest concerning the topic of maltreatment of the mentally ill, which Dix had intended (Deutsch 167-169).

Besides the abuse patients suffered, another reason why Dix believed they should stay in state hospitals rather than prisons and poorhouses was the fact that they needed to be separated from criminals and prostitutes in order to receive proper treatment24 (Colangelo 5). Furthermore, removing patients from prisons would help end the stigma of equating “mentally ill” with “criminal.”

Since Dix was a supporter of the Moral Treatment, she was of the opinion that mentally ill patients should be treated with kindness and respect in order to increase their chances of being cured. She also traveled to England and inspected Dr. William Tuke’s “York Retreat.” During her travels in Europe, Dix

23 Even though state hospitals and asylums were at times used interchangeably, Dix criticized the manner in which prisons, poorhouses and almshouses were organized. These also housed the mentally ill but – as opposed to state hospitals – oftentimes did not receive financial support from the government.
24 Years later, Dix’s intent to keep the mentally ill separate from criminals and prostitutes failed, despite the foundation of mental hospitals. As word had spread that living conditions in state hospitals were much better than in almshouses, the number of admissions increased significantly. Soon, mental hospitals were just as overcrowded as early asylums had been (Colangelo 31).
observed the effectiveness of this approach to treatment; she took that knowledge back to North America.

As a means to raise money for her projects, Dix approached wealthy and influential individuals – a plan which often did not aid her popularity. Her opponents attacked her verbally and did everything they could in order to prevent her success. Against all odds, she realized her project step by step; Dix made it her mission to fight for the mentally ill and despite her poor physical health, she found the energy to continue her plan (Deutsch 169-171).

After the establishment of mental hospitals in Massachusetts and Rhode Island, Dix addressed the issue in New Jersey, where she faced even stronger resistance. Here, tax-payers and the legislation had “blocked all efforts to establish a state asylum for the insane, despite the urgent need for one” (Deutsch 171). Following a long and bitter fight to pass her bill, Dix’s demand of founding a mental hospital in New Jersey was granted. Her success was due in part to the extensive knowledge she had acquired regarding psychiatric care and medical practices. Furthermore, each of her proposals included practical suggestions and ideas on, for example, “the selection of proper sites, the most suitable institutions, etc.” (Deutsch 172). The submission of these memoranda was her only way to advance her cause as women could not vote, “could not hold office, and did not present such testimonials themselves before the legislature – a male representative had to read the text aloud” (Parry 625).

Dix’s health had been an issue throughout her adult life and, after years of campaigning, she began to feel the effects. In a letter to a friend she explained the extent of her travels: “I have traveled more than ten thousand miles in the last three years, […] visited eighteen penitentiaries, three hundred country jails, more than five hundred almshouses, and other institutions, besides hospitals and houses of refuge.” (Deutsch quoting Dix 173).

When the Civil War started, Dix became a superintendent nurse of the Union Army and continued to care for the injured and ill. Even though she was familiar

25 Her physical ailments included general fatigue and a reoccurring cough (Parry 624).
with giving commands and presenting an authoritative figure, this occupation did not make her happy. Her male colleagues were at times displeased with Dix’s strong will and her air of superiority, and her dominant and argumentative personality was not appreciated. She was known to choose nurses based on their moral background instead of their medical skills (Deutsch 182).

According to Dix’s biographer David Gollaher, Dix also suffered from mild mental issues herself. Due to her stressful projects, she allegedly developed depression and experienced a mental breakdown. Her personal experience with physical and mental struggles may have made her more compassionate toward the mentally ill and more committed to saving the failing asylum system (Parry 624-625).

After returning from another visit to Europe, at nearly 80 years of age, Dix retired from active work and spent the last six years of her life in Trenton State Hospital, New Jersey – an institution which had been founded in 1848 due to her effort. One of Dix’s closest friends, Dr. H. Nichols, shared the following sentiment at her burial: “Thus has died and laid to rest, in the most quiet, unostentatious way, the most useful and distinguished woman America has yet produced” (Deutsch 185).

All in all, Dix “played an instrumental role in the founding or expansion of more than 30 hospitals for the treatment of the mentally ill” in the United States and Canada (Parry 624). She also popularized the idea of Moral Treatment in North America. Thus, she is known as a leading figure on both a national and an international level and due to her work, the understanding and treatment of mentally ill people changed enormously.

26 An image of Trenton State Hospital, New Jersey is shown to the left
Picture source: http://www.asylumprojects.org/images/9/9b/Trenton_State_Hospital_NH001.jpg/
Psychiatrist and neurologist Jean Martin Charcot (1825-1893) revolutionized both the understanding and treatment of mental illness in the late 19th century. His work influenced Sigmund Freud, and Charcot served as Freud’s role model regarding the treatment of hysteria and hypnosis (Porter 136). According to Charcot, hysteria “was marked by definite, law-governed, predictable, clinical manifestations” and it was not a medical mystery without a point of reference (Porter 139).

Charcot worked as a professor at the “Hôpital de la Salpêtrière” and soon had a reputation of being its most competent teacher. His primary passion was neurology, “hence his soubriquet, the Napoleon of the neuroses” (Porter 137). In order to find the optimal treatment for epileptics or people suffering from general paralysis, he closely studied their physical symptoms as in his opinion, the origin of these illnesses must lie in some defective area of the body. According to Charcot, “These diseases [...] do not form, in pathology, a class apart, governed by other physiological laws than the common ones” (Porter 137-138). Another of Charcot’s projects was further developing “James Parkinson’s early work on the ‘shaking palsy’” (Porter 139). It was due to Charcot’s continuation of Parkinson’s work that the illness received the name “Parkinson’s disease.”

In his later years, Charcot began using hypnosis as a diagnostic device to expose hysteria. He believed that only people suffering from hysteria could be hypnotized. However, he received harsh critique regarding this assumption. Critics claimed that the behavior of his young female subjects was merely a product of their psychiatric environment. They argued that the young women were “artefacts produced within the supercharged theatrical atmosphere of the Salpêtrière” (Porter 188). Thus, it was stated that the pathological behavior of Charcot’s hysterics was actually a performance resulting from the suggestive influence of a psychiatric professional.

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27 A famous mental clinic in Paris which housed the mentally ill as well as people suffering from neurological disorders such as epilepsy (Porter 136).
As opposed to his predecessors such as Rush, Pinel or Tuke, Charcot concentrated on sufferers of neurosis, anxiety and obsessive compulsions and “virtually ignored the major mental illnesses such as schizophrenia and paranoia” (Colangelo 12). It has been suggested that this focus was due in part to Charcot’s belief that these illnesses were more common and thus would be more lucrative to treat than rarer conditions such as schizophrenia or paranoia. Perhaps due to his assumption, which cannot be proved in any way, a historian described him as “quite lacking in common sense and grandiousity [sic] sure of his judgment, it harbors it harbors the potential for calamity” (Colangelo quoting anonymous historian 12).
3. The life of Edgar Allan Poe

3.1 Biography

3.1.1 Parents and childhood

Edgar Allan Poe (1809-1849) was born in Boston, Massachusetts to Eliza and David Poe. Edgar was their second child; his brother Henry had been born in 1807.

Born in England, Eliza immigrated to the USA when she was a child. She had been a successful actress since the age of nine, and her second husband David Poe worked in the same business. Critics praised her, with one newspaper claiming, “She has supported and maintained a course of characters more numerous and arduous than can be paralleled on our boards during any season” (Silverman 5).

David Poe, however, suffered from terrible stage fright and faced harsh critique for his acting. He was accused of mumbling incomprehensibly and had trouble pronouncing certain words. Poe’s biographer Kenneth Silverman states, “David found himself caricatured in the press […] and was renamed ‘Dan Dilly’ for thus misspeaking on stage the name Dandoli” (7). Furthermore, there were rumors that he had a drinking problem, which allegedly caused him to be short-tempered,—attacking the critics verbally. Aside from his stage fright, he appeared to be a confident and strong-minded man.

The couple had moved around for a short period of time but settled down in Boston, where they stayed for three years. After Edgar’s birth, David struggled to feed his family of four. They decided to move to New York to find work at another theater company, were David quickly developed a reputation for being a drunk. After only a few weeks in New York, David quit his job at the company and left his family. He was never heard from again.

28 Most of the content in this section is taken from Edgar A. Poe – Mournful and Never-ending Remembrance by Kenneth Silverman. The sources will be indicated in a footnote at the end of each sub-chapter.
A few months after David's disappearance, Eliza gave birth to her third child, Rosalie. Shortly after her daughter’s birth, Eliza began experiencing frequent illness and had serious issues with her health. She was rumored to have had infectious fever, among other ailments. Thus, she had to stop acting and her health continued to decline rapidly. Eliza died when Edgar was three years old. She left three children between the age of one and five who needed to be cared for. Rosalie was taken in by a Richmond family and Henry moved in with David’s parents in Baltimore. This left Edgar in need of new guardians.

The Allan family, from Richmond, Virginia took Edgar in, although they never formally adopted him. At first, John Allan was not fond of the idea of housing an orphan child, but, not being able to resist his wife’s pressing, he finally agreed to welcome Edgar into their family. Frances Allan shared many similarities with Edgar’s biological mother, Eliza. Both women were quite petite and frail, and both had issues with their health despite their young age.

John Allan was a tobacco merchant and, together with his business partner Charles Ellis, owned the successful “House of Ellis and Allan” company. The Allan family was financially well off, so during the first few years of living with them, Edgar was fortunate and well taken care of in terms of material things. John Allan wrote letters to David’s family frequently, telling them about Edgar’s current state and repeating how well the boy was provided for.

When Edgar was at the age to begin his schooling, the Allans decided to move to London; the House of Ellis and Allan was an internationally successful chain business. Frances Allan was strongly opposed to her husband’s idea, and long after they arrived in England, she continued to miss her Richmond friends and life at home. In addition, she was, just as Eliza Poe had been, frequently ill and probably “cannot often have been available to Edgar in London either” (Silverman 19). Edgar attended several boarding schools and later recalled his first years of education to have been lonely and unhappy.

Meanwhile, John Allan’s dream of having a successful international business was crushed. The House of Ellis and Allan collapsed and left Allan and Ellis with
an incredibly large amount of debt. As a result, the family returned back to Richmond; John Allan’s creditors granted him “a year to settle his debts” (Silverman 22).²⁹

3.1.2 Adolescence

Due to financial issues and having to manage the large debts, the Allan family was forced to move multiple times. Edgar enrolled in school in Richmond and according to his classmates, he had a great talent for languages, wrote poetry and was quite a competitive young man. Additionally, he was a good swimmer and overall a talented athlete. However, he felt like an outcast and had a strong sense of not belonging. He was neither a Poe nor an Allan, but very much torn in his identity. In addition, he lacked a strong mother figure as Frances Allan continued to suffer constantly from various illnesses. John Allan and Edgar’s relationship began to decline as well since Edgar’s unstable mood gave John the impression that the boy was simply ungrateful and did not appreciate everything that had been given to him. Originally an immigrant from Scotland, John Allan had had a hard upbringing without all the comfort he provided for Edgar. He wanted to raise Edgar in a manner that taught him responsibility and self-reliance.

Shortly before leaving Richmond for college, Edgar met a girl named Elmira Royster. Both of them were quite fond of each other and Elmira later recalled that Edgar made the impression of a quiet young man. She stated that he was “not very talkative, although pleasant when he did talk” (Silverman 30). When Edgar set off to start his studies at the University of Virginia, the difficulties with his adoptive father were not over. Even though Edgar was very fond of his new endeavors and enjoyed the challenge of his classes, he still felt like an outcast since he was one of the youngest students and quite sensitive. Many of his fellow students were rather aggressive and there was a lot of violence on campus. The University of Virginia had been designed to be a more relaxed institution compared to the strict environment in Harvard. Its founder, Thomas Jefferson, “established a system of minimal rules and maximum self-governance, hoping students would monitor one another’s behavior for the good

²⁹ Source of section 3.1.1. (Silverman 1-22)
of all” (Silverman 31). Unfortunately, this idea failed; it even led to riots and physical abuse of professors. During this time, Edgar wrote letters to John Allan, describing the dangerous situation on campus and confessing how uncomfortable and uneasy the violent environment made him.

Furthermore, Edgar struggled greatly with financial issues and asked John Allan to send him more money in order to pay for academic expenses. Despite the fact that Allan wanted to support Edgar in his studies, he was stingy with money. Edgar’s adoptive father only provided him with enough money to cover tuition costs, but Edgar also needed to pay for rent, furniture and books. Thus, his debts began to accrue as soon as he began at school. In contrast to other students, who were from wealthy backgrounds, Edgar did not make the impression of a well-off gentleman, and according to his recollections he was “immediately regarded in the light of a beggar” (Silverman 33). Edgar was also said to have had a gambling problem and he spent money on unnecessary non-academic items.

Consequently, Edgar returned to Richmond in debt after his first year at school. Initially, he wanted to continue his studies, but John Allan denied him further financial support. In addition, his former love interest Elmira Royster was in a relationship with another man, which left Edgar devastated. Meanwhile, Edgar’s resentment toward John deepened, as his adoptive father did not approve of his interest in literature. Instead, John wanted his son to pursue a career in the social field or support him with a business of his own.

When creditors contacted the Allan family and demanded the money Edgar owed them, John refused to pay his adoptive son’s debts. Due to the constant fighting between the two, Edgar decided to move out, despite not knowing where to stay and not having the financial resources to pay for any expenses.

It did not take long until Edgar began to write letters to John Allan again, begging for money and dramatizing his situation in order to make his adoptive father pity him. Edgar grew more and more desperate, and soon he resorted to emotionally blackmailing John and accusing him of not truly loving his son. One
passage of a letter read, “I have heard you say (when you little thought I was listening and therefore must have said it earnest) that you had no affection for me…” (Silverman 35). His behavior was a cunning attempt of regaining John’s support, although Edgar’s words may also suggest that he was actually hurt and felt unloved.

Since John stopped replying to the letters and ignored any requests for money, Edgar decided to move back to Boston – the city of his birth. There he worked in a small newspaper office and his love for literature continued to grow. Edgar began to write poetry again, a hobby that he had since his early days of schooling. Byron was one poet who inspired Edgar greatly and fueled his wish to make writing his future career. While in Boston, he published his first poem, *Tamerlane*, anonymously.

Due to his financial issues, Edgar decided to enlist in the army. Little is known about the two years he spent in the army, but Edgar was said to have enjoyed the discipline greatly. He relished the structured environment and always made an effort to please his superiors. Initially, he enrolled for five years of service; however, after two years he felt ready for a change. He tried to convince his lieutenant to discharge him, but was only granted his wish under the condition of reconciling with John Allan. Thus, Edgar resumed writing letters to his adoptive father and explained his situation but again he never received a reply. Desperately waiting for his adoptive father’s approval to leave the army, Edgar wrote dramatically:

> I have thrown myself on the world, like the Norman conqueror on the shores of Britain & by my avowed assurance of victory, have destroyed the fleet which could alone cover my retreat – I must either conquer or die – succeed or be disgraced. (Silverman 44)

All his efforts were in vain, so he tried a different approach: he told his father he wanted to enroll in the United States Military Academy at West Point. At that time, John Allan’s wife was seriously ill again and Edgar wanted to see her one last time before she died. Unfortunately, the traveling took more time than expected, and he arrived one day after she was buried. John Allan’s personality
changed after his wife's death and he became kinder and more compassionate. This explains why he and Edgar finally made peace – at least for a little while.

The application to West Point took Edgar longer than expected as there was a long waiting list; as a result, John Allan became impatient. He accused Edgar of procrastinating and not taking his future seriously. The fights about money started again and Edgar once more had the impression that John did not truly love and accept him. As a result, Edgar set off to Baltimore again, where his passion for literature and poetry encouraged him to publish his writing. However, finding a publisher proved to be difficult and he had to approach different newspaper agents and publishers numerous times.

After one year of waiting, he could finally start his studies at West Point. According to Poe, life at West Point was exhausting and the demands for both physical fitness and mental capability were high. His day was filled with drills, studying and sports from dawn until dusk. However, Edgar was an ambitious young man and similar to his days at the University of Virginia and his army service, he wanted to be the best and impress his superiors. The routine West Point offered and the iron discipline it required provided an environment in which Edgar flourished. He made the impression of an interesting and entertaining young man who was incredibly intelligent yet also dark and mysterious. Despite the strictness in the academy, Poe appreciated the companionship and the feeling of belonging – the comfort he felt he had been missing his whole life and had desperately longed for. He also continued writing poetry and received positive feedback from his fellow cadets.

However, his mood plummeted when he was informed that John Allan had remarried. Edgar was hit with feelings of jealousy and feared that “others would now receive the attention and comfort he had looked out for himself” (Silverman 63). He reacted calmly on the outside but congratulated the couple in a quite cold and distant way.

His worst fears came true when a few months later, John Allan communicated to him that he no longer wished to stay in contact. This news prompted Poe to
write another letter in which he shared at length how hurt, unloved and abandoned his adoptive father had made him feel throughout the years. He accused him of not keeping his promise in regards to financial support for a proper education and consequently blamed John for his debts as well. Edgar did not feel responsible for the fact that he started to drink and gamble; according to him, the prospect of never being able to afford even the bare necessities caused him to resort to these unhealthy coping mechanisms. Additionally, he stated, “it was my crime to have no one on Earth who cared for me, or loved me” (Silverman quoting Poe 64).

Perhaps, besides the desire to share his feelings, Poe’s honest letters were written as a means to guilt John Allan into sending him money again. Lastly, he set an ultimatum in case John would not reply – Edgar vowed to disobey orders at West Point and quit the academy. He wrote, “From the time of writing this I shall neglect my studies and duties” (Silverman quoting Poe 66).

Indeed he stuck to his word and soon accumulated numerous offenses such as neglecting his duties and refusing compliance. He was tried for his offenses and pleaded guilty with the consequence “that the cadet EA Poe be dismissed from the service of the United States” (Silverman 67).30

3.1.3 Early literary career and marriage
Poe decided to travel to New York City, but had no plans on where to live or – more importantly – how to afford his life. Not much is known about his stay in New York other than that he tried to make a living by publishing his poems. He decided to move back to Baltimore.31 He realized how much he had missed his adoptive father and tried once more to contact him by sending a letter. It seemed as if he had still not given up on their relationship and desperately craved John Allan’s attention and affection. Allan’s second wife had just given birth to their first child; however, due to the fact that Poe had not heard from him in a long time, he had not received the news. He started his letter with:

30 Source of section 3.1.2. (Silverman 23-68)
31 There he was reunited with his older brother Henry. Unfortunately, “Edgar’s cherished reunion with his brother barely lasted six months, for Henry died...” (Silverman 85).
I am sorry that it is so seldom that I hear from you or even of you [...] for all communication seems to be at an end: and when I think of the long twenty one years that I have called you father, and you have called me son, I could cry like a child to think that it should all end in this. (Silverman quoting Poe 94)

Following his typical pattern, Poe also mentioned the poverty he was struggling with and requested money but had little hope that his father would even acknowledge the letter, let alone send him money. However, he was sent money and soon went home to visit his father who was sick at that time. His death was very sudden; he was not yet 60 years old. When John Allan remarried, initially, Poe’s fear had been that his adoptive father would give him even less attention than before. A fact that truly shocked him, however, was the ascertainment that Allan did not mention him in his will. Struggling with money throughout his life, Edgar would have at least hoped that he would receive an appropriate inheritance.

Having to deal with the lack of any financial support, Poe had to accept a job as an editor for a magazine called the *Messenger*. He started working for Thomas Willis White, a printer from Richmond. Soon, Edgar realized that working in the publishing industry could in fact prove to be very useful in regards to sharing his own literature. White recognized Poe’s potential and the magazine flourished during the time Poe worked there. Edgar boasted about the fact that he had such a positive influence on the success of the *Messenger*, and for the first time in his life, he was earning a decent amount of money. Additionally, he claimed that publishing his writings was the main reason for the rise in subscriptions. Unfortunately, he soon became restless again and began drinking. Poe was also regularly plagued by various illnesses; his health in general had been quite unstable for all his life.

While working for White, Poe lived in a boardinghouse with his aunt Maria ‘Muddy’ Clemm and her young daughter Virginia. Even though he was already 27 years old at that time, he developed feelings for his 13-year-old cousin. They married in 1836. According to reports, “This was probably a second ceremony,
designed to make public in Richmond when Sissy was fourteen what had already been done in Baltimore when she was thirteen, and much too young” (Silverman 124). Poe did actually care a great deal about the fact that other people might think negatively about their enormous age difference and more so, that his wife was barely in her teens. Due to this, he generally lied about her age, stating that she was already of age. Adding to the already large age difference, Virginia looked even younger than her years, since she was a bit chubby and had quite a childlike appearance. Moreover, her behavior was also not mature and according to Poe, they did not sleep in the same bed for the first two years of their marriage and he did not “assume the position of husband” at the beginning (Silverman quoting Poe 124). This ambiguous statement may imply that they also did not have sex during that time.

Despite earning a decent amount of money when working as an editor for the *Messenger*, Poe struggled to provide for his family. He was living with Muddy and Virginia and had to financially support the three of them. The majority of his salary went towards his wife’s education, which Edgar had promised her father he would support. As he had a history of pleading for money, Poe tried to raise a large enough sum in order to make it possible for his aunt and mother-in-law to open a boardinghouse. However, the plan fell through when Edgar realized that his project would not be nearly as lucrative as he had hoped; this resulted in additional debts from the furniture he had already bought.

Constantly struggling to make a living, Poe also resorted to asking his boss, Willis White, for financial support. While White was willing to help out Poe at the beginning, their relationship worsened as Poe did not put as much effort into his work anymore. Furthermore, he demanded to have more power over decisions regarding the magazine, yet simultaneously continued to drink and neglect his job. White threatened to discharge Poe and for a while, the situation improved. After all, Poe was very much dependent on the salary and, in a way, he was ambitious to maintain the magazine’s success.

32 Virginia’s nickname
Despite White’s patience, Poe’s health declined once more, which resulted in the final break between him and White. It is not known what finally led White to discharge Poe, but he spoke quite mean-spiritedly about Poe after they had parted ways. White complained, “The truth is [...] Poe seldom or ever done [sic] what he knew was just to any book. He read few through [...] and his only object in reading even these, was to ridicule their authors…” (Silverman quoting White 129).

After a 15-month stay in New York – where he purportedly published some of his writings yet still lived in poverty – Poe moved to Philadelphia with Virginia and Muddy. He took it upon himself now to educate his wife in languages and algebra and encouraged her to sing.

Since his lack of money was dire as ever, Poe was desperate for employment, which he soon found as an editor for Billy Burton at Burton’s Gentleman’s Magazine. Being a passionate writer himself, Poe had earned himself a reputation for “uncalled-for severity in criticism” as a literary reviewer. He called other famous writers, such as Irving, overrated and lacking in talent. Poe seemed quite envious of other authors’ success; in his opinion, he himself deserved equal fame and admiration. Burton was not someone to accept unfair and rude reviews, so he confronted Poe about the matter. One the one hand, Poe was harsh and critical, but on the other hand, he assumed the role of a vulnerable victim. Burton, however, did not react positively to Poe’s pitiful behavior and told him, “I have been severely handled in the world as you can possibly have been, but my sufferings have not tinged my mind with a melancholy hue” (Silverman quoting Burton 143). Essentially, he expected Poe to pull himself together and focus on his career.

During his time at Burton’s Gentleman’s Magazine, besides writing literature reviews and editing, Poe published his work successfully. However, despite this success, he grew tired of his job and quit after about one year of employment.

He started working for Graham’s Magazine when his young wife became seriously ill for the first time. Poe was sick with worry and did everything he
could to help Virginia’s condition improve. He stayed by her bed, was overly protective towards her and attended to her every need. Remarkably, he stopped drinking during that period in his life but his mood shifted quickly nonetheless. Virginia’s illness made Poe even more melancholic and depressed than he had been before.

Virginia was suffering from tuberculosis and her health improved again, only to worsen shortly after. This cycle would continue for the rest of her short life. She was only 19 years old when her illness began and Poe would do anything to improve her state. He, for example, “recorded the cycles of recovery and relapse” (Silverman 182).

Poe himself also suffered from ill health during the course of Virginia’s illness. He resorted to self-medicating and took up drinking again, also as a means of calming his worries. The question of how heavily he drank is controversial but according to reports, “after one drink he could not stop” (Silverman 183). His binge drinking episodes had serious physical consequences as he would feel sick for days after and had to stay in bed. In extreme cases, he would drink until he passed out and later, he could not recall what had happened. Sometimes, Poe would wander off and not find his way back until someone came to his rescue and took him home. His aunt and mother-in-law Muddy later recalled that when in a drunken state, “he was not responsible for either his words, or actions” (Silverman 184). However, when drinking socially, Poe always had the excuse that he was influenced or forced to drink by his peers. Oftentimes, he would not take responsibility for his decisions and actions – a personality trait that had been present throughout his life. His ill wife worried about him as well since he would go on drinking binges and be absent for several days.

Although constantly blaming other people and his dire life circumstances for his drinking, Poe knew that it was up to him to change his behavior. Thus, he made resolutions to stay abstinent and invest all his time and energy into his literary career and the care of his wife. However, his plans never lasted long enough and he fell back into self-loathing and continued his cycle of alcohol addiction. One of his excuses was the fact that he had to deal with Virginia’s illness and serious financial problems. Despite having worked for numerous magazines
and published his writing, Poe was hardly able to afford the bare necessities for him and his family.

Virginia died, at 25 years of age, after long and reoccurring illness. Both Muddy and Poe were devastated and plagued with grief. Muddy Clemm stated that “she wished to die […] but had to live to take care of poor disconsolate Eddie” (Silverman 329). Poe also suffered from serious health struggles again after the death of his wife.33

3.3.4 Final years
After getting over his illness and having found a way to deal with the grief of his wife’s death, Poe planned to concentrate on his literary career again. Also, he was looking for a new romantic relationship and possibly a second wife. Despite his plans, he initially did not want to meet Sarah Helen Whitman.34 A mutual friend, Anne Lynch, wanted introduced them to each other, and Whitman had been already been a fan of Poe’s writing.

Eventually, he did want to pursue a relationship with Helen, and as a means to convince her of his love, he dedicated a poem to her titled “To Helen.” They started writing letters to one another and soon Poe visited her in Providence, Rhode Island. Literature was one of Helen’s biggest interests, but Poe detested her friends and the writers she admired, such as Margaret Fuller. Despite their different preference in literature, Poe proposed to her after only one day of staying with her. Helen, however, was reluctant to agree due to his unstable mental health and alcohol addiction. After his departure, Helen elaborated on other reasons for her objections in further letters; one major aspect was that she had heard quite negative rumors concerning Poe’s personality. Her friends told her that he had “great intellectual power, but no principle – no moral sense” (Silverman 366). This statement left Poe hurt and resentful.

33 Source of section 3.3.3. (Silverman 85-185, 326-329)
34 She went by ‘Helen’
When he went to visit her again, Poe made an unsuccessful suicide attempt by swallowing one ounce of laudanum. He survived and as he arrived at Helen’s, she was furious as she assumed he had been drinking again. He made a quite delirious and unstable impression but did not confess his suicide attempt. Helen’s mother was strictly opposed to their marriage and Helen herself gave him an ultimatum to stop drinking if he wanted to marry her.

Poe returned home defeated and started to pursue a relationship with his former girlfriend Elmira Shelton (née Royster), who was now a divorced mother. For Poe, this meant that if he wanted to marry her, he had to quit drinking in order to be a good husband and father for Elmira’s son. Poe struggled immensely with his mental and physical health during this period. According to Elmira, “He was very sad […] and complained of being quite sick” the last time she saw him alive (Silverman 433).

The exact reason for Poe’s death remains a mystery, however, in his final days, he was reportedly seen “strangely dressed and semiconscious,” “rather the worse for wear” and “in great distress” (Silverman 433). Shortly before his death, he was taken to the hospital by people who saw him wandering on the streets in a delirious state. Poe did not know how he had reached the hospital nor why he was there. At first he was talking non-stop and resisted to stay in bed. Strangely, he was said to have called his uncle-in-law’s name – Henry Herring – in his delirious state. According to Dr. Moran, who treated him, Poe final words were “Lord help my poor Soul” (Silverman quoting Moran 435).

Many rumors exist regarding the cause of his death, one of which is attributed to a “lethal amount of alcohol” in his blood (Silverman 435). The press, however, stated that his cause of death was “congestion of the brain” or “cerebral inflammation” (Silverman 435). But said assumptions are not contradictory as a lethal amount of alcohol could in fact lead to these diseases. According to Poe’s biographer Silverman, “the terms were used euphemistically in public

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35 “...a solution of powdered opium in alcohol, weaker in opium content than morphine or heroin” (Silverman 373).
announcements of deaths from disgraceful causes such as alcoholism, [and] they may in this case have come from the hospital staff itself” (435-6).

Besides alcohol poisoning, he could have also died exposure to the rainy and stormy weather while poorly dressed. His physician, Dr. Moran, attributed his death to a condition called “encephalitis”, which is “a brain inflammation brought on by exposure” (Silverman 436).

Poe’s burial was held only one day after his death, which is why barely anyone attended. According to reports, the service only lasted three minutes and neither Elmira Shelton nor Muddy were present as they had not yet even been informed of his death. When Muddy finally received the news, she did not want to believe it and mourned “If it is true […] God have mercy on me, for he was the last I had to cling to and love” (Silverman quoting Muddy 437). 36

3.2 Speculation about Poe’s mental state

As there is no information on whether Poe received professional help for his mental struggles, it is impossible to diagnose him properly. His tales with mentally unstable, unreliable narrators may suggest a possible autobiographical connection; however, Poe never confirmed that any of his short stories were based on himself. The only sources available were written after his death and merely include subjective, personal recollections from his friends and family. Thus, one can only speculate and not claim any diagnoses with certainty.

Admittedly, Poe’s life was turbulent from the start. According to Erica Gimmarco, there is little information about his early childhood, and he was reportedly “a mischievous child, playing practical jokes on classmates and teachers” (4).

In his adolescence, he had ongoing fights with his adoptive father. They were in contact via letters and Poe repeatedly accused John Allan of not loving him. Later in his life, Poe turned to drinking excessively and was, according to his

36 Source of section 3.3.4. (Silverman 348-363, 373-381, 427-437)
family and friends, “chronically melancholic” (Gimmarco 4). His suicide attempt may also suggest a deep depressive episode; however, the fact that he knowingly took only half the amount of laudanum, might indicate he did not want to die. Thus, “it is unknown if this a suicide attempt or done for attention” (Gimmarco quoting Kennedy 5).

Contrastingly, Lorine Pruette, author of A Psycho-Analytical Study of Edgar Allan Poe, is not of the opinion that Poe’s suicide attempt was done solely for attention. She argues that it was indeed “one evidence of the profound state of melancholia into which he had sunk” (398). In addition, she claims that there is an apparent autobiographical connection between Poe and the characters in his stories. Pruette states that “they are melancholic men, pursued by unrelenting fate: they are neurotic, hypochondriac, monomaniac, victims of vain delusion; they are the prey to melancholia, insane from sorrow or from the thirst for revenge” (384).

According to Teive et al., “Poe's behavior, with recurring episodes of depression and behavioral changes, together with abuse of alcohol and other drugs, […] could suggest a diagnosis of bipolar affective disorder” (467).

Indeed, there may be a link between bipolar disorder and creative occupations such as authors. Many scientific studies that investigate the connection between creativity and mental illness have been conducted.

The following part of this section is based on and relates to the content of a previous written work of mine (a paper for “PS Literature” in WS 2013/14).

In 1994, Ludwig conducted a study, testing a group of writers along with a control group of non-writers in order to determine whether or not writers were more likely to suffer from a mental disorder. The study found that depression and mania were much more prevalent in the group of writers (Johnson et al. 4). Another study by Jamison (1993) revealed that the frequency of mood disorders, suicides, and institutionalizations in poets between 1705 and 1805 were 20 times higher than those of the general population (Johnson et al. 2).
These results suggest that people with creative occupations such as writing are indeed more likely to suffer from bipolar disorder. Dean Keith Simonton, however, does not agree with the assumption that genius and creativity go hand in hand. According to his research, poor mental health can even have a negative effect on creativity. Psychopathology, in particular, can influence creativity negatively; this assertion is supported “by historiometric, psychiatric and psychometric sources” (Simonton). Furthermore, Simonton claims that creative people must have the ability to take on new ways of thinking and consider random techniques and possibilities in order to increase their knowledge and performance. “From this requirement arises the need for creators to have such traits as defocused attention, divergent thinking, openness to experience, independence and nonconformity,” he states. “Let us call this complex configuration of traits the 'creativity cluster’” (Simonton). Studies have shown that artists are more likely to demonstrate these “creativity clusters” than scientists. Individuals who appear to be more creative also “display these traits to a higher degree” (Simonton). Furthermore, individuals in occupations which require more creative thinking also show these traits to a greater extent\(^{37}\).

In conclusion, it is impossible to determine if Poe suffered from a mental disorder and if the protagonists of his stories are based on himself. It is known that he tried to manage his struggles and hardships in life by relying on alcohol and as mentioned at the end of subsection 3.3.4., this addiction may well have cost him his life.

\(37\) Source: (http://www.psychiatrictimes.com/articles/are-genius-and-madness-related-contemporary-answers-ancient-question)
4. Present day mental pathologies exhibited in Poe’s works

4.1 Alcohol Use Disorder

Alcohol use disorder (AUD), formerly called alcohol abuse disorder, falls into the larger category of “Substance-Related and Addictive Disorders” and is subcategorized into three groups, depending on the severity of symptoms present (APA 481-483). Experiencing two or three symptoms would be considered “mild” (DSM-5 code F 10.0), while four or five symptoms indicate “moderate” (F 10.20) alcohol use disorder. Cases in which six or more symptoms are present would be classed as “severe” (F 10.20). Additionally, a diagnosis requires the presence of said symptoms for a period of at least 12 months. These are the criteria used to diagnose AUD, as referenced in the DSM-5:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol […]
   b. Alcohol (or a closely related substance, such as a benzodiazepine 38 ) is taken to relieve or avoid withdrawal symptoms. (APA 490-491)

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38 “A class of compounds with antianxiety, hypnotic, anticonvulsant, and skeletal muscle relaxant properties” (Farlex Partner Medical Dictionary © Farlex 2012)
Adult males have the highest risk of developing AUD. According to the DSM-5, 16.2% of men between the ages of 18 and 29 suffer from AUD. Interestingly, there is a significant gender difference concerning the prevalence of the disorder. The American Psychiatric Association states that 12.4% of men are affected by AUD while only 4.9% of females are suffering from it (APA 493).

There are strong genetic risks associated with AUD. Individuals with a family member affected by this condition have a three to four times higher risk of developing AUD. The DSM-5 states that “Alcohol use disorder runs in families, with 40% - 60% of variance of risk explained by genetic influences” (APA 494). Furthermore, the risk increases exponentially with the number of family members affected by AUD. Interestingly, even children given up for adoption who have not grown up around their alcoholic biological parents, and have never been exposed to their substance use, have a “three- to fourfold increase in risk”39 (APA 494).

Concerning comorbidity40 of AUD and other psychiatric disorders, it must be mentioned that specifically “bipolar disorder, schizophrenia, and antisocial personality disorder are associated with a markedly increased rate of alcohol use disorder” (APA 496). Besides said conditions, anxiety disorders and depression are also known to co-occur with AUD. However, acute intoxication or alcohol withdrawal can also trigger temporary “alcohol-induced comorbid depressive symptoms” (APA 497).

4.2 Antisocial Personality Disorder

Antisocial personality disorder (DSM-5 code F 60.2) falls into the category of Personality Disorders: more specifically, the Cluster B type. Other Cluster B

39 Connection to Poe: His biological father David Poe had been an alcoholic as was Edgar himself, but Edgar did not grow up around his father.

40 “[T]wo or more coexisting medical conditions or disease processes that are additional to an initial diagnosis.” (Mosby’s Medical Dictionary, 9th edition. © 2009, Elsevier).
personality disorders are Borderline Personality Disorder (F 60.3), Histrionic Personality Disorder (F 60.4) and Narcissistic Personality Disorder (F 60.5) (APA 659-669). People suffering from antisocial personality disorder (ASPD) are informally regarded as sociopaths or psychopaths; however, it must be noted that these terms do not exist in the DSM-5 and are not used in professionals diagnosis. The following criteria are used to diagnose ASPD:

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
B. The individual is at least age 18 years.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder. (APA 659)

0.2% - 3.3% of the general population suffer from this condition and the prevalence is higher among individuals with low socioeconomic status. Strikingly, more than 70% of people with severe alcohol use disorder display a wide array of symptoms associated with ASPD (APA 661). Thus, the comorbidity between said conditions appears to be rather high. However, in order to receive a valid diagnosis of antisocial personality disorder, signs of it must have already been present in childhood and continued into adulthood. If symptoms of ASPD present merely as results of substance abuse, an individual will not receive a separate diagnosis. Similarly, ASPD also should not be diagnosed if an individual displays the symptoms “exclusively during the course of schizophrenia or bipolar disorder” (APA 662).
Compared to the general population, the risk of developing ASPD majorly increases if a first-degree relative suffers from this condition. In addition to genetic risk factors, environmental circumstances also appear to be influential. According to studies observing adopted children, the risk of developing ASPD increases both for individuals with biological parents who suffer from this disorder as well as those whose adoptive parents do (APA 661).

Furthermore, this disorder is almost exclusively diagnosed in male individuals; however, it is argued that “antisocial personality disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder” (APA 662).

### 4.3 Bipolar Disorder

There are two forms of this condition: bipolar disorder I and bipolar disorder II. Both belong to the category of “Bipolar and Related Disorders” and in the past, bipolar II was seen as a milder form of bipolar I. Nowadays, however, both are acknowledged to be of equal seriousness. They are diagnosed as either “mild,” “moderate” or “severe.” Since the DSM-5 lists the criteria for both rather extensively, a shortened summary of the definitions and a comparison will follow (APA 123).

Both bipolar I and II are characterized by extreme mood swings, ranging from major depressive episodes to mania. Essentially, the main difference between bipolar I and bipolar II is that the latter has less severe forms of mania, termed “hypomania.” While both mania and hypomania cause elevated mood, increased risk taking, an increase in energy and a sense of grandiosity, manic individuals may additionally present symptoms of psychosis, delusion or hallucination. Thus, people suffering from mania might require hospitalization when considered a threat to themselves and others around them. Individuals experiencing hypomania are typically able to go about their daily lives and do not require inpatient psychiatric treatment for their hypomanic episodes. In short, bipolar I presents hypomania and mania, while bipolar II presents only hypomania (APA 123-126, 132-133).
Individuals suffering from bipolar I are on average 18 years old at the onset of the condition, whereas bipolar II presents slightly later: typically around age 20.

With regard to prevalence, the American Psychiatric Association (136) states that “bipolar I, bipolar II, and bipolar disorder not otherwise specified yield a combined prevalence rate of 1.8% in the U.S. […] with higher rates (2.7% inclusive) in youths age 12 years or older.”

Concerning environmental risk factors, it can be stated that bipolar disorder is more common in higher-income countries. In addition, the DSM-5 claims that “Separated, divorced, or widowed individuals have higher rates of bipolar I disorder than do individuals who are married or have never been married, but the direction of the association is unclear” (APA 130). Moreover, bipolar disorder presents very strong genetic risk factors. An individual is ten times more likely to develop this condition if a close relative suffers from it as well (APA 130). In comparison to the general population, the risk of committing suicide is increased 15-fold in individuals with bipolar disorder (APA 131). In regards to gender differences, bipolar I is relatively evenly distributed between women and men compared to bipolar II, which affects females more often. Moreover, women generally experience rapid-cycling to a greater extent.

In terms of comorbidity, it can be said that the majority of individuals with bipolar disorder I or II is also diagnosed with another, co-occurring mental disorder. 75% suffer from anxiety disorders and 37% are diagnosed with substance use disorders such as alcohol use disorder (APA 136).

4.4 Claustrophobia

Claustrophobia is classified as an anxiety disorder and belongs to the subcategory of specific phobias. It shares the DSM-5 code (F40.248) with other "situational" phobias, such as the irrational fear of airplanes or heights. It should

41 Extremely quick mood swings; quick switches of depression and mania
noted that the term claustrophobia is not explicitly stated in the DSM-5, but it is rephrased as fear of “enclosed spaces” (APA 198). Since there is no specific entry for it, claustrophobia shares following criteria with other specific phobias:

A. Marked fear or anxiety about a specific object or situation […]
B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia): objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in post-traumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder). (APA 197)

The American Psychiatric Association (199) states that, globally, 6% - 9% of the population suffers from some form of specific phobia. Individuals in Africa, Asia and Latin America are typically less affected by specific phobias, with rates between 2% and 4%. Concerning gender differences, the DSM-5 states, “Females are more frequently affected than males, at a rate of approximately 2:1, although rates vary across different phobic stimuli” (APA 199). In addition, the majority of people with this condition have more than one object or situation of which they are phobic (APA 198).

Both environmental and genetic factors play a role in the susceptibility of specific phobias. Physical, emotional and sexual abuse during childhood are increasing risk factors which may cause specific phobias later in life. Contrastingly, parents who are too overprotective may also be a tautological risk factor. Traumatic events (such as being trapped in small spaces, in case of claustrophobia) in the past are often the direct cause for triggering the
development of specific phobias. Concerning genetics, APA (200) claims that having a first-degree relative with a specific phobia significantly increases an individual's risk of developing one.

Individuals dealing with specific phobias have a 60% higher rate of committing suicide compared to the general population. That being said, comorbidity and suicidality are often intertwined, as specific phobias typically co-occur with either depression, bipolar disorder or personality disorders. These conditions combined with a specific phobia may be a major reason for the significant increase in suicidality (APA 201-202).

4.5 Persistent Complex Bereavement Disorder

This condition differs from other disorders mentioned in section 4, insofar that it does not have a DSM code – it belongs to the category of “Conditions for Further Studies.” Thus, more research needs to be done in order to re-categorize it into the standard classifications. Essentially, it shares many criteria with conditions categorized as “Depressive Disorders,” however, as opposed to Major Depressive Disorder, the symptoms occur exclusively as a result of personal loss such as death of a loved one (APA 792). Despite the absence of a DSM code, the American Psychiatric Association still came out with an extensive list of criteria.42

Summarized, some of the main symptoms are “intense sorrow and emotional pain in response to the death,” “preoccupation with the deceased,” “reactive distress to the death” and “social/identity disruption” (APA 789-790). Individuals affected may also display somatic reactions such as pain or fatigue. In some cases, people diagnosed with complex bereavement disorder could experience “hallucinations of the deceased (auditory or visual) in which they temporarily perceive the deceased's presence (e.g., seeing the deceased sitting in his or her favorite chair)” (APA 791).

42 The full list of criteria can be found on pp. 789-790 in the DSM-5
In regards to prevalence, the DSM-5 states that approximately 2.4% - 4.8% of the general population is affected by complex bereavement disorder. The risk increases if there was a high dependency on the person who died. In addition, females are more likely to develop complex bereavement disorder (APA 791).

It is essential to clearly draw the difference between what is called “normal grief” and complex bereavement disorder. Experiencing grief after the loss of a loved one is not considered abnormal, and is a normal human reaction to extreme emotional distress. The symptoms of normal grief and complex bereavement disorder might be very similar; however, the duration of grief determines whether individuals are diagnosed with PCBD. Thus, the American Psychiatric Association (792) argues that, “It is only when severe levels of grief response persist at least 12 months following the death and interfere with the individual's capacity to function that persistent complex bereavement disorder is diagnosed.”

This condition mostly co-occurs with other depressive disorders such as major depression or persistent depressive disorder (dysthymia). Additionally PTSD is also a relatively common comorbid condition. The DSM-5 claims that “individuals with persistent complex bereavement disorder frequently report suicidal ideation” (APA 791-792).

4.6 Narcissistic Personality Disorder (NPD)

Narcissistic personality disorder (DSM-5 code F 60.81) is a Cluster B type Personality Disorder. Briefly summarized, NPD is characterized by increased yearning for admiration, a “pervasive pattern of grandiosity (in fantasy or behavior) […], and lack of empathy” (APA 669). In order to diagnose NPD, five or more of the following criteria must apply:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends)
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes. (APA 669-670)

Another important indication of NPD is an inability to accept criticism. Despite appearing self-confident and arrogant, individuals with NPD are in fact extremely vulnerable to perceived threats that could expose their inadequacy. In order to avoid humiliation, narcissists may avoid social interaction if criticism is a possible outcome. In addition, they may even develop symptoms of various depression disorders. Contrastingly, during periods of displaying grandiosity and increased self-importance, individuals with NPD show signs of hypomania (APA 671).

Cornering prevalence, an estimated 6.2% of the population meets the criteria for NPD. Between half and three quarters of these individuals are men.

It is crucial to clearly differentiate between NPD and other Cluster B personality disorders, as all of them share many characteristics and may be confused easily. In comparing BPD and NPD, for example, despite the need for attention being present in both conditions, individuals with BPD yearn for attention in order to avoid emotional abandonment, whereas people with NPD need attention primarily in the form of admiration. Additionally, as opposed to BPD, individuals affected by NPD are rarely impulsive, self-destructive or afraid of abandonment. They also do not experience the immense self-hate and low self-worth individuals with BPD struggle with. In comparison to people with ASPD, people with NPD typically lack criminal and overly aggressive behavior. Also, yearning for admiration is not characteristic for ASPD (APA 672).
4.7 Schizophrenia

Schizophrenia (DSM-5 code F20.9) belongs to the category of “Schizophrenia Spectrum and Other Psychotic Disorders.” According to the American Psychiatric Association (87), the key features of all disorders in this category are: “delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior or (including catatonia), and negative symptoms.”

The following list of criteria is used to diagnose schizophrenia:

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment, incoherence).
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another

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43 Thus, on the neurosis-psychosis spectrum, schizophrenic disorders are located at the psychotic end.
medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated). (APA 99)

Regarding prevalence, the DSM-5 states that between 0.3% and 0.7% of the general population will develop schizophrenia (APA 102). Generally, both genders are affected by it almost equally, with females having only a slightly lower risk. However, women typically experience more mood and psychotic symptoms, whereas men display negative symptoms more often. In addition, men have poorer outcome, the course of the disorder tends to be more serious, and the acute phases last longer (APA 103-104).

Concerning environmental risk factors, the DSM-5 claims that individuals from ethnic minorities and people growing up in urban surroundings are more likely to develop schizophrenia. In terms of physiological risk factors, most schizophrenics do not have parents with a history of psychosis. However, greater paternal age was reported to increase the risk of an individual developing this condition (APA 103).

As many as 20% of schizophrenics attempt suicide and between 5% and 6% succeed. Young men who also struggle with substance abuse are specifically at risk for committing suicide. Generally, individuals with schizophrenia attempt suicide for different reasons than those with depressive disorders. Schizophrenics report that voices or other signs force them to consider suicide (APA 104).

Compared to the general population, schizophrenics have lower life expectancies due to neglecting their health and engaging in damaging behaviors such as smoking cigarettes and abusing other substances. Concerning comorbidity, the DSM-5 states that depressive disorders, as well as
obsessive-compulsive disorders and anxiety disorders, are more common in individuals with schizophrenia (APA 105).
5. “The Black Cat”

5.1 Summary

The tale “The Black Cat” is told in first person perspective by an unnamed narrator; at the beginning, it is implied that he is in prison and will be executed the next day. In order to ease his conscience, he tells the reader about his life and the events that led to his death sentence. Also, he stresses that he is not insane. He repeatedly mentions how docile and kind a person he has been since his childhood. Additionally, he states that he has loved animals for all his life and had a dog when he was growing up. Then he talks about his marriage and the fact that his wife also loves animals.

Together, he and his wife take in a black cat named Pluto. However, the narrator soon begins drinking, which leads him to become aggressive and brutal toward both his wife and his cat. He recalls a particularly cruel incident in which he cut out Pluto’s eye after returning home drunk. The narrator describes this brutal scene in detail and claims to have been possessed by “[t]he fury of a demon” (Poe 64). Soon after this incident, the narrator is again overcome by a perverse impulse and ultimately kills Pluto by hanging him. He admits that he knew what he did was wrong and that he was committing a sin. That night, the narrator’s house burns down inexplicably. The next day, upon his return, the narrator finds a crowd of people in his bedroom, staring at the only wall left standing. On the wall, he sees a gigantic image of a cat with a noose around its neck.

After some time, the narrator is once again out drinking, and a big black cat appears that looks almost exactly like Pluto, with the exception of a white spot of fur on its chest. He instantly connects with the animal, which follows him home. Soon after, the narrator becomes annoyed by the cat and the fact that it follows him everywhere. This annoyance is quickly replaced by irrational anger. When he realizes the new cat is also missing one eye, his hatred toward the animal was growing even more. He also becomes increasingly aggressive toward his wife due to his drinking habit and his frustration with the new cat. One night, he
decides to kill the cat with an axe while he and his wife are walking down the stairs to the cellar. As his wife tries to stop him, he furiously kills her with the axe.

He decides to get rid of the body in order to avoid being caught. He considers his options, seemingly void of emotion, and finally puts the corpse between two walls in the cellar. After he finishes the work, he wants to find the new cat in order to kill it as well, but it is nowhere to be found. This relieves the narrator; he believes he will finally be able to live in peace. When the police arrive, he manages to get through their inquiries without raising suspicion.

However, four days after the murder, the police return. The narrator readily invites them into the house and offers them to search the whole property, specifically the cellar. Right as they are ready to leave again, he starts bragging about the stability of the walls and taps his cane on the exact spot where he buried his wife’s body. Suddenly, a cry emerges from the wall; the police tear the wall down. They find the wife’s body with the cat sitting on top of her head. At the end of the story, the narrator admits that this is the reason why he will be hanged. He ends his story by saying, “I had walled the monster up within the tomb!” (Poe 70).

5.2 Character analysis with regard to mental disorders

Firstly, it must be noted that whether the narrator suffers from any mental disorder is unclear and can only be assumed by comparing his actions and behavior with the diagnostic criteria in the DSM-5. It is not possible to diagnose a fictional character, but one can argue that he shows symptoms of certain disorders.

In the introduction, the narrator is determined that he is not insane even though his story sounds unbelievable. He claims, “For the most wild […] narrative which I am about to pen, I neither expect nor solicit belief. Mad indeed would I be to expect it, in a case where my senses reject their own evidence. Yet mad I am not – and very surely do I not dream” (Poe 63).
He openly discusses his problems with alcohol and mentions the resulting aggression. He states, “But my diseases grew upon me – for what disease is like Alcohol! – and […] even Pluto began to experience the effects of my ill temper” (Poe 64). He also shares that during his aggressive outbursts, he feels out of control and as if “the fury of a demon” possesses him (Poe 66). In addition, he speaks of regretting his actions: “[w]hen reason returned with the morning – when I had slept off the fumes of the night’s debauch – I experienced a sentiment half of horror, half of remorse, for the crime of which I had been guilty” (Poe 64). In the DSM-5, alcohol addiction falls under “alcohol use disorder” and the American Psychiatric Association (496) claims that “[s]evere alcohol use disorder, especially in individuals with antisocial personality disorder, is associated with the commission of criminal acts, including homicide.”

Strangely, the narrator claims to have felt guilty after gouging out Pluto’s eye, yet he still goes on to kill the cat. He admits to committing the crime despite knowing it was wrong and says he hung Pluto “in cold blood” but was remorseful for doing so. The reader does not know whether the narrator was intoxicated at the time, but it is likely that he was sober since he typically mentions when he committed acts of violence while drunk (as a means to justify his actions). Also, he tries to gain the reader’s sympathy and wants his violent behaviour to appear relatable: he asks, “Who has not, a hundred times, found himself committing a vile or a silly action, for no other reason than because he knows he should not?” (Poe 65).

Moreover, the fact that he often contradicts himself and constantly finds excuses for his unlawful behavior further indicates that he might have ASPD. He claims that alcohol caused his horrible, uncontrollable actions; this vindicates him of responsibility. Furthermore, will not admit that his disordered mind and personality might have led to the abuse and killings. Instead, he continues to justify his violence with external factors beyond his power, such as the alcoholic rage or the “spirit of perverseness” which, according to him, is familiar to everyone (Poe 65). In addition, he openly admits that the reason he killed Pluto
was “this unfathomable longing of the soul to vex itself – to offer violence to its own nature – to do wrong for the wrong’s sake only…” (Poe 65). The narrator seems to enjoy inflicting pain upon others, and in this instance he does not even blame it on his use of alcohol anymore.

Although he claims to have been a kind child with an affinity for animals, his manipulative character makes it unclear if he is telling the truth. If this is true, he would not receive the diagnosis of ASPD, as one of the key features is that the symptoms have been present since childhood (APA 662).

While ASPD is highly comorbid with substance use disorders, substance use disorders may also result in behavior which can be found in the criteria for ASPD. This means that an individual with ASPD quite regularly resorts to alcohol or other substances, whereas people struggling with various substance use disorders only exhibit antisocial behavior due to the effects of said substance (APA 662).

Up until the point of murdering his wife, the narrator justifies his actions by blaming his sins on external factors (such as alcohol). However, the brutal murder of his wife, who only wanted to prevent him from killing the new cat, implies that he has no conscience and acts impulsively, without any regard for the lives of others. In addition, he does not mention guilt or regret after having killed her, but instead methodically plans to get rid of the body. Colloquially, this behavior would be regarded as psychopathic; the narrator is manipulative and only acts in his own best interest.

In the narrator’s case, the clear lack of remorse after killing his wife and the fact that he acts so calm while being questioned by the police strongly suggests that he lacks a conscience and violates the rights of those close to him. Thus, he exhibits many symptoms of ASPD.

All in all, mental illness is represented rather negatively in “The Black Cat.” The narrator’s mental instabilities, namely symptoms of antisocial personality
disorder with comorbid substance abuse, lead him to act impulsively and commit murder without remorse.

5.3 Symbolism – the cats

Firstly, Pluto is a black cat; on its own, this typically has a negative connotation. Black cats are associated with bad luck and it is said that one should avoid crossing their paths. Secondly, in Greek mythology, Pluto is the ruler of the underworld, which also suggests death and horror. Thus, at first look, both of these aspects would lead to the assumption that the symbolism behind Pluto is negative.

However, in the case of “The Black Cat,” Pluto could act as a symbol of the narrator’s sanity. He treats the cat well and loves it in the beginning, but as he grows “more moody, more irritable, more regardless of the feeling of others,” he begins to treat Pluto badly (Poe 64). His bouts of violence are caused by alcohol and at first, he only harms Pluto. By drinking, the narrator also harms himself and his sanity. Essentially, his tendencies toward ASPD are amplified by abusing alcohol.

The way in which he harmed Pluto—by gouging out one eye—can be interpreted as an attempt to avoid being seen as the evil and manipulating character he truly is. He kills the cat by hanging him: ironically, this is the same way in which the narrator will be executed for his crime.

After killing Pluto, the narrator’s life spirals downwards and the little sanity he has left vanishes. Soon he meets the new black cat and realizes it looks exactly like Pluto except for a white patch of fur on its chest. At first he likes the new cat, but after he realizes it is missing an eye, he resents it. This could imply that it provokes feelings of guilt and shame for killing Pluto and simultaneously losing his sanity.

Furthermore, the narrator mentions that the new cat’s patch of white fur is shaped like the gallows, which acts as a reminder of the way the narrator killed
Pluto and foreshadows the narrator’s demise. Thus, the new cat symbolizes the narrator’s guilt with regard to killing Pluto.

6.1 Summary

This tale is told in first-person perspective by a narrator whose name is revealed to be Montresor. It begins with him telling the reader that his friend Fortunato wronged him by insulting him. Then, Montresor tells the story of how he took revenge on Fortunato.

First, Montresor shares that he did not let Fortunato know about his hatred toward him in order to not raise any suspicion concerning his deadly plan. Fortunato is a wine expert, and one evening during carnival season, Montresor seizes a chance to carry out his plan. Fortunato is intoxicated when Montresor tells him about a cask of Amontillado he wants him to taste, as he feels that the seller may have cheated him. He flatters Fortunato and tells him that since he is a true connoisseur, he could definitely tell whether it is authentic Amontillado.

They walk back to Montresor's home and enter the vaults. The narrator has carefully planned his revenge, making sure his attendants are not at home so no one will witness what he is about to do. He lures Fortunato deeper and deeper into the vaults and offers him more wine. Fortunato's cough worsens due to the damp air, so Montresor suggests that they return; Fortunato insists on tasting the Amontillado. Due to Fortunato's uninhibited state, he becomes feisty and makes jokes about Montresor, sealing his fate.

Montresor lures Fortunato into a niche and quickly chains the unsuspecting drunk to the wall. Fortunato first assumes the narrator is simply joking with him, and thus does not realize the gravity of the situation. Then Montresor builds a brick wall in front of Fortunato. Even when Montresor is almost finished and has only one brick left to place, Fortunato laughs and tells him it is a good joke indeed and they will laugh about this later. However, shortly after, Fortunato understands the fate he is about to face. The reader learns the narrator's name when Fortunato shouts, “For the love of God, Montresor!” (Poe 196). But
Montresor does not even consider freeing Fortunato and instead mocks him by repeating his pleas. When Fortunato stops replying, Montresor calls out his name repeatedly. At last, he places the last brick into the wall. At the end of the story, Montresor informs the reader that Fortunato’s body has not been found during the past 50 years.

6.2 Character analysis with regard to mental disorders

Firstly, it must be mentioned that Poe does not explicitly state that Montresor is mentally ill. Additionally, the contemporary understanding of mental illness was very limited in the 19th century. Poe could not have had a specific 21st-century diagnosis in mind when creating his characters, as the conception of mental illness was vastly different and psychology had not been explored extensively. Thus, one can only assume by comparing Montresor’s behaviors to diagnoses found in the DSM-5.

In contrast to “The Black Cat,” the matter of sanity or insanity is not discussed in “The Cask of Amontillado”: Montresor does not claim sanity. Furthermore, Montresor’s motive for murder is vastly different. He kills Fortunato neither due to a perverse, uncontrollable impulse, nor as the result of an alcoholic rage.

The sole trigger leading Montresor to kill Fortunato is revenge. He starts his tale by admitting, “The thousand injuries of Fortunato I had borne as I best could; but when he ventured upon insult, I vowed revenge” (Poe 191). Montresor does not reveal in what way he was insulted, so it is possible that he exaggerates the insult. One indication for this assumption is the way Montresor speaks of Fortunato. He calls him his “friend” repeatedly and mentions that he is “a man to be respected” (Poe 191).

However, Montresor also claims that he was consciously attempting to treat Fortunato well in order not to raise any suspicion concerning his evil plan. He states, “It must be understood, that neither by word nor deed had I given

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44 The topic of mental illness in the 19th century has been discussed extensively in section 2.
Fortunato cause to doubt my good-will. I continued [...] to smile in his face, and he did not perceive that my smile now was at the thought of his immolation” (Poe 191). This, along with the fact that he carefully plans Fortunato’s murder, leads to the assumption that Montresor is a narcissist. His behavior and statements indicate the presence of all nine criteria used when diagnosing NPD.45

Firstly, he sees himself as superior to others. When talking about telling his attendants to leave, he states, “These orders were sufficient, I well knew, to insure their immediate disappearance, one and all, as soon as my back was turned” (Poe 193). It is clear that Montresor sees himself as special and superior, fulfilling one criterion for an NPD diagnosis.

Secondly, the fact that he feels entitled to murder Fortunato due to an insult further indicates that Montresor is a narcissist. A key feature of NPD is the inability to deal with criticism and oversensitivity to perceived insults (APA 671). He is obsessed with taking revenge in order to prove no one should dare to insult him. Montresor argues:

> At length I would be avenged; this was a point definitely, settled – but the very definitiveness with which it was resolved precluded the idea of risk. I must not only punish but punish with impunity. A wrong is unredressed when retribution overtakes its redresser. It is equally unredressed when the avenger fails to make himself felt as such to him who has done the wrong. (Poe 191).

Furthermore, Montresor mentions that no one has ever found the body, subtly implying that he outsmarted anyone who searched for Fortunato. This again makes it apparent how highly he thinks of himself, without him explicitly stating it.

However, it seems strange that Fortunato was not missed after his disappearance. Montresor does not mention a search for Fortunato, stressing only that he was not found. Additionally, at the carnival, many people must have seen the two friends together, so it is likely that Montresor would have been a

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45 The full list of criteria can be found in sub-section 4.6.
suspect. But Montresor does not inform the reader regarding these matters. It is common for narcissistic individuals to avoid sharing their own weaknesses and negative experiences as it might suggest that they are not infallible.

When they are in the vaults, Montresor uses reverse psychology as a way to manipulate Fortunato and ensure that his plan will be successful. He tells his victim, who has a cough, “Come [...] we will go back; your health is precious. You are rich, respected, admired, beloved; you are happy as once I was. You are a man to be missed. For me it is no matter” (Poe 193). By complimenting Fortunato and exaggerating his friend’s importance, Montresor expects Fortunato to insist on staying. The narrator also uses manipulation by complimenting Fortunato and simultaneously devaluing himself. When he encounters his friend and wants to persuade him to try the Amontillado, he claims he is not sure whether he was sold authentic wine: “…and I was silly enough to pay the full Amontillado price without consulting you in that matter” (Poe 192).

For the reader it is apparent that Montresor is merely pretending to be inferior but Fortunato does not seem to notice that his friend is manipulating him through flattery. The fact that Fortunato is intoxicated and his judgment is impaired further highlights Montresor’s ill will as he takes advantage of his friend.

In comparison to the narrator of “The Black Cat,” who shows signs of ASPD, there are many indications that Montresor has NPD instead. The main aspect, which excludes a diagnosis of ASPD, is the fact that Montresor thoroughly planned the murder and it is not a result of impulsive behaviour. Furthermore, in contrast to the narrator in “The Black Cat,” Montresor does not blame his actions on exterior factors. He also does not mention guilt or regret. For the reader it appears as if he is almost proud of his perfect crime.

Concerning the murder, Montresor chooses a relatively non-violent and non-invasive method as opposed to directly inflicting violence on his victim. The DSM-5 does not include aggressive behaviour or extreme violence in the
criteria for NPD. One of the main aspects of ASPD, however, is “irritability and aggressiveness, as indicated by repeated physical fights or assaults” (APA 659). Contrastingly, the unnamed narrator in “The Black Cat”, who shows signs of ASPD, uses very aggressive methods such as hanging the cat and bludgeoning his wife with an axe.

The question of guilt or innocence is not addressed by Montresor as he does not consider his actions to be wrong. He is convinced that Fortunato’s murder is justified due to the fact that Fortunato insulted Montresor. To a rational individual this reaction seems extreme; however, to a narcissist, personal insults are perceived as much more extreme and vicious than they are intended to be. Since Montresor clearly exhibits many symptoms of NPD, one can claim that his self-worth is in fact rather fragile if a mere insult causes him to take revenge in the form of murder.

On a different note, Montresor continuously mocks Fortunato while they are walking down the vaults. His victim is not aware of the plan, so he does not grasp the irony behind his statements. For example, when Fortunato expresses, “the cough is a mere nothing; it will not kill me. I shall not die of a cough,” Montresor ironically replies with, “True – true,” fully aware of his victim’s fate (Poe 193). The fact that Montresor appears to enjoy the act of deception and ultimately causing Fortunato’s death further indicates that he sees himself as superior and also as someone who gets to decide others’ fates.

Another example of Montresor’s ironically dark personality is his statement on completion of the wall. He says, “My heart grew sick – on account of the dampness of the catacombs” (Poe 196). The first half of his statement may cause the reader to think he feels guilty and uneasy due to the murder, but this is quickly discredited with the words that follow. Montresor implies that the murder does not affect him at all; instead, his ill-being is caused by the setting. Once again this emphasizes his emotional detachment and highlights the fact that he feels entitled to kill a person. Thus, he does not realize the seriousness of his actions. On a meta level, this irony demonstrates how Poe added wit to an otherwise dark story.
In “The Cask of Amontillado,” the narrator is presented as a bitter, narcissistic individual who wants to seek revenge due to an insult – likely minor. Again, mental illness is portrayed as something dark, negative and dangerous. Montresor’s mental instabilities, namely traits of NPD, drove him to murder his friend and neither feel nor show any remorse.
7. “The Fall of the House of Usher”

7.1 Summary

This short narrative is told in a first-person perspective by an unnamed narrator. He describes his uncanny experiences at the House of Usher and begins by saying that an old boyhood friend, called Roderick Usher, sent him a letter in which he asked the narrator to visit him. Roderick mentions that he has been feeling ill for quite some time.

When the narrator comes closer to the house, he senses an eerie atmosphere and notices a crack running down the wall of the house. As he meets Roderick, the narrator makes remarks about his frail yet beautiful appearance. In addition, he mentions Roderick’s quick shifts from agitation and restlessness, to ambivalent and depressive behavior. As a result, the tone of his voice and speed of his speech change rapidly as well. Roderick also mentions that he is hypersensitive to sounds, smells, food and clothing fabric. Due to his ailments, Roderick has not left the property in a long time. Furthermore, he suffers from insomnia and expresses his feelings through excessively creating art. Roderick paints and plays the guitar to escape from reality.

Although the causes for Roderick’s mental instabilities are mostly unknown, he claims that one contributing factor is his sister Madeline’s illness: seeing her suffering negatively affects his own well-being. Thus, Roderick is suffering from mental illness while his sister is physically sick. She dies a few days after the narrator’s arrival and upon Roderick’s request, he helps put Madeline into a casket and entombs her temporarily. The reason for this is Roderick’s fear of their family doctor unburying Madeline to examine her body due to the unusual nature of her illness.

The narrator states that her cheeks are rosy, which is unusual for people with her illness. Also, while aiding in the temporary burial, the narrator learns that Roderick and Madeline are twins.
Roderick’s mental state quickly deteriorates after his sister’s death. The narrator makes remarks about his restlessness, such as hurrying from chamber to chamber. Roderick claims that he hears noises, and about a week after Madeline’s burial, the narrator hears the sounds himself for the first time. Roderick hysterically enters the narrator’s room and opens the windows to show him gas that surrounds the building; however, the narrator has a logical explanation for this phenomenon.

To calm Roderick down and pass the night, the narrator starts reading “Mad Triste” by Sir Launcelot Canning to him. Subsequently, both of them hear sounds that correspond to the plot. Roderick seems to be out of his mind and mumbles to himself with his eyes wide open. When the narrator asks what he is talking about, Roderick shares that he has heard these sounds for the past week and fears that they might have entombed Madeline alive and she is trying to escape. He gets enraged and yells rhetorical questions, implying that he was right all along and the noises and sounds were not merely his imagination.

Suddenly, he shouts that his sister is at the door. It is swung open by the storm and indeed, Madeline stands in front of them. She is bloody and her struggle to escape the tomb is apparent. After a few seconds of trembling, she runs towards Roderick and violently throws both of them to the ground. The narrator is horrified and flees from the house.

Only a moment after exiting the building, he turns back and witnesses the crack he noticed upon arrival grow longer and longer until the mansion completely breaks in half and collapses. It is implied that both Madeline and Roderick die as a result.

7.2. Roderick Usher’s mental illness

As opposed to “The Black Cat” and “The Cask of Amontillado,” this story explicitly mentions Roderick Usher’s mental pathologies. However, Poe merely describes his symptoms and does not clearly name the illness. As mentioned, diagnosing mental illnesses was vastly different in the 19th century than it is
today, and most modern diagnoses did not exist at that time. Still, the explicit focus on mental illness in “The Fall of the House of Usher” is unusual when compared to Poe’s other short stories.

Firstly, in his letter to the unnamed narrator, Roderick Usher admits that he suffers from “acute bodily illness – of a mental disorder” (Poe 178). Throughout the story, Usher discusses his mental state several times and seems to have a vast (for the period) understanding of his disorder. The symptoms of his illness cause rapid shifts in mood and energy which, in today’s terms, would indicate bipolar disorder. During Poe’s time the terms “melancholia” and “mania” had already been established, but there was no combined diagnosis such as bipolar disorder.

The narrator describes Roderick’s changes in behavior by stating:

His voice varied rapidly from a tremulous indecision (when the animal spirits seemed utterly in abeyance) to that species of energetic concision—that abrupt, weighty, unhurried, and hollow-sounding enunciation—that leaden, self-balanced and perfectly modulated guttural utterance, which may be observed in the lost drunkard, or the irreclaimable eater of opium, during the periods of his most intense excitement. (Poe 180-181).

Interestingly, the narrator compares Roderick’s behavior to that of an alcohol or drug addict. It is not uncommon for individuals with bipolar disorder to show signs of delirium, especially during manic episodes. In addition, Roderick suffers from insomnia, which can be a sign of both depression or mania (APA 125).

Furthermore, Roderick’s sensitivity to sounds, smells, tastes and certain fabrics is also experienced by individuals in a manic state. The narrator states:

He suffered much from a morbid acuteness of the senses; the most insipid food was alone endurable; he could wear only garments of certain texture; the odours of all flowers were oppressive; his eyes were tortured by even a faint light; and there

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46 In section 4.3., bipolar disorder is discussed extensively and it is mentioned that two subtypes of the disorder exist. In order to avoid confusion and because it is not necessarily relevant, only the broader term “bipolar disorder” will be used in relation to Roderick Usher.
were but peculiar sounds, and these from stringed instruments, which did not inspire him with horror. (Poe 181)

In the online article “When Noise Annoys: Coping with Hypersensitive Hearing”, mental health expert Stephanie Stephens also writes about hypersensitivity in people with bipolar disorder – specifically during manic and hypomanic phases. She interviewed bipolar individuals, one of whom reported, “colors are brighter, sex is enhanced, and you feel smarter. There’s a heightened openness to experience, so it doesn’t surprise me that there’s heightened sensitivity to sound. Meanwhile, almost the opposite happens with depression”.

Without knowing that Roderick suffers from sensory sensitivity, one could assume that he is schizophrenic instead of bipolar. Until the narrator also hears the noises, the reader is made to believe that Roderick is only having auditory hallucinations. Another implication that Roderick suffers from schizophrenia is his paranoia and psychosis. Especially after Madeline’s death, his mental health deteriorates further and he seems even more detached from reality. On the night when Roderick’s sister escapes her tomb, Roderick seems to experience severe psychosis, and mumbles to himself while the narrator reads to him. However, paranoia and psychotic behavior may also be experienced by severely manic individuals. According to the DSM-5, “If there are psychotic features, the episode is, by definition manic” (APA 125).

Roderick also discusses his obsessive fear and how he dreads the future. Speaking about his mental disorder, he states, “In this unnerved – in this pitiable condition – I feel that the period will sooner or later arrive when I must abandon life and reason together, in some struggle with the grim phantasm, FEAR” (Poe 181). This behavior might indicate a depressive state, since a pessimistic outlook and no will to live are symptoms of depression. Alternatively, these symptoms are also associated with anxiety disorders. According to the DSM-5,

47 Online source: “When Noise Annoys: Coping with Hypersensitive Hearing” by Stephanie Stephens (2016)
it is common for sufferers of bipolar disorder to have comorbid anxiety disorders: up to 75% of bipolar individuals are also diagnosed with an anxiety disorder (APA 136).

In general, mental illness is a major focus of “The Fall in the House of Usher.” In Roderick Usher, Poe creates a protagonist with whom he has certain similarities. Poe was rumored to have suffered from bipolar disorder, so it is possible that some aspects of his own illness might have inspired him when writing this short story. Roderick Usher is presented as a complex individual who is aware of his disorder. Additionally, it is rather revolutionary to include an openly mentally ill protagonist since in the 19th century, “insane people” were looked down upon. 48 Roderick describes his symptoms extensively, which indicates that Poe himself had knowledge on this topic.

7.3 Symbolism – the crack in the wall

The crack in the house wall is mentioned early in the story and does not seem to bear much significance at first. The narrator notices it before entering the building, at which point the crack is small. After the horrific experiences, as he is leaving the house, the narrator notices the crack again; this time, it gets larger and larger until the mansion breaks in two and crashes down.

In relation to Roderick Usher, the crack can be interpreted as a symbol of his bipolar disorder. The opposites of the mood disorder spectrum, depression and mania, represent either side of the crack. Even though Roderick does not have a “split personality,” 49 his symptoms are representative of two extremes. At the beginning, the crack is small but as events progress, it grows to portray Roderick’s ever growing insanity: namely, the increasing intensity of his depression and mania.

48 Section 2 extensively deals with mental illness in the 19th century.
49 Individuals with DID (Dissociative Identity Disorder, formerly known as Multiple Personality Disorder) have “split personalities,” which means that different alters may be present at different times. Roderick Usher, however, neither mentions nor appears to have more than one personality.
Another way to interpret the crack is as the contrast between the twins. Both of them are ill, but while Madeline suffers from a physical disease, Roderick is mentally ill. They have a very strong bond, and together they act as a whole.

While Madeline is fighting for her life, Roderick grows progressively more unstable, as if he feels her struggle. After she escapes, Madeline searches for Roderick and they both die since Roderick cannot continue his life without his sister.
8. “The Pit and the Pendulum”

8.1 Summary

This tale is narrated in past tense by an unnamed narrator and has a Latin poem as its epigraph. Although the narrator speaks of inquisitors, which implies that the events take place during the Spanish Inquisition, several aspects are not historically correct. For example, the Spanish Inquisition was abolished before the French army captured Toledo, so the time period does not align. The reader knows the narrator survives since he is the one telling the story.

At first, the narrator shares that he was trialed, was sentenced to death and had little hope to change his fate. He does not mention the reason for his sentence. In the beginning of the story, he fades in and out of consciousness, describes his surroundings and mentions the presence of “black-robed judges” (Poe 197). He discusses his senses in great detail and states that he is battling to remain conscious. As he is sentenced to death, he finally loses consciousness; upon waking up, he finds himself in a new location.

Initially, the narrator is afraid to open his eyes in the constricting atmosphere. He is scared that he might be in a tomb but soon realizes the room is a dungeon. The narrator does not know the size of the cell, so he tries to measure it. However, he loses consciousness again before he can finish his measurements.

When he wakes up again, the narrator finds water and food next to him, which he consumes. Afterwards, he continues to measure the cell; when he falls on the floor due to stepping on the hem of his robe, he realizes he almost fell down a circular pit. He wants find the pit’s depth, so he throws a small fragment down and waits until he hears its landing.

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50 Online source: https://en.wikipedia.org/wiki/The_Pit_and_the_Pendulum
After fainting and awakening again, the narrator notices that he is now strapped onto a wooden contraption with his face towards the ceiling. Shockingly, he realizes that a swinging pendulum is moving toward him in order to cut him in half. The narrator describes the movements of the pendulum in great detail and conveys that death gets closer and closer with each swing. He is aware that he will succumb to his fate if he does not come up with a plan to escape. In addition, he is surrounded by rats that steal almost all of the food he was provided with.

Suddenly, he gets the idea of attracting the rats by smearing the remaining food onto the straps that bind him. He hopes the rats will eat the food and also chew through the ropes. The pendulum has already cut through his robe when the narrator is finally able to free himself. However, due to his death sentence, he expects that the inquisitors will find another way to kill him.

The walls of his prison turn red and begin to move closer to him, forcing the narrator to the edge of the pit. Suddenly, he hears thunder and trumpets; just as he begins to trip and fall down the pit, he is rescued by General Lasalle. At the end of the story the narrator explains that the French army entered Toledo and thus, the Inquisition “was in the hand of its enemies” (Poe 207).

8.2 The effects of mental torture on the narrator’s psyche

Compared to the narrators from the stories discussed in section 5, 6 and 7, the narrator of “The Pit and the Pendulum” stands in stark contrast concerning the matter of insanity. Unlike the narrators of the previously discussed stories, this narrator neither claims sanity nor admits insanity. In fact, the topic of mental disorders is not specifically discussed in “The Pit and the Pendulum.” However, the narration implicitly deals with many aspects of mental struggle. The overall tone is one of fear and panic and the majority of the plot consists of the narrator’s internal monologue. Moreover, due to the first-person narrative (which Poe also employs for the stories discussed earlier), the reader has a sense of being in the situation themselves. This evokes feelings of being personally
affected by the events in the story and may, in the case of “The Pit and the Pendulum,” result in fear and anxiety in the reader.

At the start, the narrator talks about his fight to remain conscious. He wants to stay in control of the situation even though realistically, he is not. Still, by trying to avoid fainting, he demonstrates the will to fight for his life. This makes him a rather mentally strong person since he still has hope that somehow, he has a chance to survive. He shares, “I had swooned; but still will not say that all of consciousness was lost. What of it there remained I will not attempt to define, or even describe; yet all was not lost” (Poe 197).

One aspect that affects the narrator while simultaneously activating the reader’s mind is the feeling of claustrophobia. The narrator perfectly describes his situation and thus affects the reader due to its realistic and poignant nature. When the narrator finds himself in the dungeon, he does not know its size, which causes him to experience symptoms of claustrophobia.⁵¹ He states, “The blackness of the eternal night encompassed me. I struggled for breath. The intensity of the darkness seemed to oppress and stifle me. The atmosphere was intolerably close” (Poe 198). In some cases, claustrophobia can lead to anxiety attacks or panic attacks – but difficulty breathing and the feeling that one’s surroundings are incredibly close (even though they are not) can also be indications of claustrophobia and other specific phobias.

Furthermore, the narrator desperately wants to measure his cell. Perhaps he does this to ease his anxiety and to find out if it is really as constricting as it seems to be. He may also be subconsciously trying to distract himself in order to stay rational. Essentially, the size of his cell does not matter since this aspect will, at this stage, not be his cause of death. The narrator himself addresses this topic and does not seem to understand his own preoccupation regarding the cell’s measurements, considering his overall hopeless situation. He states:

⁵¹ As mentioned in section 4.4., the term claustrophobia is not separately discussed in the DSM-5. As claustrophobia means “fear of enclosed spaces,” it falls into the category of specific phobias.
In its size I had been greatly mistaken. The whole circuit of its walls did not exceed twenty-five yards. For some minutes this fact occasioned me a world of vain trouble; vain indeed—for what could be of less importance, under the terrible circumstances which environed me, than the mere dimensions of my dungeon? (Poe 201)

Later, as the narrator finds himself strapped to the wooden contraption, he feels helpless and constricted once again; this time his fear is valid since he literally cannot move. Moreover, his life is in immediate danger, which justifies his fear and anxiety. In this instance, one should not define his behavior as claustrophobic since the key element in the definition of all phobias is an unreasonably strong reaction to certain objects or situations even though they do not pose an immediate danger. The DSM-5 puts it as follows: “The fear, anxiety, or avoidance is almost always immediately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed” (APA 189-190). The narrator describes his mental state while observing the pendulum that will inevitably slice him in half:

I gasped and struggled at each vibration. I shrunk convulsively at its every sweep. My eyes followed its outward or upward whirls with the eagerness of the most unmeaning despair; they closed themselves spasmodically at the descent, although death would have been a relief, oh, how unspeakable! Still I quivered in every nerve to think how slight a sinking of the machinery would precipitate that keen, glistening axe upon my bosom. (Poe 204)

Even though the narrator experiences symptoms of claustrophobia, his fear is appropriate and valid. Once again he demonstrates immense mental strength as he tries to devise a plan to escape. The fear and anxiety are not paralyzing him but instead motivate him to think creatively in order to save his life.

The story climaxes when the walls move in on the narrator and threaten to push him into the pit. Even though the pit would prevent the narrator from death by crushing, the walls’ closing in will still result in death since this will inevitably force the narrator to fall down the pit. In addition, the walls turn red and the cell
gets incredibly hot. Thus, the pit represents hell and the walls would acts as the trigger to the narrator’s demise. He describes it as follows:

I could have clasped the red walls to my bosom as a garment of eternal peace. “Death,” I said, “any death but that of the pit!” Fool! might I not have known that into the pit it was the object of the burning iron to urge me? Could I resist its glow? or if even that, could I withstand its pressure? (Poe 207)

Similarly to the situation where the narrator is strapped onto the wooden contraption, this situation is also an actual threat to his life; therefore the diagnosis of claustrophobia does not apply.

Generally, the topic of mental disorders is not central in this short story. Despite the mental torture, which surely challenges the narrator’s psyche and threatens his sanity at times, he manages to think rationally in order to establish plans to prolong his survival.

9.1 Summary

This short narrative is told by an unnamed narrator who begins by trying to justify himself regarding his sanity. He claims not to be mad while simultaneously mentioning a “disease.” He goes on to share his motive for murdering an old man. The narrator mentions that it was neither revenge nor greed or hate that drove him to kill; instead, he was offended by the old man’s “vulture eye.”

He reveals his calculated plan to kill the old man: namely, observing him in his sleep for seven days until, on the eighth day, he finally decides to commit the murder. However, the old man awakens, and after an hour of waiting at his door, the narrator rushes in and throws himself onto the old man, dragging him to the ground. Then he pushes the bed onto him and waits for the man’s heart to stop beating.

As soon as the deed is done, the narrator places the corpse under the floor’s wooden planks. Shortly after, the police arrive and the narrator invites them into his house in a friendly manner. At this point, the narrator does not expect anything to go wrong. He tells the police that the old man left earlier and shows them the empty room and bed. He chats with the officers, but soon his paranoia resumes and he hears the sound of the old man’s beating heart. The narrator grows increasingly nervous and raises his voice to prevent the police from hearing the heartbeat which, according to the narrator, is becoming louder and louder.

Finally, the narrator is convinced that the police are merely toying with him and that they must hear the heartbeat as well, so he confesses his crime and admits that he placed the old man’s corpse under the wooden planks.
9.2 The narrator’s disordered psyche

Similarly to “The Black Cat,” this story starts with the narrator denying his insanity. However, he does use the term “disease,” and claims that aspects of it have actually been beneficial to him. The narrator puts it as follows:

TRUE!—nervous—very, very dreadfully nervous I had been and am; but why will you say that I am mad? The disease had sharpened my senses—not destroyed—not dulled them. Above all was the sense of hearing acute. I heard all things in the heaven and in the earth. I heard many things in hell. How, then, am I mad? Hearken! and observe how healthily—how calmly I can tell you the whole story. (Poe 121)

The way he describes these aspects of his “disease” strongly indicates that he suffers from hallucinations, delusions and paranoia. The narrator goes on to explain that he killed the old man because of his evil eye that resembled a vulture. Thus, as opposed to “The Black Cat,” where rage was the reason for murder and “The Cask of Amontillado,” where revenge triggered Montresor’s crime, the narrator in “The Tell-Tale Heart” kills out of paranoia and magical thinking.52 He states:

It is impossible to say how first the idea entered my brain; but once conceived, it haunted me day and night. Object there was none. Passion there was none. I loved the old man. He had never wronged me. He had never given me insult. For his gold I had no desire. I think it was his eye! yes, it was this! (Poe 121)

Both the narrator’s claim that he has a special gift of hearing and his irrational motive for murder indicate schizophrenia. His auditory hallucinations fall into the category of “positive symptoms,” which together with delusions and paranoia are key criteria for this disorder. The DSM-5 asserts that magical thinking is also common in schizophrenic individuals. The narrator is affected by magical thinking since he senses a threat from a human eye simply due to its unusual appearance – “a pale blue eye, with a film over it” (Poe 121). However, this fear is unreasonable since logically, an eye is non-threatenning, especially

52 In the DSM-5, magical thinking is defined as “a variety of unusual or odd beliefs” (APA 101).
considering that the old man was harmless according to the narrator himself. He argues, “for it was not the old man who vexed me, but his Evil Eye” (Poe 121). Of course, the narrator is unreliable; the reader cannot fully trust his claims.

Another example of the narrator’s magical thinking is the way perceives his capabilities and talents on the night of the murder: “Never before that night had I felt the extent of my own powers – of my sagacity” (Poe 122). He is convinced that he planned the perfect crime and does not even consider that he could get caught.

When the narrator describes how the old man groans in fear that someone might be behind the door, he shares that this feeling of imminent danger is familiar to him. He says, “I knew the sound well. Many a night, just at midnight, when all the world slept, it has welled up from my own bosom, deepening, with its dreadful echo, the terrors that distracted me” (Poe 122). Perhaps he aims to express that due to his “sharpened senses,” which make him hear sounds that are inaudible to others, he himself has also experienced the threatening feeling that someone might be in his house to kill him. Thus, as a result of his auditory hallucinations, the narrator experiences paranoia, which is quite common in individuals with schizophrenia.

Shortly after, the narrator mentions his hyperactive senses again and asks, “And now have I not told you that what you mistake for madness is but over-acuteness of the senses?” (Poe 123). Throughout the story, he tries to justify his actions and wants to portray himself as sane. Admittedly, he does not fit the criteria of disorganization: in some cases, schizophrenics have a hard time planning actions in an orderly manner. Thus, the calculated planning of the old man’s murder would not be typical for the majority of individuals with schizophrenia. However, not all criteria must be met in order to diagnose someone with this disorder.

Right before committing the murder, the narrator mentions that the old man’s heart is beating so loudly that he is afraid the neighbors might hear it as well. He states, “The old man’s terror must have been extreme! It grew louder, I say,
louder every moment! [...] And now a new anxiety seized me—the sound would be heard by a neighbor!” (Poe 123). Again, he shows signs of paranoia, and as a result, he decides he must kill the old man. After finishing the deed, he expresses relief: “His eye would trouble me no more” (Poe 123). The narrator has mentioned this previously, but this statement again indicates his motive. He truly believes the old man’s eye is evil and therefore, to him, the only logical conclusion must be to take the man’s life.

The narrator also shows irony when describing where he hid the corpse: “...no human eye – not even his – could have detected anything wrong” (Poe 123). Additionally, his nervousness seems to be completely gone after committing the murder. The old man’s eye scared and offended him so much that he feels actual relief after killing him. Furthermore, he believes that he no longer has to be afraid. This way of thinking is quite delusional which is, as mentioned, a key sign of schizophrenia. In the narrator’s version of reality, the consequences of murder do not matter since he thinks no one will suspect him. As the police arrive, he argues, “I went down to open it with a light heart – for what had I now to fear?” (Poe 123). And as he describes the police questioning him and searching his house he states again, “I smiled – for what had I to fear?” (Poe 124).

However, his delusional self-confidence changes when he hears a ringing in his ears. At first he cannot identify the sound, but the fact that it gets louder and louder makes him increasingly anxious. The narrator fears and soon assumes that the police must hear it as well. Finally, he breaks down and admits to the unsuspecting police that he killed the old man and hid the corpse under the wooden planks. Lastly, the narrator identifies the sound as the old man’s heart, still beating. One could argue that the narrator’s guilt causes him to hear the beating heart; however, he has had auditory hallucinations before and he does not show other signs of feeling guilty. In addition, up until the end of the story, the narrator appears not to have a conscious at all, because he admits the old man never wronged him. Essentially, a rational person would not kill someone who has never affected him negatively.
As opposed to Montresor in “The Cask of Amontillado,” the narrator of this story does not kill out of anger or revenge. He does not claim that his pride was insulted, and he is not proud of his murder. Additionally, he admits he is nervous on several occasions, which indicates that he is not extremely sure of himself in comparison to Montresor. Thus, he is probably not a narcissist.

Concerning aggression, he does mention some degree of anger when he sees the old man opening his eye, but again, only his irrational fear of the “vulture eye” causes his fury. Additionally, compared to the method in “The Black Cat,” the way in which the narrator kills the old man is not given much importance. Although he aggressively throws himself onto the man, he does not kill him with his hands but instead pushes a bed onto him. There is little mention of blood, and the narration lacks gruesome details. Since he does not portray overly aggressive and violent behavior throughout the story, it can be argued that the narrator does not fit the criteria for ASPD.

In “The Tell-Tale Heart,” Poe presents mental illness as something that causes an individual to act irrationally. Perhaps the narrator’s continuous insistence on his sanity is the biggest indicator that he is actually insane. He does exhibit many symptoms of schizophrenia: hallucinations, delusions, paranoia and magical thinking.
10. “The Raven”

10.1 Structure

“The Raven” is a poem comprised of 18 stanzas, each six lines long. For the most part, it is written in a trochaic octameter, which means that it is made up of eight trochaic feet per line. However, Poe argues that it was his intention for the poem to be a combination of acatalectic octameter, catalectic heptameter, and catalectic tetrameter (Sowa 208). Regarding rhyme scheme, the poem is ABCBBB; when taking internal rhyme into consideration, it is AA,B,CC,CB,B,B. Interestingly, the last stanza is told in the present tense, while the rest of the poem is told in past tense.

10.2 Summary

The poem is narrated in first-person perspective by an unnamed narrator. It is a bleak day in December when the narrator sits by the fire in his chamber and reads a book. The narrator is depressed and thinks about his lost love, who the reader later learns is named Lenore. Suddenly, he hears a tapping on the door and opens it but no one is there. After hearing the tapping a second time he opens his window and sees a raven. The narrator wonders why it sought shelter in his chamber. He speaks to the raven and asks it questions but the bird only answers with the word “nevermore.” The narrator shares that he expects the raven to leave soon, just as his other friends have left him. The bird still only answers with “nevermore.” The narrator then speaks of Lenore and asks the raven if he will ever be free of his grief. The raven again answers with “nevermore.” Although the narrator assumes that the bird merely learned this one word from his previous owner, he still feels mocked since the bird’s reply implies that the narrator will never be able to forget his lost love. Consequently, he becomes enraged and accuses the bird of being a “prophet” and a “thing of evil” (Poe 756). However, the narrator still hasn’t given up on seeking reassurance: near the end of the poem, he asks the bird if he will at least see Lenore again in heaven. Once again, the raven replies with “nevermore.” This answer further enrages the narrator and he shouts at the bird angrily, telling it to
stop hurting him, to leave and return to the “Night’s Plutonian shore” (Poe 754). But the raven does not move. Finally, the narrator says that his soul is trapped under the raven’s shadow and “shall be lifted nevermore” (Poe 754).

10.3 Character analysis – mentally ill due to grief

The general atmosphere of “The Raven” is dreary and depressive. The narrator grieves for his lost love, and by setting the poem on a stormy day “in the bleak December,” Poe certainly adds to the dark and mysterious atmosphere.

Moreover, the narrator himself appears depressed due to the loss of his love. The first line recounts that he “pondered weak and weary” (Poe 754). Another indication of the narrator’s depression due to grief is when he speaks about sorrow: “From my books surcease of sorrow - sorrow for the lost Lenore / For the rare and radiant maiden whom the angels name Lenore” (Poe 754). Defining his low mood as melancholia (or, as it would be termed today, depression) does not negate the fact that the narrator feels this way due to grief. Many individuals with depression cannot identify the reason for their low mood; however, a person suffering from depression caused by grief would be diagnosed with complex bereavement disorder (PCBD).

Persistent complex bereavement disorder is hardly mentioned, let alone properly discussed, in society at large. Individuals who suffer from extremely low mood due to grief have a mental illness much more closely related to PTSD than to major depressive disorder. The depressed state appears as a result of an event such as the death of a loved one, similarly to how individuals with PTSD suffer from flashbacks, panic attacks and depressive episodes as a result of a traumatic event (APA 274 – 276). In contrast, major depressive disorder does not necessarily develop as a result of an external event. Oftentimes, chemical imbalances in the brain are the cause for major depressive disorder. Thus, depression is usually intrinsically triggered (APA 169).

Persistent complex bereavement disorder has only been added to the DSM-5 recently and is thus in the category of “Conditions for further Studies.” As
discussed in section 4.5, PCBD not only has a similar trigger to PTSD but also has a high comorbidity with this disorder (APA 791-792).

Interestingly, the narrator even ascribes depressive and fearful characteristics to inanimate objects, such as the curtain: “And the silken, sad, uncertain rustling of each purple curtain / Thrilled me – filled me with fantastic terrors never felt before” (Poe 754). Thus, one can argue that his grief also causes fear and anxiety, which are symptoms that occur in both PCBD and PTSD. Another example of the narrator’s fear and loneliness is the following excerpt: “Deep into the darkness peering, long I stood there wondering, fearing / Doubting, dreaming dreams no mortal ever dared to dream before; / But the silence was unbroken, and the stillness gave no token,” (Poe 754). The narrator describes the intensity of his mental and emotional pain by stating, “all my soul within me burning” (Poe 754).

In response to the appearance of the raven, the narrator first mentions that it cheers him up a bit: “Then this ebony bird beguiling my sad fancy into smiling” (Poe 755). He asks the raven’s name, but when it replies with “nevermore,” it leaves the narrator confused since he does not understand the meaning of the reply. He assumes that the raven’s “unhappy master” (Poe 755) must have taught it this word. Thus, due to his own grief, he believes that the raven’s previous owner was also unhappy. Shortly after, he demonstrates further signs of negative thinking and dramatization when he says, concerning the bird, “On the morrow he will leave me, as my hopes have flown before” (Poe 755).

As the narrator realizes that the bird is only able to speak the word “nevermore,” his attitude changes. He describes the raven as “this grim, ungainly, ghastly, gaunt, and ominous bird” and states that the bird’s “fiery eyes now burned into [his] bosom’s core” (Poe 755). The narrator ascribes supernatural powers to the bird and humanizes him, implying that the bird replies with “nevermore” as a means of mocking the grieving narrator.

He thinks of Lenore again as he leans back into a cushion that “She shall press, ah, nevermore” (Poe 755): although the raven briefly distracted him from his
grief over Lenore, his obsessive thoughts have begun to haunt him again. He smells a scent in the air and imagines that God sent him “nepenthe” to drink in order to erase the memories of Lenore. Interestingly, in severe cases of PCBD, individuals may experience hallucinations (APA 791) similar to those the narrator describes: “Then methought the air grew denser, perfumed from an unseen censer” (Poe 756). The narrator then encourages himself to consume the imaginary drink by saying, “Quaff, oh quaff this kind nepenthe and forget this lost Lenore” (Poe 756). However, the raven answers again with “nevermore,” implying that the narrator will never be free of his grief.

Consequently, the narrator grows even more furious and accuses the bird of being a “thing of evil! – prophet still, if bird or devil” (Poe 756). He now assumes that the raven was sent from hell. However, the narrator has not completely given up on reaching peace of mind, and asks the bird again, “Tell this soul with sorrow laden if, within the distant Aidenn / It shall clasp a sainted maiden whom the angels name Lenore / Clasp a rare and radiant maiden whom the angels name Lenore” (Poe 756). Once, he only receives a “nevermore.”

The narrator shouts at the raven to leave. He finally breaks down and claims that his soul is trapped beneath the raven’s shadow. The narrator immerses himself in his grief: he has lost the fight for sanity due to his obsession with his lost love.

It can be argued that the narrator displays many signs of persistent complex bereavement disorder. Additionally, it is essential to note that this disorder is not equatable with major depressive disorder since the trigger for PCBD is specifically the loss of a loved one. “The Raven” exemplifies how grief can affect a human being. Furthermore, it shows that in extreme cases, the emotional and mental pain of losing a loved one can turn an individual insane.

10.4 The raven as a symbol of grief

Besides the narrator’s symptoms of persistent complex bereavement disorder, one can also view the raven itself as a symbol of grief. Due to the dark
atmosphere of the poem, the raven is an optimal animal to represent the emotional and psychological pain grief causes. As the narrator is unreliable, the reader never truly knows if the raven is real. Poe may have used the raven as an allegory for and manifestation of grief. Its black color and aura of mystery make it suitable to compare to the negative emotions of grief. Even though it cannot be said for certain whether or not there is an autobiographical relation between Poe and this poem, he did indeed lose the love of his life – his wife Virginia. Thus, Poe certainly is aware what grief feels like since he had to experience the death of Virginia.
11. Conclusion

This thesis examined the ways in which mental illnesses are portrayed in five of Edgar Allan Poe’s short stories and one of his poems.

Since the life and times of Edgar Allan Poe, the study of mentally ill individuals has made tremendous progress with regard to theoretical understanding as well as practical therapeutic approaches. Admittedly, upon comparison to today’s knowledge, there is a stark contrast with how this topic was viewed during 19th century.

Even though Poe had to endure many hardships in life and may have struggled with both alcohol addiction and bipolar disorder himself, it is essential to mention that his literature is not to be viewed as autobiographical. But although his alleged mental disorders were never officially confirmed, one can certainly recognize parallels between the author and his characters – from Roderick Usher’s erratic mood swings or “The Black Cat” narrator’s affinity for alcohol. Again, one must merely rely on and trust information gathered during Poe’s life and reported after his death.

Lastly, it should be noted that all analyses and interpretations of characters and their hypothesized mental disorders were made based on both personal knowledge and opinion, but most of all on professional references: namely, to DSM-5.
12. References


**Quote:**


**Visuals:**


Gyrator https://s-media-cache-ak0.pinimg.com/originals/a9/ab/fe/a9abfe725568112f5d7f2bf8609a2e35.gif/ (2 April 2017).


William Norris http://m1.wyanokecdn.com/2a5c4af72775d0b54632f5eaa71c5348.jpg/ (2 April 2017).
13. Appendix

13.1 Abstract

This thesis deals with the representation of mental illness in selected works by Edgar Allan Poe. It begins with an overview of the understanding and treatment of mental illness in the 19th century, including the abuse mentally ill people often experienced during this period. This is followed by a biography of Edgar Allan Poe, with particular focus on his own mental state and the personal events and tragedies which impacted his life and may have contributed to his early death. The next chapter proposes modern-day diagnoses fitting the symptoms exhibited in a selection of Poe’s works, using criteria from the DSM-5.

The second part of this thesis deals with the critical analysis of five of Poe’s short stories and one of his poems (“The Black Cat,” “The Cask of Amontillado,” “The Fall of the House of Usher,” “The Pit and the Pendulum,” “The Tell-Tale Heart” and “The Raven”). The analysis indicates that the characters who demonstrate traits of mental illness either commit terrible crimes or suffer a complete mental break down by the end of the work. This rather bleak portrayal reflects how mentally ill people were viewed during the first half of the 19th century.
13.2. Deutsche Zusammenfassung
