

Fall 2013

Mental illness, narrative, and rhetorics of recovery

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Mental Illness, Narrative, and
Rhetorics of Recovery

A Project Presented to
the Faculty of the Undergraduate
College of Arts and Letters
James Madison University

in Partial Fulfillment of the Requirements
for the Degree of Bachelor of Arts

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December 2013

Accepted by the faculty of the Department of Writing, Rhetoric and Technical Communication, James Madison University, in partial fulfillment of the requirements for the Degree of Bachelor of Arts.

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Acknowledgments

First, I would like to thank my project advisor, Dr. Traci Zimmerman, for helping me navigate logistics, for being a pillar of support throughout this process, and for inspiring me to study writing and rhetoric in the first place.

Next, I would like to thank the members of my committee, Dr. Scott Lunsford and Dr. Sean McCarthy, for their incisive feedback and extensive support over the past three semesters of research and writing. I would also like to thank honorary committee member Dr. Susan Ghiaciuc for sparking my interest in disability studies and for being a wonderful sounding board as I have explored these ideas.

This fall, I had the opportunity to present a paper adapted from this project at the 24th Annual Conference of the Mid-Atlantic Popular and American Culture Association (MAPACA). I owe this opportunity to the School of Writing, Rhetoric, and Technical Communication and the Honors Program, both of which provided crucial funding. I am grateful to Dr. Ghiaciuc and Dr. Cathryn Molloy for helping me revise my conference paper proposal. I am also grateful to my committee members for helping me get the conference paper itself into presentable shape.

Introduction

Recovery from mental illness is a hotly contested topic. Pro-psychiatric groups like the National Alliance on Mental Illness (NAMI) tout medication as a tool that makes life livable; skeptical groups like Mind Freedom International (MFI) see medication and diagnosis as part of the problem. These conflicting notions of recovery reflect competing models of mental illness, which can be classified into two broad categories: medical and social. People with mental illnesses are often left to find their own way between these poles, trying to reconcile lived experience with binaristic representations of recovery.

In this project, I aim to complicate the binary oppositions that so often inform the discourse surrounding mental illness. First, drawing on concepts from disability studies, I investigate the evolution, implications, and limitations of different models of mental illness. Then, I explore the ways in which narrative works as an imperfect but functional tool to navigate a hybrid path between models. Choosing particular written artifacts as rhetorical case studies, I analyze how advocates mobilize narrative in promoting hybrid visions of recovery. Throughout, I intersperse fragments of my own experience with mental illness that illustrate the complexity of defining, let alone realizing, recovery. I aim to show that binaristic models of mental illness fail to capture the nonlinear, contingent, and—frankly—maddening nature of recovery from mental illness.

Disability Theory and Madness

My primary lens for theorizing mental illness (a term I will use interchangeably with *madness*) is disability theory.¹ Scholars of disability are devoting increasing attention to madness, conceptualizing it as a kind of mental disability. A recent issue of *Disability Studies Quarterly* with the theme “Madness and Disability” exemplifies this trend. In their introduction to this issue, editors Noam Ostrander and Bruce Henderson describe how disability studies can be used “to trouble the borders of normal/abnormal and sane/insane.” In seeking to trace and destabilize popular attitudes toward recovery from mental illness, I hope that my work, too, will trouble the borders of such binaries.

The Medical Model: Recovery as Binary?

Binaristic conceptions not only of mental illness but of disability in general can be traced, in large part, to longstanding medical approaches. Disability theorist Tobin Siebers succinctly summarizes the medical model of disability:

Briefly, the medical model defines disability as a property of the individual body that requires medical intervention. (25)

That is to say, in much medical discourse, disabilities are framed as diseases that must be overcome, or at least battled, through medical treatment. The term *disability*, in this conception, is essentially synonymous with *illness* or *impairment*. The complexity and variety of disabled people’s lives and circumstances tends to be overlooked, with doctors, caregivers, and other would-be allies instead focusing on the “cure or elimination” of the impairment in question (3). In other words, able-bodiedness is defined as the absence of disability. Within a cure-or-

¹ The term *mental illness* implicitly endorses a medical model of the mind; after all, the word *illness* is present in the term itself. Disability scholars, who tend to favor social constructionist rather than medical approaches, therefore prefer to use the term *madness*. I use the two terms interchangeably in hopes of blurring this distinction; after all, my goal in this project is to negotiate a hybrid path between paradigms too often represented as mutually exclusive.

eliminate approach to impairment, ability and disability—and, accordingly, sanity and insanity—are thus positioned as polar opposites.

For much of the twentieth century, medical treatments of mental illness were based on a cure-or-eliminate approach. Chief among these treatments were Freudian psychoanalysis and the lobotomy, a surgical procedure that has since been discredited. The medical doctor and historian Mical Raz has examined how these two treatment modalities, despite their apparent differences, gave rise to a shared, medicalized discourse of psychiatry. She notes that “tens of thousands of lobotomies were performed on Americans in order to treat and *cure* mental illness” between 1935 and 1965 with “very little opposition [from] psychoanalytically oriented psychiatrists” (387, emphasis mine; 388). Indeed, the two modalities operated in tandem; typically, a patient subjected to a lobotomy would subsequently receive psychoanalytic talk therapy. Raz discusses how Walter Freeman, a physician who personally performed more than 3,500 lobotomies, frequently framed his work in psychoanalytic terms. For example, Freeman claimed that during “nearly a quarter of a century” spent performing lobotomies he had “been hunting the Super Ego,” asserting that lobotomy constituted “the solution of the most malignant forms of Super Ego dominance” (Freeman qtd. in Raz 410). By the same token, the psychoanalyst John Rosen compared the “sever[ing] of connections in the brain [i.e. lobotomy] with the severing of the connections between schizophrenics and their mothers” (411). Within this entwined psychiatric discourse, lobotomy combined with psychoanalysis was thus represented as a “solution” or “cure” that eliminated psychological malignancies.

Within public discourse more broadly, the cure-or-eliminate approach exemplified by lobotomy helped to reinforce a sane/insane dichotomy. Diefenbach et al., a group of psychological and media scholars, examine popular reportage on the lobotomy between 1935

and 1960. In earlier coverage especially, the moment at which the patient receives the lobotomy represents a dramatic break between a preceding period of illness and a post-op period of recovery. For example, a news article from 1941 portrays the procedure in glowing terms:

From problems to their families and nuisances to themselves, from ineffectives and unemployables, many... have been transformed into useful members of society. (Kaempffert qtd. in Diefenbach et al. 65)

In this account, recovery from mental illness is nothing less than a transformation. The pre-op insanity of “nuisances” and “unemployables” is contrasted with the post-op sanity of “useful members of society.” A *Time* magazine article from 1942 expresses the same contrast in direr terms, warning that mentally ill people who failed to obtain lobotomies risked an “unchanged psychotic personality leading to complete insanity” (65). Sanity is represented as easily distinguishable from insanity, with medical treatment resulting in complete and recognizable recovery from mental illness.

Contemporary Medicalization: Recovery as Continuum

Today, an epoch of psychoanalysis and lobotomy has given way to an emphasis on psychiatric drugs. The journalist and science writer Robert Whitaker, in his book *Mad in America*, traces contemporary psychiatric practices back to the invention of the antipsychotic Thorazine in 1953. Thorazine seemed to have an unprecedented degree of success in treating the psychosis that can accompany mental disorders such as schizophrenia and manic depression (now known as bipolar disorder). Whitaker questions whether Thorazine and subsequent psychiatric drugs have actually been as effective as they are reputed to be; however, a thorough investigation of the science behind medication would exceed the scope of this paper. What is important from a rhetorical standpoint is that Thorazine and other drugs have, especially since

the '60s, been *represented* as the most effective means of treating mental illness and therefore vital to recovery.

The creation and popularization of the chemical imbalance hypothesis of mental illness serves as the basis for such representations. This hypothesis picked up steam in the '60s, following the invention of the antidepressant drugs iproniazid and imipramine. These drugs, which both worked on the neurotransmitters (brain chemicals) serotonin and norepinephrine, seemed to improve symptoms of depression. Consequently, some researchers theorized that depression was caused by a deficit of those neurotransmitters. As Whitaker writes, "the NIMH's Joseph Schildkraut, in a paper published in the *Archives of General Psychiatry*, reviewed this body of research and set forth a chemical imbalance theory of affective disorders" in 1965 (62). Since then, this theory has become a cornerstone of pro-psychiatric rhetoric. Doctors, as Whitaker describes, regularly draw upon the language of chemical imbalance in explaining psychiatric conditions to their patients and prescribing psychotropic medication (97). The notion that madness is caused by chemical imbalance is invoked in claims that psychiatric drugs treat symptoms by balancing brain chemicals and, therefore, address the root cause.

January 2010

The doctor tells me I've had a panic attack. She says I have a "chemical imbalance." That I may need medication for the rest of my life.

The idea is comforting: With proper treatment, I can manage my feelings. And it feels right. For as long as I can remember, I've been inundated by rhetoric that portrays mental disorders as lifelong, biological illnesses best treated with medication. I think of TV commercials where sad people take drugs and become happy. I'm willing to give it a try.

She prescribes an antidepressant for daily use and Xanax for the bad days.

The contemporary model of the chemical imbalance does ameliorate some of the binaristic excesses of the previous psychoanalytic/surgical paradigm. To begin with, in modern psychiatric practice, the idea of *treating* a root cause is distinguished from *curing* or *eliminating*

the underlying illness. Rhetoric posted on the website of the National Alliance on Mental Illness (NAMI), the largest and most well-known mental health advocacy group in the United States, reflects this distinction. In online factsheets about specific conditions, such as Obsessive-Compulsive Disorder, NAMI recapitulates the medicalized notion that mental illnesses are caused by chemical imbalances that medication can address (Duckworth and Freedman 1). However, in a more generalized discussion of recovery, NAMI does not portray these medications as curing those conditions:

Mental health medications do not cure mental illness. However, they can often significantly improve symptoms and help promote recovery and are recognized as first-line treatment for most individuals. (“Treatment and Services”)

This quotation illustrates how contemporary psychiatric practice is focused on helping patients cope with symptoms rather than promising to eliminate those symptoms entirely. There is a marked difference between claims that medications can “improve” symptoms and “help promote” recovery and the exuberant endorsements of transformative treatment that characterized the era of the lobotomy. Psychiatry today has thus come to conceive of recovery in more measured and incremental terms.

Medicalization and Advocacy Discourse

While contemporary medical practices allow for a continuum of recovery, pro-psychiatric advocates sometimes appropriate medicalized language to promote a more simplified and binaristic view. For example, even as NAMI asserts that mental disorders cannot be cured, the organization distinguishes rigidly between *treated* and *untreated* mental illness in a factsheet called “About Recovery.” The factsheet first defines recovery as “a process, beginning with

diagnosis and eventually moving into successful management of your illness.” To support this definition, the factsheet then frames madness in explicitly medical terms:

Severe mental illnesses are treatable disorders of the brain. Left untreated, however, they are among the most disabling and destructive illnesses known to humankind. [...] Stigma, shame, discrimination, unemployment, homelessness, criminalization, social isolation, poverty, and premature death mark the lives of most individuals with the most severe and persistent mental illnesses. (“About Recovery”)

The statement above is clearly intended to elicit the reader’s interest by raising concern about a “disabling and destructive” societal problem. But it also achieves a subtler aim: By equating “[s]evere mental illnesses” to “treatable disorders of the brain,” the statement above embraces a medical model of the mind.

The factsheet proceeds to present medication as the best available solution to this societal problem:

Science has greatly expanded our understanding and treatment of severe mental illnesses. [...] Newer classes of medications can better treat individuals with severe mental illnesses and with far fewer side effects. (“About Recovery”)

Recovery, having been explicitly defined as “successful management of your illness” and implicitly equated to medical treatment, is here represented as a fairly straightforward matter of compliance with a medication regimen. The “disabling and destructive” effects of mental disorders “left untreated” are contrasted with the ostensibly scientifically-validated healing power of psychiatric drugs. This treated/untreated dichotomy reiterates the sane/insane—i.e. abled/disabled—binary that disability studies seeks to complicate.

But what if “recovery” is sometimes more complicated than simply complying with a medication regimen? What if medication sometimes makes the patient worse? And, regardless of how effective medical treatment may be for some patients, what effect does the medical model have on the identity formation and rhetorical participation of mad people as a whole?

*August 2011
(Xanax withdrawal: month 4)
The inside of my skull is boiling
when I dart outside for a run. The air is
so heavy and wet it sticks to my lungs.
I think about heading back inside to
use the treadmill instead, but I'm afraid.
When I use the treadmill, I have to pay
careful attention to the numbers on its
display screen: distance traveled, time
elapsed, calories burned. If the digits of
those numbers don't add up to
particular sums, then something horrible
will happen.*

Binaries, Oppression, and Identity Politics

Historical medical practices, along with some contemporary medicalized discourse, uphold binaries that distinguish rigidly between sane and insane, treated and untreated. Siebers discusses how such attitudes, which he conceptualizes as an “ideology of ability,” work to exclude disabled people from full and equitable participation in public discourse (7). The ideology of ability “alienates the individual [with disabilities] as a defective person” (72). This alienation is particularly pronounced for mad people. After all, per NAMI’s aforementioned “About Recovery” factsheet, mental disorders are widely considered to be “destructive,” a stigma that reinforces the sane/insane binary. Siebers argues that this kind of alienation hinders “the ability of people with disabilities to organize politically” (72). Due to its size, funding, and institutional heft, a group such as NAMI exerts extensive rhetorical influence in propagating sane/insane and treated/untreated binaries. By contrast, due to these very dichotomies, it is difficult for mad people to form advocacy groups of their own or otherwise participate in discourse.

Despite some progress, then, the medical model continues to prevent disabled people from identity politics effectively and, consequently, has a dehumanizing effect. Siebers observes that "it is extremely unlikely [in this model] that a blind person will *be allowed* to take a leadership position in the blind community, let alone in the sighted community" (72-73, emphasis mine). Notice the words "be allowed"; rather than disabled people choosing their own leaders, nondisabled caregivers and other allies are privileged as decision-makers. PhebeAnn Wolfram points out a similar way in which medicalization impedes mad activism specifically:

Mad people's political affiliations (for example, choosing to take part in a public protest) [...] can similarly be framed as symptoms within the context of having been given a psychiatric diagnosis.

Relative to disabled people in general, mad people thus face a unique burden in trying to organize politically: Activism can itself be construed as a symptom and, on those grounds, their rhetoric can be excluded from public discourse. The rhetorician and disability scholar Catherine Prendergast points out that this sort of exclusion denies full rhetorical citizenship and, indeed, personhood to mentally disabled people ("On the Rhetorics" 57). Overall, such rhetorical disenfranchisement illustrates how, although psychiatry has made some progress toward conceptualizing recovery as a continuum, medicalized binaries retain enduring discursive force.

The Social Model

In order to combat such oppression, disability scholars have tended to favor social constructionist rather than medical perspectives. Siebers positions the social model in opposition to its medical alternative:

The social model opposes the medical model by defining disability relative to the social and built environment, arguing that disabling environments produce disability in bodies and require interventions at the level of social justice. (25)

In this model, a state of disability is not a quality of an individual body but rather a question of context. Disability becomes re-imagined as a social construct that emerges out of interactions between people and their built and social environments. Consider a person who has a vision impairment. The social model would argue that myriad architectural and social features of that person's surroundings actually create his/her state of disability. Architecturally speaking, crosswalks with visual but not auditory cues would make it more difficult for that person to get from place to place independently; socially speaking, discrimination in hiring continues to this day (Kwoh). Within an accessibly-designed context, that person would cease to be disabled.²

Social constructionists, then, do not endorse an abled/disabled binary, for they do not deem bodies to be either inherently able or impaired. Rather, they stress the need to redesign inaccessible environments and reshape prejudicial attitudes in order to create a more equitable society for people of all bodies. That is to say, they take a social justice approach rather than a cure-or-eliminate approach. Social constructionists recognize how what the disability theorist and literary scholar Rosemarie Garland-Thomson calls the “opposing twin figures” of abled and disabled—for our purposes, sane and insane—work together to “legitimate a system of social, economic, and political empowerment” that privileges the abled and sane (Thomson qtd. in Lewis 116). The social constructionist goal is to destabilize these dichotomies and build more accessible environments for all people.

² Siebers provides a historical illustration of how the social environment can determine whether a condition is disabling or not: “Deafness was not, for instance, a disability on Martha’s Vineyard for most of the eighteenth century because one in twenty-five residents was deaf and everyone in the community knew how to sign. Deaf villagers had the same occupations and incomes as hearing people (Shapiro 1993, 86)” (74).

Social constructionism creates a space where disabled minority identities can thrive. In Siebers's account, the social model has "changed the landscape of thinking about disability because it refuses to represent people with disabilities as defective citizens and because its focus on the built environment presents a common cause around which they may organize politically" (73). People with disabilities, organized around this common paradigm, have come together to form politically potent identity groupings. Such organization has resulted in important successes. By practicing identity politics, disabled people have secured legal protections such as the Americans with Disabilities Act (ADA) and begun to make headway against discriminatory environments and attitudes.

Social Constructionism and Mad Pride

One model of madness closely related to the social model of disability is the Mad Pride movement. Mad Pride, it should be noted, is not a monolithic bloc but rather a coalition of activists who self-identify in different ways. The three most notable identity groupings within Mad Pride are consumers, survivors, and ex-patients, which in conjunction are referred to as C/S/X. Consumers do not call for our current mode of mental health treatment to be abolished altogether but advocate reforms to reduce coercion and increase choice. Survivors and ex-patients, meanwhile, emphasize the harm that psychiatric treatment can cause, pointing to medical and judicial coercion as well as the debilitating side effects and withdrawal symptoms that can result from use of psychiatric drugs.

The disability scholar Bradley Lewis reviews the history of Mad Pride. He situates its origins during the 1970s in relation to other social justice activism, particularly the disability rights movement. "Early founders of the movement," Lewis writes, "shared common experiences of being treated with disrespect, disregard, and discrimination at the hands of

psychiatry”; meanwhile, activists in the burgeoning disability movement also expressed discontent with callous and dehumanizing medical treatment (118). These common origins reflect common goals.

In subsequent decades, though, the two movements have grown apart. Building on Lewis’s research, Nev Jones and Robyn Lewis Brown, scholars of disability and madness, discuss persistent tension between the fields:

[T]he historical and sub-cultural trajectories of the consumer/survivor/ex-patient (c/s/x) and disability rights movements have diverged significantly, and individuals involved with both movements have at times accused each other of implicit ableism or saneism.

One point of contention is that C/S/X perspectives remain underrepresented in academe—even within disability studies itself. Another more fundamental issue is that services for mental health users and people with other disabilities “have developed independently of one another, draw on different private and federal funding sources, and employ clinicians and providers with divergent training and disciplinary backgrounds.” These different social landscapes result in different sorts of lived experiences for mad people on the one hand and people with other kinds of disabilities on the other.

Still, reflecting the intersections of these two fields, C/S/X advocacy draws on many of the same concepts and arguments as the social model of disability. Like disability activists, Mad Pride activists speak from a social constructionist standpoint to refute medicalized binaries and ableist/saneist privilege. Jones and Brown observe that “criticisms of biomedical and cognitivist models of mental illness are consistent with the repudiation of medical and moral models of disability in favor of broadly social models that acknowledge social, cultural and structural

forces.” As C/S/X discourse points out, much of the distress associated with madness actually stems not from the symptoms themselves but from stigma, shame, lack of employment opportunities, and other factors in the built and social environment. Hence, as Jones and Brown argue, “disability studies can clearly provide a forum for discussing issues concerning psychiatric disability or diversity.”

January 2011

The Xanax starts to have bad side effects. Now that I'm taking the drug every day, people are telling me that my personality has changed. I seem "foggy" and irritable; I'm forgetting things. And, although I don't yet know it, my brain has become physically dependent on Xanax.

Although potential coalitions of c/s/x and disability activists are still emerging, the Mad Pride movement has attained vital victories of its own. Lewis writes that a turning point for the movement came in 2003: a hunger strike targeting a trade organization for psychiatrists during which

participants “demanded evidence that mental and emotional distress results from ‘chemical imbalances’ in the brain” (115). After initially stonewalling, the American Psychiatric Association (APA) replied in writing that “brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathological lesions or genetic abnormalities that in and of themselves serve as a reliable or predictive biomarkers of a given mental disorder,” a response that, like the strike, was widely reported in national media (APA qtd. in Lewis 124). Following this admission from the APA, Mad Pride activists leveraged their national stage to defeat planned budget cuts to peer support products. By framing mental disorders not as defects of the individual but as forms of socially-constructed oppression, Mad Pride has created a discourse within which mad people can claim minority identities for themselves and practice the kind of identity politics that Siebers envisions.

MindFreedom Advocacy: Reductivist Recovery

Social constructionism is far from a panacea, and Mad Pride does not offer a perfect fit for every mentally ill person. Socially-oriented advocacy rhetoric can at times lapse into reductive, wholesale dismissal of medical models of treatment. Online advocacy literature created by the Mad Pride organization MindFreedom International (MFI) exemplifies this risk. For example, on a Frequently Asked Questions page, MFI makes a sweeping statement about psychiatric diagnoses:

[Diagnostic] labels are words that are put on others without their permission.

MindFreedom helps turn the tables. For more than a decade, MindFreedom has helped promote and network groups and individuals who celebrate "Mad Pride."
(“MindFreedom”)

Diagnoses of mental disorder can certainly be used oppressively; as Wolframe notes, political or religious involvement is often seen as suspect in the context of a mental health diagnosis. On the other hand, many people choose to seek a diagnosis following months or years of severe distress and, upon being diagnosed, use their “labels” to obtain appropriate medical treatment, accommodations, and other positive valences. The blanket statement that diagnoses are “words that are put on others without their permission” fails to consider the complex, nuanced, and varied circumstances in which different mad people live. Indeed, the “consumer” aspect of C/S/X recognizes that many mad activists continue to draw on medication, therapy, and other medical approaches to recovery. One tool for recovery that epitomizes this medical/social blending is narrative.

December 2009

My heart is throbbing so hard that I think it will force its way out of my chest. The physical sensations are scary—the racing heart, the gasps for air, the trembling of my hands.

But the really scary part is that I think I'm having a heart attack. I'm convinced that I'm about to die.

Why Narrative?

Narratives can offer further insight into medical and social conceptions of recovery and into potential intersections of the two paradigms. Interestingly, medical and social perspectives alike vest narrative with purported therapeutic power. In both paradigms, the act of writing one's story is seen as potentially healing, while reading a firsthand account of madness is presumed to offer insight into the experience. This preoccupation with narrative reveals a fundamental flaw in both models: a desire to structure, to order, to *fix*. Furthermore, rhetors working within both medical and social models often share personal stories to promote particular visions of recovery. Accounts of personal experience thus function in multiple, intersecting ways to codify assumptions about and approaches to recovery from mental illness.

Narrative as Healing Rhetoric

Narrative is often represented as a kind of rhetoric uniquely vested with healing potential for both rhetor and audience. For example, people with mental illnesses are often encouraged to keep journals in the context of medical treatment. In Dialectical Behavioral Therapy (DBT), one of the most popular treatment modalities for mental disorders, patients track their symptoms and coping techniques day-to-day using worksheets and diary cards. This kind of quotidian self-narration is presumed to be helpful to patients in studying and managing their symptoms (Koerner and Linehan 84). By the same token, friends and relatives of mentally ill people, along with clinicians in training, are urged to read firsthand accounts of madness in order to understand better their loved ones' or patients' conditions. The medical doctor and literary scholar Stephen T. Moran, looking at narratives of depression by Hemingway and other notable authors, writes that "it may be helpful for clinicians to study narratives of illness" because such narratives convey the "heterogeneity" of patients' lived experience (79). He coins the term

“autopathography” to describe life-writing about illness. In these contexts, autopathography is represented as a tool that helps patients to manage their own symptoms and that assists others in supporting patients.

The rhetorician Jacqueline Rinaldi echoes this view, portraying narrative as a kind of therapeutic knowledge production. She proposes a "therapeutic rhetoric" based on her experience helping seven students to write about their "struggles with disability" (822, 825). She writes:

Though writing and revising narratives of disability could not restore the crippled bodies of these writers, the insights learned from the heuristics of writing did seem to have therapeutic value for those grappling with the darker issues of chronic illness. (831)

In Rinaldi's account, narrative's benefit to disabled people is that it assists them in coming to terms with their symptoms and gaining "insights" into their conditions. Implicitly, then, the disabled writers must have *lacked* insight prior to writing their narratives. It would seem that lived experience is not sufficient, in itself, to generate knowledge; it must be reflected upon—ordered—fixed in writing.

Rinaldi's argument comports with the work of the rhetorician Jim Corder, who contends that narrative is essential to the formation of *all* knowledge. He argues that, "[w]hether consciously or not, we always station ourselves somewhere in our narratives when we use language" (17). In turn, he presents all knowledge as dependent on language; writing with James Baumlin, he characterizes knowledge as "language-based" and "language-bound" (Corder and Baumlin 465). If language use always emerges out of narrative, and if knowledge always originates in language, then all knowledge stems from narrative.

Within a framework where all knowledge is narrated, all knowledge must also be subjective. Accordingly, Corder and Baumlin exhort scholars to eschew methodologies that aspire toward objectivity; they argue that true objectivity is neither possible nor desirable. In hewing to methodologies that produce "fact papers" rather than "opinion papers," scholars assume a rhetorical posture of objectivity, but the production of knowledge remains inherently subjective (464). Corder and Baumlin call for academic inquiry to be re-imagined around the principle that "as opinion derives from research, research is opinion; research is, at every stage, interpretation" (465). In breaking down the barriers between research and opinion—between knowledge and interpretation—scholars can liberate themselves from "the tyranny of certain models over our conception of fact and knowledge" (469). So-called "objectivity," in this reading, is not conceptualized as an avenue for discovering capital-*T* Truth. Rather, objectivity is reframed as an ideological mode of knowledge-production that valorizes itself by dismissing competing modes as "opinion."

Corder and Baumlin are hardly the first scholars to challenge notions of objectivity; nor have they been the last. Unlike other critics in this vein, however, their description of subjectivity as necessarily narrated lends an interesting perspective to portrayals of autopathography as a mode of healing. In both Rinaldi's and Corder and Baumlin's work, narrative structure is presented as an ideal mode for producing and ordering subjective knowledge, a process resulting in healing. Looked at in conjunction, then, the perspectives of these rhetoricians evince a worldview where language, narrative, knowledge, and healing are inextricably intertwined. Though narrative cannot, as Rinaldi acknowledges, mend "crippled bodies," might it not be beneficial for mental disorder?

Problems with Narrating Mental Illness

Prendergast raises a fundamental issue with attempts to prescribe narrative as a tool for recovering from madness: People with certain mental disorders may be incapable of constructing coherent narratives, or at least narratives that are recognizable as such. She questions “the therapeutic value of rich, descriptive, and ambiguous narratives,” especially for people with conditions that interfere with normative language use, noting that “too often [these narratives’ therapeutic] value is assumed” (“On the Rhetorics” 55). These kinds of narratives, especially in the case of a disorder like schizophrenia, reflect exceptional experiences. Prendergast argues that a typical or “unexceptional” experience of madness is likely to be characterized by fluctuating circumstances and degrees of impairment (“The Unexceptional Schizophrenic” 61). The desire to fix mad experiences with narratives reflects that “the public does not want to allow for fluctuation between states, and even less for the possibility that both states exist at once” (61).

Corderian notions of narrated subjectivity become troubled within this frame. While a writer reflecting on a past experience of depression may be able to write cogently and vividly, a writer in the midst of florid psychosis is unlikely to be capable of the same. The idea that narrative is central to subjectivity therefore borders on saneism; the internal lives of people with language impairments are conceptualized as being less generative of knowledge. Within a strong Corderian paradigm, where knowledge and narrative are seen as essentially synonymous, people incapable of normative narration could be characterized as lacking any knowledge at all!

More insidiously, readers of firsthand accounts may not realize that they are only being exposed to a narrow subset of mad experience, which reinforces ableist and saneist assumptions. Disability scholar and rhetorician Margaret Price examines the “hegemonic history” of the autopathography. Responding to Moran’s piece, she notes that “Moran selects for attention only

‘unusually articulate’ and quite canonical ‘sufferers,’” reflecting a larger societal tendency to focus on conventionally articulate stories of extreme mental states (178). Writers with more profound language impairments, or whose experiences resist linguistic expression, may lack reliable Web access and a safe place in which to write, let alone the ability to publish in print form a memoir about mental illness. Perhaps the problem is that readers expect such a degree of comprehensibility and structure when reading narrative. These complications speak to the potentially oppressive effects of assumptions—per Rinaldi and Corder and Baumlín—that subjectivity should be structured in order to count as knowledge.

Because such a limited range of mad people’s lived knowledge is able to find linguistic expression, the narratives that do get written represent a skewed sample—one that runs the risk of recapitulating harmful binaries. The people who do write “unusually articulate” accounts of madness tend to be those who either respond well to medication or whose symptoms resolve on their own; people contending with ongoing symptoms of mental illness are more likely to find articulate self-expression beyond their grasp.

Another fundamental issue with the notion of therapeutic narrative is the presumption that structured subjectivity—an ordered self, fixed in writing—is desirable in the first place. Siebers helps to complicate this presumption in describing the body as “vital and chaotic,” asserting that it “possess[es] complexity in equal share to that claimed today by critical and cultural theorists for linguistic systems” (26). The body, in this account, becomes a set of systems vested with complexity and significance that precede, inform, and rival language use. Unlike the written word, the body is not fixed and linear, but rather “chaotic.”³ The idea of the

³ Of course, many scholars would dispute whether the written word is necessarily fixed and linear. The same caveat applies to narrative in particular. For example, Ochs and Capps—like Corder—examine narrative as a lived process, finding that children are especially likely to produce “nonlinear narratives” (88). Moreover, narrative need not be reduced to the written word alone; Wolf discusses how video games present dynamic, “maze”-like narratives using

body as capable of signification *even absent language* provides a welcome counterpoise to Corder and Baunlin's theory. Indeed, Siebers criticizes the limitations and inflexibility of theorists who interpret "nearly all symbolic behavior in strictly linguistic terms" (2). He positions this critique within a larger argument about the potential for disabled bodies to exert rhetorical force—an argument to which I will later return. For now, suffice it to say that disability theory allows for lived knowledge that transgresses norms in ways so fundamental as to resist linguistic expression.

Ethos in Tatters

From my story—depending on how I might tell it—you might take away that I was a non-compliant patient and serial medication-quitter. Or you might see me as a melodramatic malingerer, someone who overreacted to adolescent anxiety.

Was I never really all that sick? Or am I still sick and in denial? Maybe I do need medication. Maybe I will need medication.

What do I know about mental illness? I'm not objective. I'm not fair. I'm (chemically?) imbalanced.

“visual grammar” (109, 94). However, as Prendergast argues, subjectivity is strongly associated with the ability to speak and write in conventionally coherent ways, and conventions of coherence privilege linear, fixed storytelling.

Mobilizing Narrative

Apart from its purported therapeutic benefits, narrative is regularly deployed in defense of various notions of recovery from mental illness. The narratives examined below should not be considered representative of mad people's experiences; as discussed above, only a limited and atypical subset of mad people produce conventionally articulate autopathographies. Nor should each story even be considered representative of all narratives deployed in service of a given model. Mad people ascribe to different visions of recovery for so many different reasons, within so many different circumstances: Some use medication; some do not; some suffer debilitating withdrawals from that medication; some endure terrible trauma; and issues of gender, race, class, and other social factors inflect all of these experiences.

I do not intend for the narratives examined here to serve as referenda on entire models. Indeed, though each narrative does stress either a medical or social perspective, each draws on elements of the opposite perspective as well, showing how models tend to blend in practice. Rather, these two stories are intended to serve as rhetorical case studies. The purpose of these case studies is to show how autopathography, as a form for codifying lived knowledge, requires rhetors to make choices that artificially order and fix experiences of madness. These particular narratives were selected because, in assigning order to their experiences, the writers reinforce troubling binaries.

Recovery As Coping and Compliance: The Treatment Advocacy Center's Medicalized Narration

The Treatment Advocacy Center (TAC), founded by psychiatrist E. Fuller Torrey in 1998, favors aggressive medical treatment of mental illness. The group advocates a mode of treatment known as Assisted Out-Patient (AOT), which enables states to compel mentally ill people to obtain treatment without actually committing them to institutions. TAC favors this kind

of forcible treatment because it considers the decision not to take medication to be, itself, a symptom of mental illness. This kind of catch-22 is similar to what Wolframe describes, where mad people's political affiliations and other choices are sometimes dismissed as mere symptoms.

TAC's rhetoric makes frequent references to "recovery" from mental illness. In a post titled "Medication: The Foundation of Recovery," Edward G. Francell, Jr.—a former member of the TAC Board of Directors who himself "suffers from manic-depression [bipolar disorder]"—describes his own experience and encourages others to obtain medical treatment. He uses his story to argue that compliance with a medication regimen is indispensable in recovery from mental illness.

Francell begins the essay by defining mental illness in terms that guide readers to a particular vision of recovery:

For many consumers, proper medication management can provide the necessary foundation for recovery from neurobiological disorder (mental illness).

In equating "mental illness" to "neurobiological disorder," he frames mad experience in medical terms, setting up "proper medication management" as the primary mode of treatment. As when the National Alliance on Mental Illness equates "mental illnesses" and "brain disorder," the framing of mental illness as "neurobiological disorder" sets up an essentially foregone conclusion that meds are the best response: It is only natural to assume that medical treatment is the optimal response to a medical problem. Francell's description of "proper medication management" as the "necessary foundation for recovery" fits naturally into his medicalized definition of madness.

Francell returns throughout the essay to a theme of "compliance" and stresses social support as a means of ensuring compliance. For example, he recommends support groups on the

grounds that they help “keep you [the patient] compliant [with medication].” By the same token, he suggests to family members and other allies that “good-natured pestering can help compliance.” These recommendations evince a curious infusion of social concerns into medical modality. Social factors become incorporated into medical treatment, combined into a rhetoric of recovery-as-compliance.

Francell’s definition of recovery reveals a similar hybridity. He repudiates the cure-or-eliminate attitude of older medical approaches, writing that “[r]ecovering does not mean getting rid of the illness.” Nor does he blinker his vision of recovery by limiting it solely to the medical realm. While med compliance may be the “foundation” of recovery, he envisions the process as involving much more than simply symptom management. To Francell, recovery means “gaining back a sense of control, a sense of purpose in life.” In discussing the complex and incremental nature of such recovery, he even incorporates tenets from the social model of disability, referring to “the years lost to the illness, the loss of friends, societal stigma, and the pain of being ill itself” as “secondary disabilities.” Disability, here, is not being defined purely as biomedical impairment but as a mix of biological and social factors. In treating this kind of disability, psychiatric treatment represents a starting point, but social factors cannot be neglected.

Francell cites his own story to develop this hybrid vision of recovery. He writes:

I moved in and out of the hospital from about age 18 to 22, and “field tested” about 10 drugs in the process, until a second opinion found me a stabilizing medication. It was then that the slow process of recovery actually began.

Francell’s lengthy journey deserves respect and illustrates the benefit that some mad people do realize from medical treatment. At the same time, he describes profound side effects that complicate the cost/benefit analysis. For example:

Dystonia is a drug reaction that can be very subjectively unpleasant, where the throat muscles become rigid, like a powerful invisible force grabbing you by the neck and holding you off the ground. Dystonia scared the hell out of me, and made me feel helpless, rather like falling into quicksand.

Another side effect approaches potentially life-threatening levels:

[L]ithium once caused me to drink so much water it was backing up my esophagus and I was literally drowning

Francell describes these side effects as “controllable” and credits medication with his ability to function day-to-day. He also thanks his mother for helping to make sure that he continued taking his meds even when side effects were hard to tolerate. Recovery is thus represented as a complex calculus where symptom management, side effects, and social support must all be weighed.

Francell, then, writes honestly and vividly of both medical challenges such as symptoms and side effects and social challenges such as stigma. However, despite this blended approach, his autopathography does reinforce a treated/untreated binary. In terms of the content of the story, Francell represents treatment as so crucial—so vastly preferable to untreated madness—as to be worth the risk of drowning one’s own lungs in retained fluid. The placement of Francell’s text on the TAC website also reinforces this binary. Francell’s position as a patient who responded relatively well to medication is what enables him both to write an articulate story in the first place and to share his story on the TAC’s website; because his lived experience of madness comports with TAC’s agenda, he is given a platform to share it.

Francell’s story, like the rhetorical theories of Rinaldi and Corder and Baumlín, frames mental illness as something to be *fixed* in multiple senses of the word. At one point, he quotes an unnamed “consumer with schizophrenia”:

I once knew a consumer with schizophrenia who had a lot of restlessness, or a side effect called akathisia, who made the greatest statement about side effects I have ever heard. He said, “When I look good, I feel bad. When I look bad, I feel good.”

The subjective unpleasantness of dystonia or akathisia, in this account, is preferable to untreated schizophrenia, further reflecting the treated/untreated binary. Moreover, the ability to function socially—to “look good”—is privileged over a patient’s internal world. The chaotic subjectivity of untreated mental illness is implicitly framed as needing to be structured—through medication, narrative, or perhaps a combination.

April 2011

After three months, the Xanax isn't even helping me to sleep anymore. I lie awake for hours every night, my mind crawling, my feelings flat.

When I tell the doctor that the Xanax isn't working any more, she says there are still antidepressants we haven't tried yet.

I walk out. I'm done. That night, I stop taking my meds.

Recovery As Overcoming: Ron Unger’s Social Constructionist Perspective

Ron Unger, a licensed clinical social worker, runs a site called *Recovery from “Schizophrenia” and Other “Psychotic Disorders.”* Unger is a longtime MindFreedom International (MFI) activist who promotes a vigorously social constructionist model of recovery. His notion of recovery eschews the measured and incremental outlook of contemporary psychiatric approaches; recovery, in Unger’s account, becomes a matter of discarding oppressive psychiatric labels and embracing mad experience. As a result, though, Unger’s vision veers toward an ableist cure-or-eliminate approach, reflecting a problematic theoretical underpinning reminiscent of older medical practices.

Unger’s use of scare quotes in the site’s title around the words “schizophrenia” and “psychotic disorders” immediately suggests his skepticism toward formal diagnostic categories.

This rhetorical strategy works to situate Unger's narrative within social constructionist advocacy, reflecting Mad Pride hostility toward the idea of mental disorders as discrete disease entities.

Indeed, in a list of "Questions and Answers about Recovery" posted on the homepage, Unger explains why he uses the scare quotes:

It often helps to see words like "schizophrenia" as just labels that psychiatrists use when people have certain experiences and behave in certain ways [...] Recovery is often facilitated when people focus directly on how to manage this stress and how to reconsider their points of view and change their communication and their behavior, rather than trying to fight or escape from some abstract entity such as their alleged "schizophrenia."

Psychiatric diagnoses, in Unger's reading, are subjective constructs rather than diseases. It is unsurprising that Unger, as an MFI activist, would echo MFI's distrust of labels in his narrative

What does it mean to recover from a construct? Unger gives a definition of "recovery" markedly more optimistic and transformative than Francell's:

Recovery means having regained a meaningful life, no longer having a mental health diagnosis, and no longer being in need of any sort of mental health treatment.

Unger contrasts his definition with "the definitions used by some who suggest that recovery should be thought of as learning how to have a better life, while continuing to be mentally ill and needing treatment such as medications." He proceeds to note that "full recovery is just a possibility, not a requirement that anyone must fulfill in order to have a meaningful life"; without condemning the decision to take meds, he offers the reader an alternative. His vision repudiates

contemporary psychiatric practices oriented toward incremental improvement and, to some readers, could provide an infusion of optimism.

More darkly, this conception of recovery is reminiscent of effusive press coverage of medical treatment during the lobotomy's heyday and takes on ableist overtones. In short, Unger envisions the cure and elimination of mental illness. Despite Unger's protest that full recovery is just a "possibility, not a requirement," the notion of "continuing to be mentally ill" is presented as inherently less desirable than that of recovering fully. He explicitly describes mental disability as inferior to nondisability by referring to persistent experiences of madness as "lesser degrees of recovery." In making these rhetorical moves, Unger portrays disability as something to be overcome rather than a valuable form of diversity.

In sharing his story, Unger further develops this portrayal of recovery as overcoming. He traces his own experiences of madness to childhood trauma and reports that, in his senior year of high school, he started "getting a bit 'grandiose' or even 'psychotic'" ("Personal Steps"). The details of what Unger's "madness" actually entailed are sparse; he focuses primarily on the positive social and intellectual ramifications of being "creatively mad," writing:

I was fortunate enough to find people who could see me as "mad" in an interesting kind of way, and who had their own interest in challenging personal and cultural identity. ... I learned it was possible to challenge the limits of everything we thought we knew, and at the same time think systematically.

Unger's first experience with medical treatment came when he "sought counseling in [his] 30's to deal with unresolved trauma issues." He does not report ever having used psych meds himself, much less having been forced to accept treatment or incarcerated. Rather, he bases his vision of recovery on years of experience as a social worker who took on "a role of supporting people to

make their own thoughtful evaluations of the use or non-use of medications” and on decades of activism with groups such as MFI. His own madness, he writes, occurred within “a safe container”—a quality conspicuously absent from many others’ experiences (including Francell’s), which may be characterized by persistent distress as well as the threat of confinement.

Although shot through with veins of ableist sentiment and based on a somewhat privileged ideal of safely-contained madness, Unger’s narrative does evince the liberatory potential of *Mad Pride*. His challenge to diagnostic categories fits into a broader agenda of social reform: Rather than endorsing medicalized modes of classification and treatment to manage individuals’ impairments, Unger focuses on the role of social context in constructing mental disability. As a solution, he calls for the creation of discursive spaces where diverse ways of thinking and feeling are valued and madness can be safely experienced.

Unger’s vision of recovery fits into a frame where mad minority identity thrives. But is it practical? As someone who was harmed by psychotropic medication and no longer takes any meds, I initially found his vision to be immensely appealing. The problem, though, is that living post-meds has turned out to be messy—too messy for a narrative of overcoming, however uplifting, to capture. On days when my anxiety has kept me awake for two days in a row, for example, I’m less concerned with the question of etiology—of whether my symptoms are biomedical or socially constructed in nature—and more concerned with how to cope. I value my medication-free life, and claiming a minority identity as a mad (rather than *sick*) person has been instrumental to me as I’ve built that life. Quitting meds and moving beyond a strictly medical paradigm has helped me to reconceive of my experience—to find value and lived knowledge in

my non-normative ways of thinking and feeling. Yet my symptoms are still distressing, and they have not been eliminated. I have not been cured.

Indeed, to many people living with mental illnesses, Unger's vision seems more like a mirage. A conversation posted on the blog *Malingering Normal* between Unger, an ex-patient named Mary, and madness scholars Nev Jones and Timothy Kelly speaks to the limitations of "full recovery." Kelly and Jones argue that Unger's experiences are not representative of mad people generally. Jones asserts that a fleeting "psychotic-like" experience cannot meaningfully be compared to "enduring, repeated psychosis—including very acute/florid forms." Kelly writes that any such comparison is akin to comparing "apples and fire engines."

Reading this conversation, I become more conscious of my own standpoint. Although I had anxiety before starting Xanax, my more "severe symptoms"—to rely again on medical terminology—only flared up during the withdrawal. Even as I endured frightening changes, I did so with the assurance that my perceptions would with time return to what they had been. My thoughts and feelings, in this frame, always seemed explicable and transient—in a word, "safe." Though my anxiety lingers to this day, and though I wrestle with the distress it causes, I feel secure in the knowledge that even the most exhausting bout of insomnia or intrusive thoughts will pass.

The experiences described by Kelly and Jones lack this quality of safety and security. Kelly writes of having "struggled with ongoing psychotic episodes beginning in adolescence that have continued to recur in spite of trying many different things." Jones writes as "someone who

July 2011

(Xanax withdrawal: month 3)

I took comfort. The things I was experiencing—the perceptions so unlike any I had ever had before—would not be permanent. They were the product of a temporary disturbance in my biochemistry, one that researchers had identified, studied, and defined. I was able to separate myself from my terrifying perceptions, to conceptualize part of my mind as other, as alien, as disease.

has now been 'in the system' for 8 years, with on-going psychosis, and experience of multiple forms of voluntary, involuntary and self-initiated treatment, discrimination, etc." Neither my experiences nor Unger's can speak to this sort of persistent distress.

I am reminded, uncomfortably, of the problems with disability immersion. The idea of immersion is that a nondisabled person can, by temporarily simulating an experience of impairment, come to a deeper understanding of what it's like to live with a disability. Elizabeth J. Donaldson has discussed immersion in the context of psychiatric disabilities. She describes how, starting in the 1950s, mental health professionals ingested LSD in an attempt to simulate psychosis. These researchers' experiences were well-intended attempts to become more empathetic toward schizophrenic patients. Yet this kind of empathy should not be confused with a genuine understanding of mad people's lived knowledge. During an immersion experience, the certainty of a "return to 'normal perceptions and thoughts' and the distance from the threat of insanity" differ fundamentally from the reality of many psychiatric disabilities. To claim a familiarity with madness based on an immersion experience would be to appropriate a minority identity from a position of privilege.

My withdrawal experience, though rather more protracted than a one-day trip on LSD, arguably acquired the defining characteristic of a disability immersion experience: the assurance of transience. The same might be said of Unger's narrative, in which he describes "exploring madness within a safe container." The problem with a "safe container" is that it is not truly immersive. For me or Unger to generalize would be simplistic at best and, as Kelly writes, "offensive" to mad people whose experiences have not been so safe.

Navigating Recovery Between and Beyond Models

The hybridity given voice in Francell's and Unger's stories points to a promising way forward. While these stories incorporate different models in problematic ways, they do suggest the potential of narrative to mediate between contending paradigms. The next step is to find a way of destabilizing binary oppositions that does not fix and structure experiences. Siebers's concept of *complex embodiment* offers a framework for supra-linguistic hybridity.

Complex Embodiment

Siebers introduces this concept by describing the shortcomings of both medical and social models of disability: "Some scholars complain that the medical model pays too much attention to embodiment, while the social model leaves it out of the picture" (25). To address these shortcomings, he proposes complex embodiment as a way to blend the strengths of each model:

The theory of complex embodiment raises awareness of the effects of disabling environments on people's lived experience of the body, but it emphasizes as well that some factors affecting disability, such as chronic pain, secondary health effects, and aging, derive from the body (25).

Siebers argues that both medical and social models neglect "human mortality and fragility" as facts of life. Medical practices have traditionally been developed with the aim of curing or eliminating disability, while social models sometimes represent accommodation as a solution to all problems faced by disabled people.

Complex embodiment, in embracing human frailty, counters abled/disabled binaries. For these binaries are predicated on the "wish to return the body magically to a past era of supposed perfection" and the "insist[ence] that the body has no value as human variation if it is not flawless" (26). Such ableist aspirations toward perfection are just as implicated in discussions of

mental illness. The history of psychosurgical/psychoanalytic treatment shows how a sane/insane dichotomy long guided medical practices of cure and elimination, and contemporary rhetoric such as Unger's shows the enduring rhetorical force of aspirations toward perfect recovery.

If not through conventional narrative, then how can complex embodiment help mad people to develop and communicate lived knowledge of complicated, hybridized experiences? I end this project with a much greater consciousness of my inability to provide definitive answers. Rather, I have done what I can to raise further questions. In scattering fragments of my story throughout this project, I have aimed to model an alternative to linear narration by blending my lived knowledge with the narratives and arguments of others. I hope to have contributed, albeit in a small way, to a discourse that does not require mad people to present our complex and contingent lived knowledge in a fixed and linear way. Perhaps such a discourse could begin to include the voices of "unexceptional" mad people—those whose ongoing experiences of madness may hinder them in crafting conventional rhetoric.

I am willing to lend my voice to whatever kinds of discourse prove most accessible to people who think and feel in a variety of ways. More important, I am eager to listen.

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