Shattering Paradigms, Embracing Uncertainty: Female Mental Illness in Contemporary Fiction (2000-2020)

Allyson Trostle, B.S., M.Ed., M.A.

Supervisors:
Dr Stella Bolaki and Dr Juha Virtanen

School of Humanities
University of Kent, Canterbury
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Abstract

Just as canonical stories of female mental illness in the nineteenth and twentieth centuries – Charlotte Brontë's *Jane Eyre* (1847), Wilkie Collins's *The Woman in White* (1859), Kate Chopin's *The Awakening* (1899), Sylvia Plath's *The Bell Jar* (1963) – reflect the concerns and controversies of their respective eras, so too does the fiction of today; yet, contemporary depictions are more diverse than those of any previous historical period, with recent novels touching upon a multitude of issues – medicalisation, institutionalisation, self-care, identity, recovery – that expose an unparalleled range of inquiry into mental health.

This thesis investigates how fiction written between 2000 and 2020 represents female mental illness, tracing a shift toward open-ended and often chaotic portrayals that resist reductive stereotypes. I argue that these narratives contribute vital perspectives that complicate and enrich dominant scholarly understandings of mental illness, expanding conversations beyond clinical and sociological frameworks. Drawing on disability studies, feminist theory, cultural criticism, Mad Studies and the growing field of medical humanities, I examine how recent novels intervene in debates about diagnosis, treatment, recovery and the medicalisation of emotion, while also confronting the intersections of mental illness with race, class and sexuality. In doing so, this thesis highlights the critical role of women's writing in reshaping how mental illness is conceptualised, represented and experienced in contemporary culture.

After evaluating the literary history of female mental illness, my analysis focuses on the following contemporary works: Ottessa Moshfegh's *My Year of Rest and Relaxation* (2018) and Lucie Britsch's *Sad Janet* (2020); *Poppy Shakespeare* (2006) by Clare Allan and *Rabbits for Food* (2019) by Binnie Kirshenbaum; Jacqueline Roy's *The Fat Lady Sings* (2000), Mira T. Lee's *Everything Here is Beautiful* (2018) and Helen Oyeyemi's *The Icarus Girl* (2005); and a selection of Young Adult novels including *My Heart and Other Black Holes* (2015) by Jasmine Warga, *I Was Here* (2015) by Gayle Forman and *The Summoning* (2008) by Kelley Armstrong.

I show that these novels – with the exception of YAL – provide a wealth of representations that are finally beginning to reflect the true diversity of mental illness while simultaneously providing a social commentary that links to timely issues within the mental health landscape. These are novels that don’t end with cure, that don’t hinge on tried-and-true treatment methods, that don’t mask the messiness and chaos of mental illness; they present protagonists who self-medicate, or conversely, resist treatment altogether, women who don’t want to get better or cannot get better, characters who choose to live alongside their mental illnesses rather than treat them as life-limiting disease that must be eradicated. These are novels that challenge established health discourse by offering glimpses into often occluded, non-normative experiences. I argue that this is a welcome trend that has the power to ameliorate stigma and foster social equality by offering additional routes of recognition, education and compassion, and perhaps even more significantly, position mental illness front and centre in a way that demands – and deserves – to be heard.

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Introduction

The last twenty years has seen a dramatic increase in the number of novels featuring female characters with depression, anxiety and other mental illnesses, ranging from Ottessa Moshfegh's darkly humorous *My Year of Rest and Relaxation* (2018) to controversial pop culture sensation *13 Reasons Why* (2007), written by Jay Asher. This is mirrored by a rise in the percentage of women diagnosed with these conditions as well as the growing openness with which mental illnesses are discussed in early twenty-first-century Western society; Simone Biles,[1] Britney Spears,[2] Caroline Flack[3] and Naomi Osaka[4] have all recently made women's mental health a front-page issue, raising awareness at a time when women appear more at-risk than ever. The statistics speak for themselves. One in five UK women over the age of 16 has a common mental illness (CMD),[5] compared with only one in eight men; these figures reflect a 20% increase of incidence in both genders between 1993 and 2014. The statistics in young people expose an even wider gender gap, with social media, peer pressure and online bullying putting young women at particular risk for developing mental illness: 26% of women aged 16-24 have CMD, compared to only 9% of their male counterparts. Despite the acceleration in cultural representations, medical diagnoses and social discourse involving mental illness, nine out of 10 people with CMD have reported facing stigma and discrimination, and only around one in three women seeks help for her mental health (McManus et al.).

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[1] The American gymnast pulled out of several events during the 2021 Tokyo Olympics, citing mental health concerns (Park).

[2] While under conservatorship of her father for 13 years, Spears was involuntarily medicated with lithium and forced to undergo psychiatric evaluations, with her mental health being called into question by her family and cited as a reason to control her finances and day-to-day life decisions (Ma).

[3] The *Love Island* presenter was diagnosed as bipolar just weeks before she took her own life; Flack faced public scrutiny over allegations that she assaulted her boyfriend and was due to stand trial for the charges (A. White).

[4] The Japanese tennis star withdrew from the French Open in 2021 due to mental health issues; she subsequently penned an article for *Time Magazine* explaining her situation and condemning competitive sports for failing to support athletes' mental health (Osaka).

[5] generalised anxiety disorder, depression, phobia, obsessive compulsive disorder, panic disorder or non-specific CMD ("Depression and Other")

This thesis examines fiction as part of the cultural landscape in which this relationship between gender and mental illness is constructed, explored and exposed on the page, and then consumed by the public. I investigate the ability of contemporary fiction, specifically female-authored novels of the early twenty-first century, to contextualise these statistics, to unpack the female experience of mental illness in a way that broadens our understanding of what it means to be mentally ill while underpinning the complexity of navigating these conditions in 21st century society. Just as canonical stories of female mental illness – Charlotte Brontë's *Jane Eyre* (1847), Wilkie Collins's *The Woman in White* (1859), Kate Chopin's *The Awakening* (1899), Sylvia Plath's *The Bell Jar* (1963) – reflect the concerns and controversies of their respective eras, so too does the fiction of today; yet, contemporary depictions are more diverse than those of any previous historical period, with recent novels touching upon a multitude of issues – medicalisation, institutionalisation, self-care, identity, recovery – that expose an unparalleled range of inquiry into mental health.

The aims of this thesis are two-fold: firstly, I illuminate, commend and critically assess the growing breadth of representation provided by contemporary fiction of female mental illness, arguing that a shift toward open-ended, chaotic portrayals resists reductive stereotypes and contributes vital, often-occluded perspectives that unsettle and reframe dominant scholarly narratives of mental illness; I also seek to position this plurality of experience within the larger interdisciplinary framework of mental illness scholarship, demonstrating how female-authored novels of the early 2000s expand and complicate existing conversations. Over the course of five chapters, I explore how recent novels by women writers contribute to the current debates surrounding mental illness, situating my analysis in the context of disability, feminist, cultural and Mad Studies, as well as the growing field of medical humanities. By addressing the following questions, this thesis seeks to demonstrate the critical role of women's writing in reframing how mental illness is conceptualised, represented and experienced: (1) How do contemporary literary representations of female mental illness compare to those from the past, and what does this comparison reveal about attitudes towards women and mental healthcare across time? (2) To what extent does contemporary fiction subvert the dominant diagnosis–treatment–recovery paradigm that underpins narratives of mental illness? (3) How does recent fiction intervene in debates over the biological and sociological causes of mental illness and the medicalisation of everyday emotions? (4) How do female authors conceptualise recovery in ways that contribute to interdisciplinary debates about its meaning, necessity and nature? (5) In what ways is female mental illness compounded by larger issues of race, class and sexuality, and how is this intersectionality represented in early twenty-first-century fiction?

This introduction lays the necessary theoretical groundwork for the in-depth exploration of these questions in further chapters. I begin by examining *why* these interrogations are so vital, how the fiction of mental illness has diversified and evolved to necessitate a pivot in analysis that has yet to be undertaken, opening up a gap in research that my work seeks to fill. I move on to discuss my methodology, focusing on the multidisciplinary nature of this thesis and the ways that it incorporates and builds on a variety of critical traditions; while my research is undoubtedly literary, it also intervenes in contemporary issues of feminist and disability studies, as well as the developing field of medical humanities, and I introduce some of these key areas in this section. I also address the complexity and controversy surrounding the language of mental illness in this introduction, evaluating conflicting ideologies and justifying my own choice of terminology; I then move on to review my criteria for choosing the novels discussed in this thesis. Finally, this introduction concludes with a brief synopsis of each chapter to help orient the reader as he or she navigates through the text.

"Sad, mad, bad women"[6]

The question of why women have 'gone mad' has been explored by a variety of scholars, including prominent feminist writers Phyllis Chesler, Elaine Showalter and Lisa Appignanesi, who have studied the link between gender and madness and chastised the failure of historical – and modern –

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[6] Phyllis Chesler's *Women and Madness*, page 3

psychiatry in supporting women's mental health. They examine a bevy of factors that contribute to the ongoing medical disenfranchisement of women – ranging from social and gender expectations to inequality within a patriarchal society – and link these to canonical works of fiction that depict these issues; my thesis builds on this important research by examining twenty-first-century texts as commentary on the widespread social, cultural and political enterprises that damage women's mental health and the power of literature to tear down stigma, foster self-acceptance and engender change.

In her 2008 book *Mad, Bad and Sad*, Appignanesi traces the history of female mental illness from 1800 onwards, discussing how the trends of each period are mirrored in concurrent fiction. *The Woman in White* portrays Victorian fears of wrongful confinement and the dangers of asylums; Charlotte Perkins Gilman's *The Yellow Wallpaper* (1892) is a strong rebuke to Silas Weir Mitchell's rest cure; Scott Fitzgerald's *Tender is the Night* (1934) turns his wife's schizophrenia, an increasingly popular diagnosis at the time, into fiction. The novels of the 1960s and 70s – *The Bell Jar,* Joanne Greenberg's *I Never Promised You a Rose Garden* (1964), Marie Cardinal's *The Words To Say It* (1975) – parallel the growing women's liberation movement and attack Freudian patriarchy.[7] Phyllis Chesler's *Women and Madness* (1972, updated 2005) and Elaine Showalter's *The Female Malady* (1985) contain similar discussions of pre-21st century literature, connecting the fiction of each era to the opinions and treatment of mental illness at the time; similarly, Sandra M. Gilbert and Susan Gubar's seminal work *The Madwoman in the Attic* (1979) addresses mental illness in nineteenth century fiction, in particular noting authors' use of doubles to mirror a main character's repression and mental illness as a justifiable escape from hegemonic Victorian society.

While nineteenth and twentieth century texts have been researched and analysed in depth,[8] contemporary female novels of mental illness, in its diversity and complexity, is only just beginning

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[7] These fictional works are discussed in greater detail later in the following chapter.

[8] In addition to the texts above, Maria Caminero-Santangelo's *The Madwoman Can't Speak: Or Why Insanity Is Not Subversive* and Jane Ussher's *Women's Madness: Misogyny or Mental Illness* speak about pre-21st century canonical fiction, as well as a host of journal articles on individual novels (a Google Scholar search of '*Jane Eyre* and mental illness' elicits 18,800 results)

to be dissected in the same way.[9] Perhaps unsurprisingly, analyses of mental illness in contemporary media (Anderson; Coverdale et al.; Saleh; Sieff; Stuart; Thelandersson; Wahl), film (Adams; Hanley; Haider; N. Kondo; Livingston; Romano; Wedding) and television (Campbell; Diefenbach and West; Morris; Oostdyk; Pirkis et al.) are more prolific than those focusing on recent literature, with these more readily available, more easily consumable, more 'in your face' mediums receiving substantial and immediate critical attention in comparison to novels. Though there is a notable lack of scholarship surrounding recent fiction of female mental illness, the interest in women's mental health is clearly there; the topic has become increasingly popular within social media, journalism and academia in recent years. TikTok and YouTube boast a plethora of content involving mental health, and thousands of web pages – from those featuring professional medical advice to informal blogs run by people living with mental illness – are devoted to the topic. Within the academic sphere, scholarship has recently explored the link between mental illness and social media (Braghieri; Levy and Makarin; Nesi; O'Reilly; Valkenburg et al.), the stigma of mental conditions (Corrigan and Bink; Corrigan and Watson; Fox and Earnshaw; Fox et al.; Kapadia; Overton and Medina; Østerud) and the possibility of generating empathy through literature (Hammond and Kim; Thexton et al.). While there is a tremendous amount of research on mental illness in a wide range of contexts, including medical, psychiatric, social and literary, showing an obvious interest in the over-arching topic, there is a dearth of research involving mental illnesses in contemporary literature, particularly that which addresses the relationship between illness and gender and the way in which literature intervenes in conversations within the mental health community. This thesis sets out to fill this knowledge gap by offering a critical analysis of how women's mental illness is represented, constructed and perceived

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[9] While analyses of individual or small groups of texts certainly exist (Allitt; Behluli; Claussen; Quirk; E. Stone; Waite; Wickham; to name only a few), I have struggled to find book-length analyses that deal with a large number of texts in a way that allows for a discussion on connections, contradictions and academic/social/cultural interventions, especially outside of YAL (Meyer; Richmond) or intersectional experiences (Brown and Garvey). Many works on illness narrative (Cheyne; Hall; Jurecic) group mental illness together with other disabilities rather than focussing exclusively on mental illness narratives.

in female-authored novels of the early twenty-first century and its position within a range of existing scholarly debates, which are outlined in the following sections and woven throughout this thesis.

Over the course of five chapters, I argue that the fiction of today continues the tradition of echoing contemporary mental health trends and debates, but does so with a breadth and depth, and with an eye to destabilise conventional depictions of mental illness, that is not seen in previous eras. The sheer volume of recent novels dealing with mental illness[10] is itself a testament to this growing range of representation, which includes novels from hundreds of authors across a multitude of genres – from romance to science fiction to crime drama – that as a whole, defy generalisation. One cannot conclude that today's fiction functions primarily as a pushback to patriarchal ideals like novels of the fin-de-siècle period, or as a condemnation of institutionalisation like memoirs of the 1980s and 90s, no more than one can claim medicalisation or disenfranchisement or trauma as overarching themes; contemporary novels engage with *all* of these issues – and many more – and it is this wealth of commentary that sets the literature of today apart from its predecessors.

This thesis contends that authors are seeking to broaden not just the topics with which they engage, but the very notion of who the 21st century mentally ill woman is. The protagonists discussed in subsequent chapters are proof enough of this democratisation: the modern-day mentally ill woman is wealthy, she is poor, she is married, she is single; she is young, old, straight, gay, Black, white, Asian, multiracial. She is anyone and everyone. Disability theory is constructed around the understanding that disability doesn't discriminate, doesn't target one group or another, and the fiction of today most certainly confirms this. Contemporary novels – with their truly diverse cast of mentally ill characters – hold a mirror up to society with far more verisimilitude than literature of any previous period.

My research reveals that while recent portrayals of female mental illness are welcomingly varied and multifaceted, they are connected by a common desire to destabilise the diagnosis-

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[10] A search of 'mental illness fiction' on the Goodreads website elicits 28,063 novels, with 38 of the 50 most 'shelved' books published after 2000 ("Mental illness books").

treatment-recovery paradigm that undergirds many illness narratives. The novels of today are actively – and I argue, successfully – challenging dominant discourse by propagating non-normative portrayals of mental illness. The recovery-driven illness model that England's National Health Services (NHS) has adopted – a pattern of care that begins with medical diagnosis, proceeds to "evidence-based treatment"[11] (often with medication) and then concludes with a 'recovered' patient resuming control of his or her life, has been upheld by many memoirs,[12] tv shows[13] and media specials;[14] meanwhile, recent fiction seeks to poke holes in this prescribed presentation of mental illness with characters who resist – or fail at – completing this recovery journey. These contemporary texts give voice to experiences of mental illness that are unresolved and chaotic rather than tidy and inspiring; they show women who reject pathologisation, women who struggle and fail to improve their mental states, women who take their recoveries into their own hands, both for better and for worse. This thesis contends that contemporary fiction is not just rewriting the diagnosis-treatment-recovery paradigm but shattering the notion that any such paradigm can truly capture the complexities of living with mental illness.

There is no right way to be mentally ill, no 'normal' path to navigate illness, and the novels discussed in this thesis reflect this diversity of experience. Some protagonists that I examine seek professional help; others don't. Ottessa Moshfegh's narrator takes a multitude of drugs while *Sad Janet* takes none. Some characters embrace an identity as mentally ill, some distance themselves from it, and some refuse to characterise their distress as illness at all. Merle gets better, Poppy gets worse; Bunny lives, Lucia dies. These characters are neither victims nor heroes, and their endings are neither cloyingly happy, nor filled with doom and gloom. These novels follow not just a single trajectory of mental illness, but a multitude of overlapping and diverging branches, giving voice to an

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[11] *NHS Mental Health Implementation Plan*; quoted phrase used throughout text

[12] discussed in detail later in this introduction

[13] *Black-ish* (2014); *Crazy Ex-Girlfriend* (2015); *This Is Us* (2016); *Sex Education* (2019); *Ted Lasso* (2020); *Normal People* (2020)

[14] *Jesy Nelson – Odd One Out* (2019); *Nadiya: Anxiety and Me* (2019); Louis Theroux specials *Talking to Anorexia* (2017) and *Mothers on the Edge* (2019); *David Harewood: Psychosis And Me* (2019); *Joe Wicks: Facing My Childhood* (2022)

assortment of subversive experiences that broaden our understanding of what it means to be mentally ill and configure mental illness in shades of grey rather than black and white.

Contemporary Literature and Mental Illness Discourse: Where We Are in the 21st Century

While my research is primarily literary, it is truly multidisciplinary in nature, engaging with a variety of academic fields ranging from disability theory to Mad Studies so as to approach the sizeable topic of mental illness from multiple perspectives. Disability theory, such as work from field-defining scholars Tobin Siebers and Colin Barnes, provides an in-road for challenging social perceptions of mental illness that stem from ableist stereotypes, as well as society's configuration of mental illness as limiting and problematic. By interacting with work by Phyllis Chesler, Ann Cvetkovich and other feminist scholars, I investigate the relationship between gender, society and mental health as well as the attitudes surrounding female illness. This is particularly pertinent when discussing the social propellers of mental illness and the ways in which modern women continue to be pigeon-holed into fulfilling restrictive expectations of appearance and behaviour. Johanna Hedva's *Sick Women Theory* and other criticisms of neoliberalism, such as those from Catherine Rottenberg, Rosalind Gill and Sarah Louise Bennett, also provide a useful lens for reading the novels within this thesis. Where neoliberal feminism insists upon resilience, positivity and self-optimisation as routes to empowerment, recent women's fiction foregrounds refusal, uncertainty and ambivalence as ways of unsettling these expectations; at the same time, these novels highlight the systemic social structures – ignored by neoliberal feminism as embroiled with gender parity – that exacerbate inequality and unhappiness. Cultural studies is equally relevant, and the research of James Davies and David Pilgrim explores how the current political, cultural and economic climate shapes power structures that in turn impact mental health; this thesis investigates how fiction interprets this relationship and how contemporary authors' candid depictions of such inequities have the capacity to yield social change. I also engage with the emerging field of Mad Studies, which draws on lived experiences of mental illness to de-colonise and de-medicalise mental health. For example, the works of Hel Spandler and

Angela Woods provide new ways of conceptualising madness and challenge normalised experiences of recovery; by applying their ideas to novels like Clare Allan's *Poppy Shakespeare* and Jacqueline Roy's *The Fat Lady Sings*, I illustrate how fiction is similarly able to achieve these goals. By forging connections between fictional experiences of mental illness and real-life mental health issues, my research contributes to the developing field of medical humanities, an interdisciplinary endeavour that aims to utilise ideas and insights from non-medical specialties to "help create innovative strategies for understanding and improving health and healthcare" ("Digital Week Four"). Drawing on a multitude of academic fields, putting them in conversation with each other and interweaving them throughout my thesis ensures a well-rounded approach to female mental illness that best encapsulates the concerns, issues and questions relevant to the period between 2000 and 2020. When read through these complementary and overlapping lenses, it becomes clear that not only is contemporary fiction intervening in a bevy of thought-provoking debates, but is doing so in a way that seeks to subvert dominant experiences of female mental illness and diversify the notion of what it means to be mentally ill in the 21st century.

Literary Methodology

As I am focused on novels, my research is first and foremost literary, and I apply a variety of critical techniques, most notably close reading, to examine female mental illness in contemporary works. Each chapter is comparative; putting multiple novels in dialogue fosters a more comprehensive analysis of contemporary fiction's contribution to mental illness discourse, leading to a richer understanding of the recurring social, political and health issues within these works. As with Moshfegh's *My Year of Rest and Relaxation* (*MYRR*) and Lucie Britsch's *Sad Janet*, wherein the protagonists have divergent opinions on medicating their sadness, a comparison can present opposing sides of a controversial issue that nonetheless arrive at similar conclusions. While Moshfegh's narrator takes more than two dozen pills throughout the course of the novel and Janet takes none, both novels serve as strong rebukes of the pharmaceutical industry and the medicalisation of sadness. Other times, as in Chapter Three, bringing two novels into conversation can allow one to further elucidate ideas touched upon in another, like how Poppy's inability to prove her sanity in the outlandishly comical *Poppy Shakespeare* sheds light on Bunny's more subtle lack of agency in Binnie Kirshenbaum's *Rabbits for Food*.

As Alice Hall explains in *Literature and Disability*, "Literary writing provides an important way into the wider field of disability studies because of its potential to reach diverse populations and to locate narratives of disability in particular familial and social networks, historical and geographical locations, and political contexts" (Hall 15-16). Accordingly, I situate my analyses within the 21st century political, social and medical landscape, drawing on scientific studies and research to first uncover trends and then investigate how fiction corroborates or challenges these. For example, in Chapter Two I connect pharmaceutical and psychiatric data with *Sad Janet*'s condemnation of the overprescription of antidepressants, as well as the toxic positivity that propels the pathologisation of everyday emotion; integrating statistics and medical enquiries into this chapter helps draw out the connections between satire and real-life concerns. In Chapter Four, which centres on intersectional representations of female mental illness, I engage with the political and social enterprises that impact racial, ethnic and cultural identity and the ways in which these texturise mental health issues. For instance, working with geopolitical scholarship allows me to investigate how Jess's diasporic identity in *The Icarus Girl*, written by Helen Oyeyemi, is complicated by post-colonial Nigerian-British relations and how the emerging African Bildungsroman genre functions to destabilise traditional Western, white-centred coming-of-age stories. In a similar vein, situating *The Fat Lady Sings* within the socio-cultural context of its setting allows me to explore the extent to which Gloria's homosexuality and confidence disrupt conventional British values, resulting in a social rejection that negatively impacts her mental health. By engaging with recent novels and locating these within their contemporary historical context, I show how concerns over mental health have evolved and broadened, along with representations in fiction. Just as *The Woman in White* reflects nineteenth century society's fear of unjust medical incarceration and *The Awakening* challenges the inflexible female expectations of the fin-de-siècle era, so too do the novels of today echo contemporary mental health issues; by citing scholarship from a variety of sources – including medical reports, academic journals and newspaper articles – I illustrate just how varied and complex these concerns are and how the fiction of today displays equal latitude in an effort to comment on this growing range of interest.

My research fills gaps in existing literary research not only by examining depictions of female mental illness in contemporary novels that lack extensive critical scholarship, but also by drawing connections between these narratives to identify points of interest and contention within mental health. It is these overarching themes in which I am particularly interested, as they not only allow me to place current narratives within a larger evolution of fictional female mental illness, but also connect to ongoing discussions regarding public attitudes toward mental illness, exploring the "pedagogic function" of fiction in which it "not only documents but also shapes attitudes toward disability" (Hall, *Literature* 4). This approach led to a key finding early on in my research: while much recent fiction seeks to diversify representations of mental illness, the same cannot be said of Young Adult Literature (YAL), which continues to rely on the destructive, formulaic portrayals of mental illness that adult novels seek to overturn. Chapter Five shows that representations of mental illness in YAL are dangerously tied to the past, contingent on damaging stereotypes, such as the love-cures-all trope or configurations of mental illness as evil and dangerous, that sensationalise these conditions. This differs from novels marketed to more mature readers, whose varied and nuanced messages – ranging from criticisms of modern psychiatry to the importance of self-care – are underpinned by a collective resistance toward normative experiences of mental illness. By concluding with YAL and exploring the reductive stereotypes that exist alongside more nuanced narratives, this thesis reveals the complexity of cultural engagement with mental illness, highlighting not only the strides made but also the urgent work still to be done.

I shape my analysis with an eye towards updating and expanding upon previous scholarship like Gilbert and Gubar's *The Madwoman in the Attic* and Marta Caminero-Santangelo's *The*

Madwoman Can't Speak: Or Why Insanity is not Subversive. While Gilbert and Gubar's pivotal 1979 work reads madness as representative of the internalised struggles of nineteenth century women authors, Caminero-Santangelo criticises the pair's approach in her 1998 monograph for ignoring the historical psychiatric context of the novels they critique; she uses her own work to answer the question, "What have women been saying when they write about madness?" (9), situating late 20th-century novels within their "discursive contexts" (17). I endeavour to modernise Caminero-Santangelo's question not only by focusing on more recent novels, but by positioning contemporary novels alongside current perceptions of mental health and enmeshing my analysis with interdisciplinary research. In turn, this thesis poses the following question: What are women saying when they write about mental illness today, and how does this reflect or challenge the social, cultural and psychiatric trends of the early 2000s? This question has yet to be answered; no one has yet tracked trends and implications of female mental illness in twenty-first-century novels. My thesis intervenes in this gap by not only performing this much-needed analysis, but doing so contemporaneously, at a time when the issues explored by these novels are still relevant and significant, still directly impacting readers. With the growing incidence of mental illness in all ages and genders – but particularly young women – this is important and timely work that is invaluable in showing the power of fiction to not just mirror but influence public attitudes towards female mental illness; Chapters Two, Three and Four of this thesis illustrate how recent novels engage with social, medical and political issues surrounding mental illness in a revolutionary way that serves to destigmatise, democratise and demystify female madness.

Feminist Disability Literary Theory

While reading female madness as symbolic or metaphorical, as a response to women's suppression and oppression, was once a groundbreaking new wave of analysis, this thesis contends that female-authored fiction of the early twenty-first century necessitates an updated literary criticism that can better take into account complex representations of female disability. Rather than rejecting metaphor altogether, I argue that novels like *MYRR* and *The Fat Lady Sings* complicate the older critical tendency to treat madness primarily as an abstract sign of women's rage or rebellion; instead, they foreground the lived experiences of women with mental illness, even as they continue to operate at the level of metaphor and allegory, as all novels inevitably do.

As Caminero-Santangelo explains, Gilbert and Gubar's famous feminist reading of Charlotte Brontë's Bertha, which analyses Rochester's mentally ill first wife as an image of the author's rage against nineteenth century gender norms, configures madness as a "willed choice" that is "a preferable alternative to sanity in women" (1). This problematic interpretation in which "madness signifie[s] anger and therefore, by extension, protest" (Caminero-Santangelo 1) further ties women to the stereotypes that restrict them rather than free them, silencing them rather than empowering them. Sami Schalk similarly criticises this tendency "to represent and interpret disability as a metaphor for gender, sexuality, and racial oppression, rather than investigating the material and discursive relationships of disability and other systems of oppression or identities" (172–3), adding that such readings risk disregarding the lived experiences of those with mental illness. Elizabeth J. Donaldson corroborates this in her seminal essay "The Corpus of the Madwoman": "Indeed, one could argue, when madness is used as a metaphor for feminist rebellion, mental illness itself is erased" (102). Their work does not forbid metaphor, but cautions against a mode of reading in which madness is instrumentalised solely to represent other struggles, thereby erasing disability itself.

At the same time, it is important to acknowledge that novels, even when realist or autobiographically inspired, never simply honour lived experience in an unmediated way. Fiction always works through language, form and metaphor, and the representation of madness is no exception. The problem, then, is not metaphor itself but the reductive tendency to use madness only as a displaced symbol for other struggles, thereby effacing disability. Contemporary fiction does not escape metaphor but rather reorients it: madness remains narratively and politically resonant, yet it is also given depth and integrity as the lived and embodied experience of its protagonists.

What Schalk and others call for is a new kind of literary theory that she terms "feminist disability theory" (170), which combines disability studies discourse with that of feminist studies, allowing experiences of mental illness to come to the forefront. This is the type of analysis I apply and extend throughout my thesis, and one that I argue the fiction of today demands. Contemporary novels tend to present mental illness not only as symbolic of broader social inequities and oppressions but also – and crucially – as the lived reality of their protagonists. The traumas and systemic failures that these novels expose are still political, but they are experienced at the level of embodied, everyday life. In this way, these novels resist crudely reducing madness to other forms of oppression while still allowing for allegorical readings.

These inequities, oppressions, and traumas are still rampant in recent novels, but exposing them is no longer the endgame; it isn't enough. Today's authors narrativise the host of ways in which society is not only unjust toward women but complicit in female mental illness, showing how simply living in the world can make women unwell. Yes, authors of today are still angry, as Gilbert and Gubar famously describe Brontë, but their anger is more pointed, more precise. They are not just angry about women's limited role in society – though they most certainly still are – but more specifically about the public attitudes surrounding female mental illness and the failure of medical, social and cultural institutions in supporting those who are unwell. In recent fiction, madness need not serve a single social purpose or function as commentary on a larger issue to have value; it is deserving of attention in and of itself. At the same time, these depictions remain politically charged: Bunny's depression in *Rabbits for Food*, for example, can undoubtedly be read as a commentary on the pressures put on women to achieve both personal and professional success, but it can equally be read as a gut-wrenching, empathetic account of one woman's particular experience of mental illness. Bunny's tears need not be for all women to be powerful or have meaning; they can just be for her.

Caminero-Santangelo goes on to contend that "the madwoman has come to stand all but universally in feminist criticism for the elements of subversion and resistance in women's writing"

(1); this thesis argues that, from a feminist disability studies perspective, today's madwoman may continue to challenge and subvert, but she also hopes and dreams and, perhaps most importantly, she lives. *Poppy Shakespeare* and *MYRR* may destabilise the diagnosis-treatment-recovery paradigm, but they do so in a way that broadens our understanding of what it means to be a woman with mental illness in the twenty-first century. Mira T. Lee's Lucia may unsettle Chinese American stereotypes, but the juxtaposition of her quest for self-fulfilment and symptomatic illness is equally – if not more – compelling. The day-to-day living of these characters is at the very core of these novels. N, Bunny, Lucia, Gloria, Merle, Jess – they don't just resist, they educate, they evoke empathy, they criticise, they empower, they politicise.

This leads into what Caminero-Santangelo calls "the central question of feminist debate: How can transformation of the sex-gender system and of ideologies of gender (rather than just 'resistance' to them) take place?" (2, emphasis hers); I believe that the central question of feminist disability studies, as it relates to mental illness, is slightly different: How can the lives of women with mental illness be improved, and how will such a change benefit all women? Adding literary theory into the equation brings an additional question regarding the capacity in which literature can support and engender this positive change. This thesis unpacks the many ways that contemporary fiction performs this important work, from analysing *Sad Janet*'s condemnation of the pharmaceutical industry to untangling the way that Gloria's race, gender and sexuality complicate her mental health. It is complex and difficult work that can at times appear paradoxical: for example, by portraying Bunny's illness as valuable and provocative in and of itself, without demanding a larger purpose in order to gain significance, Kirshenbaum is sending a message of empowerment that does, ironically, have wider reach. Bunny's illness can just be illness rather than social commentary or political kindling, but this configuration begets a liberation, a self-centredness rarely afforded to women, that has the propensity to help women at large; her illness is hers, and thus benefits all women.

Recent novels present mental illness not as conflict or as a medical problem that necessitates cure, nor do they depict a single road that must be followed once mental health begins to deteriorate. By showing the many facets of mental illness and the variety of medical, social and cultural issues that impact it – and by doing so in a captivating way that incites a strong emotional response in their audiences – these novels help combat stigma, foster acceptance and challenge stereotypes one reader at a time, supporting not just women with mental illnesses, but all women.

If the goal of feminism is equality and power, Caminero-Santangelo argues that a "more productive move in feminist literary criticism might be to trace the symbolic rejection of hopelessly disempowering solutions in fictional and nonfictional narratives of madness by women" (4); while this is a shift in the right direction, I argue that a rejection of solution altogether is an even more progressive move. By operating within a new criticism that integrates both feminist and disability theory, one can recognise that the very basis of Caminero-Santangelo's statement is problematic – mental illness is not, by definition, a problem that requires a solution. As Rosemarie Garland-Thomson explains, feminist disability theory "denaturalizes disability by unseating the dominant assumption that disability is something that is wrong with someone" ("Integrating" 6). The novels I discuss within this thesis advocate for this, and they resist resolution altogether. Bunny is still depressed at the end of *Rabbits for Food*; Jess's mental health is purposely ambiguous in the conclusion to *The Icarus Girl*; N is more stable and independent at the end of *Poppy Shakespeare*, but certainly not 'cured.' Female authors of the early twenty-first century are answering Therí A. Pickens's desire for stories that "do not seek to neatly erase disability or difference writ large, but to live with it" (Pickens, "Octavia" 175). By presenting mental illness as an ongoing issue that lingers, that lacks a quick fix, these novels remove the pressure to 'get better,' opening up a new way of thinking about mental illness that focuses not on solution, but living, not on an unknown future, but the now.

This is an empowering change that is buoyed by the fact that the women in these novels refuse to be passive and silent. If reading madness as metaphor offers only the "illusion of power"

(3), as Caminero-Santangelo suggests, the implicit need here is for real power. Donaldson concurs that “madness itself offers women little possibility for true resistance or productive rebellion” (101), but it is contemporary characters’ insistence on taking control of their madness, not simply their madness itself, that conveys a true sense of power and can incite actual change. Moshfegh’s narrator concocts her own self-care plan outside of psychiatry, taking her care into her own hands rather than relying on an ineffectual medical system in an empowering – albeit dangerous – act of control. Janet resists labelling her sadness as illness and eschews all requests that she medicate it away. Merle and Gloria refuse to change who they are, just as Lucia rejects familial pressure to conform to cultural and social expectations. These women are not crude political metaphors for oppression but actual resistors to oppression – while their struggles remain narratively and politically resonant at the level of metaphor, they are also irreducibly their own.

Opening up the critical space by analysing contemporary madness in a variety of ways – as a lived experience, as a result of social inequality and pressure, as a subversion of misinformed public stereotypes – allows discussions of disability and feminism to progress and evolve, in line with Garland-Thomson’s belief that feminist disability theory “should illuminate and explain, not become ideological policing or set orthodoxy” (“Integrating” 14). Feminist disability theory is a lens, not a rule. The conversations within this thesis move beyond what Donaldson refers to as the “almost monolithic way of reading mental illness within feminist literary criticism and perhaps in the larger culture of women’s studies scholarship” that configures madness as rebellion, one that she argues “may limit our inquiry into madness/mental illness” if it “remains widely accepted and uncontested” (101). The novels have evolved and diversified, and so must the criticism that attends to them.

It is therefore clear, as Schalk suggests, that the popularity of both feminist and disability rights movements has ushered in an era where “contemporary women writers are creating more complex and empowered disabled women characters, characters who cannot as easily be interpreted as pure metaphors for oppression” (174). While I certainly agree that many twenty-first-century novels contribute to madwomen “increasingly being represented as complex, powerful characters rather than as simply villains or victims" (Schalk 174), this change has yet to take root within Young Adult Literature. I discuss in Chapter Five the propensity of YAL to perpetuate this villain/victim mentality, among other equally damaging mental illness tropes. While Donaldson argues that metaphorical readings can lead to the romanticisation of madness – for example, the "certain irresistible appeal" within the configuration of Bertha "as a rebellious woman subverting the patriarchal order by burning down her husband's estate" (100) – YAL requires no such depth of analysis to convey similarly destructive messages. The 'love cures all' trope, for example, is impossible to miss in Julia Hoban's *Willow* and Jasmine Warga's *My Heart and Other Black Holes*, as is the disturbing configuration of suicide as revenge in Jay Asher's *13 Reasons Why*. The work that authors like Clare Allan and Jacqueline Roy set out to do, the progressive representations that I discuss in Chapters Two through Four, are undermined by the YA novels that impart in young people the very assumptions that mental health advocates seek to destabilise. While feminist disability theory allows for a universal and powerful new way of reading texts, this analysis – no matter how engaging or beneficial – cannot erase the many YA novels that continue to belittle its goals; I spend time in both Chapter Five and my conclusion addressing possible solutions to this dichotomy.

Mental Health and the Neoliberal Agenda

The period between 2000 and 2020 was marked by the consolidation of neoliberalism as the dominant political and cultural logic in the West, accompanied by the rise of what scholars such as Rottenberg describe as *neoliberal feminism*. Within this framework, empowerment is framed as a matter of individual responsibility: women are expected to manage their wellbeing, cultivate resilience and invest in their own productivity through practices of self-care and consumption. As Rottenberg explains, "The neoliberal feminist subject is divested of any orientation toward the common good" (428) and is instead "constantly turned inwards, monitoring herself" (429). Mental illness, in this schema, is often treated not as a structural issue rooted in inequality and precarity but as a failure of personal self-management.

Johanna Hedva's "Sick Woman Theory" (2016) provides a powerful counterpoint to this discourse by insisting that illness, incapacity and vulnerability are politically significant states. For Hedva, the figure of the "sick woman" defies neoliberal demands for visibility, participation and productivity, making it possible to theorise withdrawal, exhaustion and refusal as forms of resistance. The theory exposes how the promise of neoliberal feminism – empowerment through self-regulation – marginalises those who cannot or will not conform to the ideal of the endlessly resilient subject.

This thesis brings "Sick Woman Theory" into conversation with female-authored novels published between 2000 and 2020 that engage with mental illness. Works like *MYRR* and *Sad Janet* repeatedly challenge the neoliberal agenda by representing protagonists who refuse, resist or fail to embody the model of the self-optimising, happy, productive woman. Instead, they foreground rest, sadness, ambivalence or uncertainty as central aspects of women's lives, unsettling the cultural demand for wellness and positivity. As Hedva insists, it is "the world itself that is making and keeping [women] sick," sustained by the "current regime of neoliberal, white-supremacist, imperial-capitalist, cis-hetero-patriarchy" (8). Reading these novels through this lens, alongside critical accounts of neoliberal feminism, reveals how contemporary fiction not only reflects the pressures of its time but also opens up imaginative space for alternative understandings of women's experiences of mental illness.

How Is Mental Illness Situated Within Disability Studies?

When disability studies first emerged in the late 20th century, it focused primarily on the disabled body – issues of blindness, deafness, paralysis – rather than the disabled mind, and mental illness's place within disability studies remains obscure. This precarious positioning is bolstered in part by the fact that, depending on which source one consults and how one interprets it, mental illness both is and isn't a disability. The inclusion of terms like "substantial" and "long-term" in government statutes like the UK's Equality Act of 2010 and the Americans with Disabilities Act are at odds with the very nature of mental illness, introducing a subjectivity and time frame that sees some mental illnesses covered by their legal protection and others not.[15] Mental illness poses similar problems for the disabled peoples' movement, which British sociologists Colin Barnes, Mike Oliver and Len Barton explain, "identifies society as the problem, and looks to fundamental political and cultural changes" (5) to eliminate social exclusion and foster acceptance. For physical disabilities, this might mean improving access to infrastructure and technology, and for learning disabilities, enhancing educational and occupational opportunities; yet, for mental illness, where marginalisation is predicated on long-standing stigma, media stereotypes and self-exclusionary symptoms, the goals of the movement aren't exactly a perfect fit. Even those with mental illness themselves are divided in the classification of their conditions, with Margaret Price noting that some consumer/survivor/ex-patient (c/s/x) activists "have much in common with disability activists, but strong differences as well—one of which is the issue of whether or not to self-identify as disabled" (302). Many in the c/s/x movement, argues Price, approach the term 'disability' with "suspicion," frustrated that a diagnosis of 'mentally ill' too often means one "is marked as permanently damaged, and as one whose rights may be taken away – unless, of course, she complies with psychiatry's requirements for 'care'" (301). It is clear that no matter where one turns for answers, mental illness poses a problem for the larger category of disability. This thesis explores how contemporary literature attends to these obstacles and addresses this configuration of mental illness as an outsider even within the realm of disability – not just an Other, but an 'other' Other. It is here where *feminist* disability studies becomes particularly valuable: it directs attention to the social, cultural and gendered dimensions of disability, providing a framework capacious enough to account for the unstable and often marginal status of mental illness.

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[15] "People with mental disorders have been excluded from generic disability programmes in areas such as employment and training, housing and accommodation support, generic social support, recreation and disability services" (Mulvany 586).

The adversity facing those with mental issues is not as visible, less easily conceptualised, than those with physical disabilities, thus making the decision as to whether or not it is "substantial" more challenging. A person in a wheelchair may find it daunting to get in and out of bed, to navigate a cobblestone town centre, to cook dinner – easily observable, difficult to dispute struggles – whereas the hardships encountered by those with mental illness are largely internal and invisible and, perhaps most significantly, reliant on self-reporting; Clare Allan addresses the difficulties inherent to quantifying mental illness in *Poppy Shakespeare*. This issue is complicated further by the fact that mental illness is a spectrum in which severity of symptoms varies person-to-person; similarly, an individual might find his life severely impacted one day and not the next, as exemplified by Lucia's extended symptom-free periods in *Everything Here Is Beautiful*. Unlike many permanent physical disabilities, mental illness isn't static, isn't linear, and shoehorning a continuum into a dichotomy raises concerns over where, exactly, the line is drawn between disability and non-disability. Because feminist disability studies resists rigid binaries and emphasises lived, embodied experience, it provides me with the tools to explore this variability without forcing mental illness into categories that erase its complexity.

The potentially transient nature of mental illness similarly complicates its place within disability. The Equality Act defines "long-term" as lasting, or expecting to last, at least twelve months ("Definition of Disability"), yet the duration of mental illness – unlike physical impairment – is far from predictable. As Susan Wendell explains, "Mental illnesses are sometimes acute, sometime recurring, and sometimes chronically debilitating." (164). Likewise, pinpointing the beginning of a mental illness, in which symptoms may come on slowly and worsen over time, is more challenging than identifying the genesis of a physical disability attained during an accident or present at birth. At what point does sadness become pathological depression, and at what point does that depression become disability? Chapter Two explores this idea, juxtaposing the incapacitating "existential ennui" (Moshfegh 33) of Moshfegh's narrator with *Sad Janet*'s affective sadness. Here, feminist disability studies helps me to keep questions of temporality and uncertainty central, recognising that fluctuating conditions are not deviations from disability but integral to its theorisation.

The many and varied treatment options for mental illness pose additional problems for its classification: Is an individual whose mental illness improves with medication or therapy still considered disabled?[16] Price addresses this in "Defining Mental Disability," revealing that her insurance refused to continue funding her talking therapy once she was deemed "well enough" (300) – clarifying that they could only resume coverage if she were to attempt suicide. This configuration of mental illness as a condition that can be cured, or at least improved, perpetuates a traversable "unwell/well paradigm" (M. Price 300) that leads to its tenuous placement alongside permanent physical disabilities. Would Price's insurance provider, one wonders, ever stop subsidising hearing aids or a wheelchair?

It is clear that mental illness unsettles the UK's formally recognised definition of disability, and accordingly, this thesis adopts a more informal approach to conceptualising the relationship between mental illness and disability. While some characters with mental illness certainly find their symptoms "substantially" affecting their day-to-day lives, their conditions undeniably incapacitating – like the reclusive Bunny in *Rabbits for Food*, for example – this criteria is too restrictive, too medical, too individual-focused in nature, and an approach that incorporates external, social, invisible barriers is more in line with the diversity within mental illness. Thus, while this thesis doesn't wholly reject the formal definitions of disability, it amends them to include the following question: Among those with physical, mental and psychological conditions, for whom is 21st society simply not built? Beyond just inaccessible physical structures, for whom are culturally recognised notions of success, relationships, participation, vocation and acceptance ill-suited?[17] By shifting the

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[16] In 1999, the US Supreme Court ruled in *Sutton v. United Air Lines* ("Sutton v. United Air Lines") that severe myopia was not considered a disability if it could be corrected with glasses; this opened the door for many similar US cases involving mental illness in which the illness was not considered a disability if it could be improved with medication or other treatment.

[17] This configuration of disability ties into the debate surrounding the medical and social models, which I discuss in the following section.

focus away from impairment alone and toward an individual’s interaction with the world, this conceptualisation of disability permits the incorporation of a wider range of conditions, including mental illness, and destabilises the stigma surrounding the term ‘disability’ that may make some in the c/s/x community reluctant to self-identify.

Operating within this more flexible framework allows this thesis to situate mental illness under the arc of disability and employ the tenets of disability studies while still acknowledging the problems that mental illness poses for the category. Furthermore, accepting mental illness as a disability allows me to focus on *why* mental illness is disabling, why it is that disability “has a negative effect on [one’s] ability to do normal daily activities” (“Definition of Disability”), including investigation into the social, cultural, political and economic structures that are absent in both the UK Equality Act and the ADA’s definitions. This is the important work that recent authors are beginning to undertake, the *why* it is disabling, not the *if* it is disabling, with their novels centring less on labels and terminology and more on activism and change.

It is this desire to instigate change, to improve the lives of disabled people, that sits at the heart of disability studies and the disabled peoples’ movement and further complicates the place of mental illness within them. In “Unhealthy Disabled: Treating Chronic Illnesses as Disabilities” Wendell describes the prototypical disabled person as “healthy disabled,” a person “whose *physical* conditions and functional limitations are relatively stable and predictable for the foreseeable future” (162, emphasis mine), someone who doesn’t present as ‘ill’ – fatigued, weak, in pain, incapacitated, desiring cure. One can see how mental illness (and, as Wendell focuses on, chronic illness) sits in opposition to this configuration in more ways than one. The negative connotations surrounding illness, including social devaluation and loss of control, as well as the underlying implication of possible cure, has caused many disabled activists to distance themselves from the equation of disability and illness in order to proffer a more positive perspective on disability that focuses on social rather than medical intervention. Those who deviate from the paradigmatic disabled person are less likely to further this aim: “Fluctuating abilities and limitations can make people with chronic illnesses" – and mental illness – "seem like unreliable activists;" therefore, Wendell explains, "It is safer and more comfortable for disability activism to focus on people who are healthy disabled" (162). What use, then, are the "unhealthy disabled" to the disability movement? Why advocate for the inclusion of mental illness as disability at all? I argue that works like *The Fat Lady Sings* and *Rabbits for Food* answers these questions in two ways: (1) by quashing the notion that that those with mental illness are by definition "unhealthy disabled," as Roy does with her portrayal of the vivacious and exuberant Gloria and Moshfegh with her forthright narrator, and (2) by depicting those who do perhaps fit Wendell's description of "unhealthy disabled" – Merle, Lucia, N, Bunny – as nonetheless empowered, motivated, loving, intelligent. As Wendell explains, "One of the goals of disability politics [is] to replace fear with the understanding that disability can be a valuable difference" (171), and while this focus on difference is a cornerstone of disability studies, the novels of today show equal value in highlighting similarities. The principles, lives and desires of the disabled and non-disabled do not inescapably diverge, but intersect and overlap, and this is an equally strong argument against the stigmatisation and exclusion of the mentally ill.

Social Model, Medical Model or Something New?

This reconfiguration of disability as "relation" (Herndl 594) rather than individual problem is more in line with disability studies' own preferred conceptualisation and feeds into ongoing debates surrounding the primary – and competing – theories of articulating disability: the medical and social models of disability. This is contentious territory, particularly when mental illness is considered, and literature is well positioned to negotiate the space between these two seemingly antithetical paradigms. Boiled down to their key elements, the difference between the two models is quite clear: within the medical model, disability is perceived as a biological problem that necessitates cure, while the social model – birthed during the heyday of antipsychiatry in the 1960s – configures social barriers as disabling rather than the impairment itself (Barnes et al.; Mulvany; Oliver, "Social

Construction"; Oliver, "Social Model"; Shakespeare; Siebers, "Disability in Theory").[18] While the benefits and drawbacks of each model have been discussed at length, modern-day disability theory leans heavily toward the social model, which locates disability not with the individual, but with the society that excludes her. Contemporary novels are less divisive, neither fully adopting nor completely rejecting either model. The texts within this thesis most certainly implicate society for its role in generating and perpetuating female mental illness, as does the social model, but they also highlight many of the problems inherent to this paradigm; these novels challenge "the notion that disability is primarily a medical category" (2), a critique that disability activist Simi Linton contends is central to disability studies, while nonetheless portraying situations in which those with mental illnesses seek medical care. This thesis argues that contemporary literature is less interested in the division between the medical and social models, in picking a side, so to speak, and more concerned with how the lived experiences of those with mental health issues are inextricably shaped by both medical *and* social landscapes, leading to the conclusion that perhaps neither of these models is quite right for conceptualising 21st century mental illness.

The difference between impairment and disability is at the very core of the social model. While impairment is the physical or mental issue itself – blindness, paralysis, depression – disability is the many ways in which society precludes those with these impairments; as social scientist Tom Shakespeare adds, "The former is individual and private, [and] the latter is structural and public" (268). Impairment is missing a leg; disability is a lack of wheelchair ramps in public spaces. While the distinction between these two terms is fairly straightforward when it comes to corporeal conditions, the division is complicated by mental issues whose symptoms cause alienation in and of themselves. What are we to make of Moshfegh's narrator, whose disdain with society leads her to withdraw from it of her own volition, or Bunny, whose depression renders her house-bound and isolated? The

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[18] One can see how the Equality Act's focus on disability as individual misfortune rather than on the existing social, cultural, economic and political structures that cause exclusion aligns it more with the medical model.

line between impairment and disability becomes muddled when the impairment itself causes disability. Deaf poet Michael Davidson argues that disability lies not in the impairment but in "social attitudes, institutional structures, and physical or communicational barriers that prevent full participation as citizen subject" (136), but this fails to address the fact that an inability to participate in society is a defining characteristic of some mental illnesses. How can we fully subscribe to the social model of disability when many of the barriers facing those with mental illness – social exclusion, inability to join in activities, negative self-image – are symptoms of the illness? By delving into the lived experiences of their protagonists – their struggles, their pain, their own perceptions of their conditions – contemporary novels obscure this impairment/disability divide and in turn, show the true complexity of mental illness and its precarious position within the larger sphere of disability.

Shakespeare argues that "while doctors and professions allied to medicine seek to remedy impairment, the real priority [of the social model] is to accept impairment and to remove disability" (268); yet elimination and acceptance aren't always possible with mental illness, and recent fiction reflects this complication. It doesn't matter if society is ready to welcome Bunny with open arms if she is too sad to leave her house; likewise, the violent acts that Jess commits while under the control of TillyTilly make it difficult to simply accept her poor mental health. "The social model demonstrates that the problems disabled people face are the result of social oppression and exclusion, not their individual deficits" (269), explains Shakespeare; yet, he is critical of this emphasis on society, arguing that "the social model so strongly disowns individual and medical approaches, that it risks implying that impairment is not a problem" (269-270). Contemporary fiction like *MYRR* and *Poppy Shakespeare* makes it clear that mental illness *can* be very much challenging, and this thesis analyses many characters whose difficulties are at times tied to their illnesses and not purely larger social injustices. Bunny punches a mirror, Lucia dies in a blizzard, Moshfegh's narrator can't maintain meaningful relationships, Poppy makes poor parenting choices. As Linton explains, "Pain, suffering, frustrations, and anxiety often accompany impairment, and no amount of social change or theory will take those away" (138). While contemporary novels do reveal the need for social transformation, they also suggest that this cannot completely obliterate the potentially incapacitating nature of mental illness; thus, the social model of disability does not entirely reconcile the needs of those with mental health issues.

The critics of the medical model of disability are vocal and numerous, comprising scholars from a range of disciplines, including Ann Cvetkovich, whose book *Depression: A Public Feeling* (2012) sets out to configure depression as a "cultural and social phenomenon rather than a medical disease" (1) and seminal disability studies scholar Tobin Siebers, who argues against a view of disability "as an individual defect lodged in the person, a defect that must be cured or eliminated if the person is to achieve full capacity as a human being" (Siebers, *Disability Theory* 3). While modern-day authors certainly don't advocate for such an extreme and negative configuration of mental illness, I argue that some contemporary novels do, however, demonstrate that receiving the right medical intervention at the right time can support mental health, and thus the medical model of disability is not totally without merit. These novels don't portray mental illness as a "defect" that must be "cured," as Siebers accuses the medical model of doing with physical disabilities, but they do depict it as a concern that one might justifiably seek to address, an issue that one might very well wish to improve. Bunny is hospitalised after she stabs her leg, not just so her wound can be tended to, but because she realises that she can no longer safely face her depression on her own. Lucia begins medication after collapsing on the street, clearly unable to carry on independently as she currently is. As a whole, the novels within this thesis don't call for the removal of medicine from the realm of mental illness altogether, but for better conceptualisation of how exactly the medical field can best help, and what changes need to occur within existing mental healthcare. While the medical model in its current state is disempowering, reactive and stigmatising, that isn't to say that issues surrounding mental health can be entirely addressed – for all people and in all cases – outside of the medical sector.

I argue that female-authored novels of the early twenty-first century adopt neither the social nor medical models of disability, but rather negotiate the divide by supporting what I refer to as the ‘self-advocacy’ model, a focus on the individual rather than the collective. In this model, those with mental illness are trusted to make decisions for themselves and to do so free from judgment. Those who seek medical help, who decide to try medication to pacify their symptoms, aren’t traitors to the disability movement, no more than those who distance themselves from pathologisation are heroes; there is no right way to be mentally ill within this self-advocacy model, nor is there pressure to align oneself with one of two diametrically opposed frameworks. An individual can take medication and undergo therapy while still recognising society as exclusionary and limiting. As Shakespeare explains, “A social approach to disability is indispensable. The medicalisation of disability is inappropriate and an obstacle to effective analysis and policy. But the social model is only one of the available options for theorising disability. More sophisticated and complex approaches are needed” (272). This thesis contends that the novels of today are not concerned with supporting one of these models over the other, but rather in allowing their protagonists to perceive their own illnesses however they choose and seek the help they deem appropriate – medical, social, personal, or none at all. Ultimately, situating the debate between medical and social models within academia further removes power from those who are actually disabled; though many scholars involved in this debate have disabilities themselves, extending their personal beliefs to the cohort at large only perpetuates the disenfranchisement of those with disabilities. A self-advocacy model reclaims this power by validating the views of every individual rather than prioritising a certain way of thinking about disability, allowing for a level of sophistication and complexity beyond that of either the social or medical models and better fulfilling disability theory’s goals of independence, acceptance and empowerment. Linton argues that “disabled people are rarely depicted on television, in films, or in fiction as being in control of their own lives – in charge or actively seeking out and obtaining what they want and need” (25); this thesis contends that this is finally beginning to change.

Medical Humanities: Riding the Second Wave

By configuring mental illness as a predominantly social issue without disregarding the potential benefits of medical intervention – and investigating how contemporary fiction teases out the complex relationship between illness, society and medicine – this thesis sits at the juncture of not just disability studies and literary studies, but also the field of medical humanities. Emerging in the 1970s, medical humanities in its first wave primarily focused on the clinical interaction between doctor and patient and the role of the humanities in fostering empathy, with the aim, as Anne Whitehead and Angela Woods explain, "to produce a shift in clinical method towards attending to and interpreting patients' subjective experience as well as scientific knowledge and data" (4). Medical humanities endeavoured, in its outset, to humanise medicine at a time when it was becoming more and more reliant on technology. Now, more than forty years after this initial conceptualisation, the pair argue that medical humanities has transitioned to a second, more critical wave, one that moves beyond medical humanities' position as servile and toward a relationship of reciprocity built on complex issues of entanglement and collaboration. This thesis contends that the fiction of today is answering Whitehead and Woods' call for second wave medical humanities "to address difficult, more theoretically charged questions, and to claim a role much less benign than that of the supportive friend" (2): contemporary novels do not simply aspire to help doctors do their jobs better, but to attack, challenge, provoke and unsettle. It is not just the doctor-patient relationship that is under the microscope, but larger institutions and systems of oppression – government policies, psychopharmacology, cultural perceptions of illness, recovery – providing a landscape in which this more critical, complex medical humanities work can be undertaken.

Whitehead and Woods contend that first-wave medical humanities operated under "a humanist emphasis on individual protagonists and the role of narrative, metaphor and gaps in communication within the dynamics of the clinical interaction;" or, simply put, it was about "the humanities [. . .] looking at medicine looking at the patient" (2). While contemporary novels offer deeper insight into the interaction of medicine and mental illness, they most certainly still provide this vantage point: every novel discussed in chapters two through four includes at least some kind of contact between protagonist and medical professional, and most often through a critical lens that highlights medical shortcomings, ineptitudes, bias and manipulation. It is easy to see how reading novels like *Poppy Shakespeare* and *The Fat Lady Sings* could inform medical practice, instil empathy in practitioners and open lines of communication, fulfilling these first-wave goals. Early stages of medical humanities were underpinned by a desire to shift authority "from the doctor's professional expertise to the patient's experience" (24), and the novels within this thesis – with their focus on day-to-day life and relationships rather than clinical visits – show that this transition is well underway in the literary realm, with fiction further centring mental illness around those who have it rather than those who treat it.

That said, it is clear that 21st century fiction has moved on from the limited methodology and aims of first-wave medical humanities. As Whitehead and Woods explain, early work in the field prioritised "realist account[s] of a particular medical condition," narratives which were "seen to provide an effective vehicle for articulating illness, and to hold potentially transformative value" (4); while memoir, by definition, continues to provide these "realist accounts" – and thus, ongoing insight into life with illness – the fiction of today has splintered off in a desire to do more than simply "articulate" what it means to be mentally ill. *MYRR* and *Sad Janet*, both satires with darkly comedic plots and eccentric protagonists, employ exaggeration in order to lambast 21st century psychopharmacology and highlight the manipulation within Big Pharma. The equally sardonic *Poppy Shakespeare*, with its caricatured day patients and laughable administrative roadblocks, takes aim at government bureaucracy and institutionalisation and, along with *Rabbits for Food*, challenges the current medical emphasis on recovery. These novels are not about simply improving the doctor-patient relationship but about overhauling the entirety of mental healthcare and the attitudes surrounding it; they provide not just a lens but a match, a bulldozer, a pitchfork. Imbuing practitioners with empathy, while certainly beneficial and worthwhile, isn't going to mitigate the complex concerns surrounding contemporary mental illness – issues of quantifying mental illness, pathologizing sadness, rampant recidivism, stigma – that cannot be solved within the confines of an examination room. What of the women who, whether by choice or by preclusion, never make it to the doctor in the first place? As Whitehead and Woods argue, critical medical humanities puts "less [emphasis] on individual patient experience and more on broader institutional and systemic problems"(24), and, while contemporary novels have by no means abandoned the individual experience of mental illness, they have certainly threaded these larger criticisms throughout it.

This thesis argues that fiction of today is about life *outside* illness, focused less on the symptoms and treatment of mental illness, and more on the facets of life that are intrinsically interwoven with it; this mirrors the shift in medical humanities from ethics, education and experience (what Whitehead and Woods refer to as the original "three Es" of medical humanities) to a fourth 'E' that the pair argues drives the second critical wave: entanglement (3). Multidisciplinary by design, critical medical humanities engages with biomedicine and the humanities, but also feminist theory, disability studies, queer theory and social sciences like geography, politics, philosophy and sociology. In "Critical Medical Humanities: Embracing Entanglement, Taking Risks," William Viney, Felicity Callard and Angela Woods note that medical humanities investigates how "'race' and ethnicity, sexuality and gender, disability (and madness), technology and media, economics, and social and environmental inequalities are central to the production of medical knowledge and to the experience of health and illness" (Viney et al. 3). The novels within this thesis bring these connections to life, evidencing the ways that mental illness is impacted by motherhood, culture and race, history and geo-politics, family, social expectations, sexuality[19] and other intersectionalities. "We call for more intensive engagement in the medical humanities with how health, illness and treatment are constituted in and through tangled webs of human and non-human biosocial organisms, political-economic formations, discourses and affects" (Viney et al. 3), and this

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[19] *Poppy Shakespeare* and *Rabbits for Food*; *Everything Here is Beautiful*, *The Fat Lady Sings*, *The Icarus Girl*; *The Icarus Girl*; *My Year of Rest and Relaxation*, *Sad Janet*, *Everything Here is Beautiful*; *My Year of Rest and Relaxation*, *Sad Janet*, *Everything Here is Beautiful*; *The Fat Lady Sings* (respectively)

thesis contends that contemporary novels are incorporating this idea of entanglement into their narratives in a way that supports this vision for the future of medical humanities.

While a second-wave emphasis on entanglement assumes a reciprocity between disability studies and medical humanities, the relationship between the two has not always been such a diplomatic one, with Stuart Murray noting in his 2023 book *Medical Humanities and Disability Studies: In/Disciplines* that their connection has been “uneven, contradictory, poorly articulated and not infrequently characterised by suspicion or intellectual one-upmanship” (19). This contention is unsurprising given that the very names of the disciplines mark a provocative difference in centredness, with medical humanities (in its original conception) on non-disabled medical practitioners and disability studies on the lives and barriers of the disabled; it is easy to see how disability studies has a propensity to claim the high ground and, in turn, view medical humanities as in dire need of its help. Yet, Murray calls for less division and more cohesion, inviting all those concerned with health – doctors, those that are disabled or ill, academics – to move past these “words that designate disciplines” (19) to focus instead on possibilities and imaginings, the ways that medical humanities and disability studies can function as systems that work together, not against each other, to spark conversations on health and improve the lives of those who are unwell. I argue that fiction offers a platform for illuminating this mutuality. For example, Jess’s diasporic turmoil in *The Icarus Girl* evidences the interaction between historical racial-cultural tensions and mental health; from a disability studies perspective, this offers a glimpse into intersectional identity and the way that intergenerational trauma can influence mental health, while reading the story through a medical humanities lens elucidates the clash between Western and non-Western mental health treatments. These readings are not adversarial or oppositional, but rather two sides of the same coin; both shed light on the connection between culture, ethnicity and health and position mental health as relational, and together offer a more holistic view of mental illness that can only benefit those who have it.

Language and Text Choices

Language

When determining how best to address language and terminology in my thesis, I turned to feminist disability theory as well as Maria Rovito's notion of a madwoman theory, which she describes as a cross-over between Mad Studies and disability studies. Inaugural feminist disability scholars such as Rosemarie Garland-Thomson view disability as socially exclusionary, borne of "discriminatory attitudes and practices" toward disabled communities and identities that must be challenged and overthrown as part of a larger goal to "denaturalize disability" ("Feminist" 1557). Garland-Thomson advocates for avoiding reductive impairment-focused or medical categories and instead concentrating on shared experiences of injustice; she argues that precise terminology is required to counteract the negative connotations of much of this kind of language, for example, reframing derogatory terms like "deformities" or "abnormalities" as "the traits we think of as disability" (1558), a simple shift in language that helps counteract the view of disability as unnatural and problematic.

I have taken these views on board in my own writing, and my usage of language is similarly exact and purposeful. For example, the term 'disorder,' defined by the Oxford English Dictionary as "an illness or condition that disrupts normal physical or mental functions" ("Disorder"), paints mental illness as deviant and anomalous, thus perpetuating the normal/abnormal dichotomy that contemporary disability theory seeks to overturn; the prefix 'dis-' – which is also seen in words like 'distrust,' 'disgrace' and 'dislike' – brings with it negative undertones that are difficult to overlook. Additionally, 'disorder' has become increasingly emotionally-charged within the landscape of mental illness, in no small part due to its frequent use in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the *International Classification of Diseases* (*ICD*) – the medical handbooks used in diagnostic settings, which have been heavily criticised for adopting a 'tick list' approach to mental illness that ignores social and personal circumstances.[20] Given that many of the novels I turn toward

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[20] I speak about this in greater detail in Chapter Two.

in this thesis – for example, *Poppy Shakespeare* and *Sad Janet* – push back against the content and language within these manuals, it seems only natural that I avoid this kind of vocabulary in my own work. I use ‘disorder’ only when employed by an author or scholar, instead opting for phrases like ‘mental condition’ or ‘mental health issues’ in my own analysis. Similarly, in an effort to combat ableist assumptions, I refrain from designating a character as ‘suffering’ from mental illness unless specifically speaking to the ways in which her life is made more difficult by her illness; I do not simply say ‘she is suffering from mental illness’ as a synonym for ‘she has mental illness.’

The term ‘mental illness’ is itself a thorny one. Rovito, as part of her conceptualisation of a new madwoman theory, chooses to use ‘mental difference’ rather than ‘mental illness,’ in the same vein that intellectual disabilities are sometimes referred to as ‘cognitive differences.’ She explains that “the paramount tenet of madwoman theory argues for understanding the lived experiences of disabled women rather than reading their lives and works as a symptom of a specific psychiatric ‘illness’” (Rovito 324-5), with much of her argument hinging on the stigma surrounding the pathologisation of mental health issues and the inherent privileging of medical discourse over patients’ voices. While these are certainly valid points, I argue that recent fiction presents mental illness in a way that intentionally prioritises the individual experience over medical interventions while also challenging the shame and negativity surrounding it. The representations of female mental illness that I discuss in Chapters Two, Three and Four are not regurgitations of simplistic, stigmatising clichés, but are instead active attempts to *destigmatise* mental illness; therefore, referring to them as representations of mental ‘illness’ is not damaging or antithetical but empowering. Just as N uses the term ‘dribbler’ to take ownership of her position as a psychiatric day patient in *Poppy Shakespeare*, so too can the term ‘mental illness’ be reclaimed. Perhaps the best way to break the connection between illness and debility isn’t to remove the term illness altogether but to show the ways that illness can birth strength, power, freedom; illness is a natural part of life – *everyone’s* life – and configuring it as a single facet that need not, by definition, occlude experiences of joy and love and independence can benefit even those outside of the mental health community. I also contend that Rovito's term 'mental *difference*' implies an aberration from an invisible norm, which, much like 'disorder,' further props up the normal/abnormal divide; to this end, while I admire Rovito's attempt toward inclusivity and enfranchisement through a shift in vocabulary, I have taken a different approach and continue to use the term 'mental illness' throughout my thesis.

The field of Mad Studies, unsurprisingly, prefers the term 'madness' instead, with Robert Menzies, Brenda A. LeFrançois, and Geoffrey Reaume explaining in the introduction to *Mad Matters: A Critical Reader in Canadian Mad Studies*, that "once a reviled term that signalled the worst kinds of bigotry and abuse, madness has come to represent a critical alternative to 'mental illness' or 'disorder' as a way of naming and responding to emotional, spiritual, and neuro-diversity" (LeFrancois et al. 10). Kimberly White and Ryan Pike use madness "to reflect a more inclusive and culturally grounded human phenomenon that encompasses various historically and contextually specific terms such as insanity, feebleminded, mental disorder, and mental illness" (White and Pike 250), viewing 'madness' as an umbrella term. While widely used among Mad Studies scholars, the term 'madness' is not without controversy. In his book *Madness: A Very Short Introduction*, Andrew Scull admits that his title "is bound to provoke, to raise hackles, in some quarters to infuriate" (2), noting that for many of those with "serious disturbances of emotion and cognition," the term is "an insult, a stigmatizing and hurtful anachronism that should be dead and buried" (1). In a 2014 interview with *The Guardian*, Kate Nightingale, head of communications at Time to Change, explains that while events like Mad Pride seek to reclaim the term 'mad,' it can still cause offence, but ultimately, "we don't want to discourage [discussions about mental health] by becoming too precious or particular about the terms used" (Nunn). While I understand Nightingale's point – these conversations are certainly important – the language surrounding mental health is so entangled with emotion and stigma that I do not feel it can be ignored, and I tend to align more closely with Garland-Thomson's belief that we should be purposeful and exact with our choice of words; accordingly, I believe that academics have a responsibility to employ terms that individuals living with mental health issues feel comfortable using, in the same way that we now ask people for their preferred pronouns before addressing them. In line with this thinking, I do, at times, use the term 'madness' as well as 'mental illness' in my thesis in an effort to continue the work of Mad Studies scholars.

The aim of my thesis is to offer a detailed literary analysis of experiences as they are presented on the page, not to offer diagnoses or medical opinions beyond my purview; consequently, I name specific medical conditions in my analysis only when they have been discussed overtly in the text, and I describe a character as having a certain illness only when an author has explicitly done so herself. As Julia Miele Rodas and Melanie Yergeau argue in *Autistic Disturbances*, retrospective and literary diagnoses reinforce the historical tradition of pathologising and labelling women without their input or consent and should be avoided, sentiments that have been echoed by both Rovito and Garland-Thompson. "This act of labeling that arises from literary and psychoanalytic scholarship" explains Rovito, "is an attempt to fix and cure these individuals through the medicalization of disability without acknowledging any perspective of patient or survivor narrative" (318); the disabled individual is imprisoned by a diagnosis without trial, jury or personal testimony, and her voice is further silenced within this medical model.

Text Selection

The novels examined in this thesis are situated within a specifically Western cultural context, spanning primarily the United States and the United Kingdom, and written in the first two decades of the twenty-first century. This period, bookended by 9/11 and the Covid-19 pandemic, is one which saw mental illness become an urgent cultural conversation, buoyed by unprecedented events that intensified discussions around vulnerability, resilience and the limits of the healthcare systems.

Focusing on this time period allows me to explore how neoliberal capitalism, with its emphasis on self-management and productivity, frames mental illness as an individual failure to cope rather than a symptom of structural pressures, and the ways in which female writers challenge this late-capitalist agenda. I draw on Rottenberg's criticism of neoliberal feminism, a concept that, underpinned by feminist manifestos like Sheryl Sandberg's *Lean In* (2013), frames the gendered subject as a self-optimising individual who is "distinctly aware of current inequalities between men and women," yet who "disavows the social, cultural and economic forces producing this inequality." As Rottenberg explains, "This feminist subject accepts full responsibility for her own well-being and self-care, which is increasingly predicated on crafting a felicitous work-family balance based on a cost-benefit calculus" (420). This framework is essential for understanding how contemporary Western expectations place mental illness firmly within the shoulders of the individual, obscuring the systemic pressures – economic, social and institutional – that shape women's psychological distress in the early twenty-first century; in turn, the novels I examine resist this depoliticising, privatising logic, instead revealing mental illness as embedded in broader structures of social expectations, cultural labour, economic disparity and care inequities within the late-capitalist Western world.

The selected texts – from Allan's *Poppy Shakespeare* to Britsch's *Sad Janet* – illustrate how women's writing during this era stages mental illness as a site of resistance to reductive diagnostic paradigms, as well as a critique of cultural ideals of productivity, rationality and resilience that frame mental illness as a private failure rather than a collective social issue. While firmly grounded in the specificities of UK and US mental health discourse, these works also highlight global concerns, from diasporic identity in Oyeyemi's *The Icarus Girl* to immigration in Lee's *Everything Here Is Beautiful*. Taken together, they reflect the cultural pressures and shifting discourses of the early twenty-first century, revealing how women's writing reimagines the boundaries of illness, disability and care under late capitalism.

The novels examined also participate in recent experiments with the form of the contemporary novel. Scholars have emphasised the extent to which twenty-first-century fiction negotiates the tension between intimacy and difficulty; it seeks to draw readers into experiences of voice, interiority and affect, while also resisting the ease of empathy through unreliable narrators, formal disruption or narrative withholding (Felski; Levine; Ngai). These dynamics are especially pronounced in novels concerned with mental illness, where the form itself becomes a way of registering the difficulty of representing chaotic or resistant states of being. By employing fragmented structures, dark humour and protagonists who refuse sentimentalisation, these texts challenge conventional empathic responses and instead create a more ambivalent intimacy between reader and character – one that mirrors the complexities of encountering mental illness in social life.

I further restricted my choice of core texts to female-authored novels featuring women[21] with mental health issues, thus enabling me to investigate the complex relationship between gender and mental health and unpack the reasons behind the higher prevalence of mental illness in women. By concentrating on women – both authors and characters – I can sufficiently delve into what is being said about the female experience of mental illness – the causes, the stigma, the day-to-day living – and the ways in which these portrayals challenge, or alternatively, support dominant discourse surrounding mental health. While I confined my novel selection in many ways, I chose not to include type of illness as one of my criteria; I analyse books that depict Common Mental Disorders as well as others such as schizophrenia. Not only does this allow for a more encompassing analysis of mental illness, but it demonstrates that the messages sent by these novels – of recovery, of identity, of social perceptions – are not limited to specific illnesses. Finally, in order to ensure my thesis's contribution to academia and beyond, I selected novels lacking extensive critical scholarship, focusing instead on compelling and artistically noteworthy works whose messages on mental illness have yet to be adequately examined.

The exception to the above conditions is the YA novel *13 Reasons Why*, which is written by a male author and, due to its adaptation into a Netflix television series, has received a substantial amount of attention. Having read the book when it was initially released in 2007 – entirely for pleasure and without a critical eye – I found it very entertaining and compelling; however, while

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[21] My focus on this thesis is on cis-gendered women. While I am aware of the many mental health concerns of trans-women, I feel that I would not be able to do this area of mental health justice within the scope of this thesis. I also did not come across any recent fiction featuring trans-women with mental health issues, a point that I make in the conclusion when suggesting the ways in which contemporary literature can improve and continue to diversify.

writing the chapter on YAL, I found myself wondering if a re-read would provoke a harsher judgment. How might my opinions have changed now that I am older and more cognizant of poor representations of suicide and mental illness? I realised, perhaps, that this is one of the key issues with YAL – it *is* wildly engaging and easy to enjoy, without comprehending the potential danger of the messages within, and this makes its influence over young readers all the more worrying. While I was initially reluctant to breach my own selection criteria, I felt that I could not complete an adequate analysis of suicide in YAL and the dangerous repercussions of such depictions without including this pivotal work.

Though I refer to specific memoirs throughout my thesis, I made the decision not to include these in my in-depth analyses and instead focus entirely on fiction. While memoir begins with a lived experience and teases out a cohesive narrative with overarching themes and insight, I am more interested in the messages that, given free creative license, women writers choose to disseminate through their character- and world-building. Free from the constraints of truth and memory, fiction allows for a bottom-up approach, a narrative crafted with intent and autonomy, thus better addressing my question of, “What are women saying when they write about mental illness today, and how does this reflect or challenge the social, cultural and psychiatric trends of the early 2000s?” The very nature of fiction, its lack of limitations – shifting perspectives, fleshed out supporting characters (whose consent to be included in the text need not be sought), detailed dialogue – allows for an arguably more comprehensive and compelling investigation into the nature and impact of mental illness. While G. Thomas Couser suggests that “memoir is more literary today than ever before,” he admits that fiction “can do things and go places that memoir cannot,” with the novel “a far more capacious and flexible genre” (176); fiction’s ability to utilise satire, hyperbole and make-believe provides an open-ended template through which all aspects of mental health can be explored and critiqued, in which authors can explore “the total milieu their characters occupy” (Couser 173). Furthermore, analysing novels rather than memoir removes the ethical implications of criticising someone's lived experience and her perception of her illness, as well as the morality involved with drawing meaning from a difficult period in someone's life.

I also believe that memoir is largely tied to a narrative structure – the diagnosis-treatment-recovery paradigm – that fiction is attempting to subvert; while this is certainly not true of all memoirs, enough popular illness memoirs adhere to this pattern that as a genre, they support the stereotyping of such an experience. William Styron's *Darkness Visible: A Memoir of Madness* (1979), Susanna Kaysen's *Girl, Interrupted* (1993) and Lori Schiller and Amanda Bennett's *The Quiet Room* (1996), while critically acclaimed for their candid depiction of trauma and mental distress, nonetheless follow this structure, as do many celebrity memoirs about mental illness, including Brooke Shields' *Down Came the Rain: My Journey Through Postpartum Depression* (2005) and Portia De Rossi's *Unbearable Lightness: A Story of Loss and Gain* (2011), which chronicles the actress's experience with anorexia. It comes as no surprise that a 2019 article on bookriot.com titled "50 Must-Read Memoirs of Mental Illness" features the term 'diagnosis' seventeen times and is equally riddled with words like 'hope,' 'inspiring,' 'overcome' and 'survival' (S. Davis).[22] Fiction, untethered from the burden of reality and the boundaries of lived experience, has the freedom – and power – to explore mental illness without this onus of 'hopeful' and 'inspiring' meaning-making, leaving authors unrestricted to explore a diversity of themes and alternative avenues of empowerment beyond stereotypical recovery.

My research reveals that untidy, discomforting, ambiguous endings – while the exception in memoir – are the norm for contemporary narratives of female mental illness. As Ann Jurecic explains in *Illness as Narrative,* "Readers' preference for triumph points to the problem at the heart of personal accounts of risk: because these chronicles follow narrative conventions, including closure, they contain the very essence of that which they engage – uncertainty" (24). Jurecic is speaking here about Stephen Jay Gould's 1985 article "The Median Isn't the Message," in which he discusses the

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[22] *hope* appears 13 times, *inspire/inspiring/inspiration* 10 times, *overcome* 5 times, *survive/survival/survivor* 5 times; in addition, *diagnosis/diagnose* appears 17 times, *treatment/treat* 8 times and *recovery/recover* 5 times

median mortality rate – eight months – of the cancer with which he has recently been diagnosed. Gould's survival nearly two decades beyond this statistic has, argues Jurecic, led to his article being adopted by cancer survivors as an "uplifting" tale of overcoming the odds, with the article ultimately functioning as a "story of triumph over adversity" that "obscures the narrative about statistics" (24) that Gould intended to be the focus of his piece. Whereas Gould's experience with illness carried on after the conclusion of his memoir, the final words in a fictional text are definitive, and the intentional messages within a novel itself cannot be eclipsed by the ongoing real-life experiences of characters that do not exist beyond the page. Similarly, the separation between character and author in fiction prevents the reader from bringing in any outside information or assumptions to the text – for example, knowledge that a memoirist is still alive and well – allowing for a fuller engagement with the "uncertainty" of which Jurecic speaks. If a novel ends with ambiguity, is it up to the reader to grapple with the implications of this, and any lingering tension – questions of 'what happens next?' – cannot simply be eradicated with a Google search of the author's name.

While many illness narratives embody the diagnosis-treatment-recovery paradigm in a way that evokes optimism and empathy, an opposing category of life-writing exists that better fits into what Couser refers to as "misery memoirs," a term he uses to describe contemporary tales of "woe and suffering" (147) that form a genre of "survivor testimony" (148). Elizabeth Wurtzel's *Prozac Nation*, for example, is described in a 1993 *New York Magazine* review as a "self-obsessed case study," a prolonged diary entry rife with self-pity that shifts from "only intermittently tolerable" to "almost unbearable" (Kirn). Although Couser admits that "misery memoirs" may be penned in an effort to heal, he argues that this is not a reason to altogether dismiss the genre, and instead, each work should be judged on its "individual merits" (148); he cites Mary Karr's *The Liars' Club* – a memoir brimming with death, adversity and woe – as a "misery memoir" that nonetheless has "considerable literary merit" (147).

While illness memoirs seem to be criticised for being either too inspiring or too dark, contemporary fiction like *Everything Here is Beautiful* and *Sad Janet* defies such a divide. Recent novels are not victim narratives or “misery memoirs,” nor are they universally uplifting experiences in which mental illness is surmounted; rather, these novels linger in the either, refusing to pin themselves down to a prescribed presentation of illness, expanding the repertoire of representation and underpinning the notion that there is no one way of being mentally ill; therein lies their power, and also, their appeal.

Breakdown of Thesis

My approach to fictional mental illness is one that focuses on literature’s capacity to evoke positive change – to broaden understandings, challenge stereotypes, foster self-acceptance, promote empathy – and this thesis is organised in a way that elucidates the extent to which fiction performs this work while – equally importantly – underpinning the social and cultural necessity of such progress.

Any successful discussion of the present must begin with an analysis of the past; situating the contemporary period within a larger historical timeline allows me to trace the evolution both of mental illness care and the fiction that depicts it and, in turn, shed light on the restrictive experiences that recent fiction seeks to diversify. In Chapter One, I detail the literary history of female mental illness from the 1600s to the end of the 20th century, showing how representations of mental health are linked to trends and concerns of the time and are subsequently limited in the scope of their social implications; I connect this to post-2000 fiction, which has expanded the range of its commentary in line with the growing public dialogue on mental illness to empower, educate and engage in a way not seen in previous time periods.

The next two chapters focus on the ways in which contemporary fiction breaks with the diagnosis-treatment-recovery paradigm, with Chapter Two focusing on medicalisation and the accompanying shift in depictions of diagnosis and treatment, and Chapter Three centring on novels that unravel traditional ideas of recovery. In Chapter Two I examine self-care, capitalism and abuse of psychopharmacology in *My Year of Rest and Relaxation* and the pathologisation of sadness in *Sad*

Janet. I argue that these novels serve as strong condemnations of Big Pharma as well as the neoliberal values and social expectations that exacerbate female mental illness. Chapter Three establishes how recent fiction confronts the heavily politicised modern-day recovery agenda through an analysis of *Poppy Shakespeare*'s satirical attack on mental health services and the configuration of 'statistical hope' and self-resignation as internal obstructions to recovery in *Rabbits for Food*. I show how these chaotic, open-ended novels challenge the normalisation of 'getting better,' resisting the "compulsory positivity" (Woods et al. 222) of the Recovery Narrative and instead embracing uncertainty.

Chapter Four addresses intersectionality in recent representations of female mental illness, examining the nature and function of intersectional identity and the degree to which issues of race and sexuality further contribute to the destruction of the diagnosis-treatment-recovery model of illness. By focusing on the fictional experiences of minority and lesbian women in *The Fat Lady Sings*, *The Icarus Girl* and *Everything Here is Beautiful*, I illustrate how 21st-century literature has moved beyond intersectionality as additional or competing Otherness to depict the subtle complexities of overlapping marginalities.

While the previous three chapters highlight the progress within contemporary fiction, its ability to empower mentally ill women through a welcome expansion of representation, Chapter Five reveals that there is still much work to be done in this arena. In this final chapter, I highlight the shortcomings of Young Adult Literature and its propensity to rely on stigma-laden stereotypes that perpetuate archaic ideas about mental health, or, at the other end of the spectrum, romanticise issues like depression, self-harm and suicidal ideation by portraying them as trendy and attractive. To what degree are young people being trained – in the name of entertainment – to prop up the dangerous stereotypes that disability theory, Mad Studies and contemporary authors are devoted to dispelling?

This leads into my conclusion, which suggests how theorists, academics, educators and authors might work together to mitigate and ultimately prevent the damaging rhetoric proliferated by YAL. I also propose areas for further research, including bibliotherapy, the notion that literature can be restorative, educational and therapeutic; using the novels in Chapters Two, Three and Four, I suggest how the fiction of female mental illness might be utilised to better the actual lived experiences of women with these illnesses. By harnessing conduits of recognition, education and empathy, fiction is well-positioned to not just depict change, but propel it.

This thesis sets out to show that novels of today provide a wealth of representations that are finally beginning to reflect the true diversity of mental illness while simultaneously providing a social commentary that links to timely issues within the mental health landscape. These are novels that don’t end with cure, that don’t hinge on tried-and-true treatment methods, that don’t mask the messiness and chaos of mental illness; they present protagonists who self-medicate, or conversely, resist treatment altogether, women who don’t want to get better or cannot get better, characters who choose to live alongside their mental illnesses rather than treat them as life-limiting disease that must be eradicated. These are novels that challenge dominant health discourse by offering glimpses into non-normative experiences, and this is a welcome trend that has the power to ameliorate stigma and foster social equality by offering additional routes of recognition, education and compassion, and – perhaps even more significantly – position mental illness front and centre in a way that demands – and deserves – to be heard.

Chapter One: A Brief History of Female Mental Illness

While my introduction serves to underpin the theoretical groundwork for my research, this literature review focuses on context, locating contemporary fiction and mental healthcare on a timeline of personal and medical experience with the aim of linking the present to past oppression, archetypes and inadequacies. I begin by exploring Phyllis Chesler, Elaine Showalter and Lisa Appignanesi's seminal feminist research as it applies to current mental health discourse, explaining how subsequent chapters of this thesis extend the scholars' arguments by interrogating them within the framework of 21st-century fiction. How do recent novels add to ongoing conversations on topics like medicalisation, gender roles and trauma, and what do these interventions tell us about contemporary madness?

I then offer a brief history of psychiatry in order to situate modern-day mental healthcare as a product of a patriarchal, disempowering, discriminatory past; since the birth of psychiatry in the 1800s, women have been treated inequitably within the medical sphere, and this thesis contends that the fiction of today not only reveals a continuation of female disenfranchisement, but seeks to challenge and overturn it. Modern-day novels unabashedly condemn the current state of mental healthcare with an eye toward change, proposing improvements, a new path forward, that would better support women's mental health. Today's authors are champions of women's rights – not just medical rights, but social, political, *human* rights – endeavouring to both disparage and dismantle the institutions that have forsaken women for generations.

I move from historical analysis to literary analysis, and the last section of this literature review examines canonical fiction involving female mental illness. What messages do these important works send about madness, how are they linked to contemporaneous attitudes about mental illness, and, as this thesis aims to uncover, how do these ideas differ from those within 21st century fiction? This inquiry into the relationship between canonical novels and historical mental illness solidifies fiction's longstanding role as a social mirror, reflecting, and at times challenging, concurrent norms surrounding the diagnosis, treatment and perceptions of female mental health; by bringing this analysis into the 21st century, this thesis argues that today's novels reflect the burgeoning range of interest and investigation into mental health, focusing on a multitude of areas from psychopharmacology to recovery to identity that far exceed the breadth of previous eras. Contemporary fiction is not merely a response to the current social, medical and political landscape but an active participant within it, not only a mirror but a picket sign, a megaphone, a call to action, with the words of authors like Jacqueline Roy and Clare Allan continuing to echo and expose but also, more importantly, to antagonise and annihilate.

Why Do Women Go Mad?

Phyllis Chesler's ground-breaking feminist work *Women and Madness* said in 1972 what women had been thinking for generations: being a woman is oppressive, and oppression and discrimination are traumatising. Women have been perpetually defined by their conformity to prescribed roles of demure daughter, dutiful wife and perfect mother and are admonished when they fall short of expectations. In *The Female Malady*, Elaine Showalter validates women's social situation as complicit in their statistical overrepresentation among the mentally ill as far back as the 17th century. "The cumulative effect of being forced to lead circumscribed lives is toxic," (25) and a breeding ground for anxiety, depression, eating disorders, stress-related illnesses and other mental problems, Chesler notes. In the 21st century, women who dare to work alongside family commitments are criticised for dividing their focus; women who choose to be full-time housewives are derided for failing to contribute financially to the household. Those women who choose not to marry or have children, or who struggle with fertility problems and cannot conceive, are met with an onslaught of invasive questions about their life choices and pitied for what must certainly be a sad little life. Society does not want women to succeed, Chesler argues, but when they "*do* succeed at anything, they have still failed if they're not successful at *everything*" (329, emphasis hers).

Though we have made progress, the gender inequality and sex-stereotyped social roles that Chesler wrote about in 1972 and again in 2005 are still prevalent today. A study by UN Women on gender equality during the Coronovirus epidemic found that the brunt of unpaid work such as housework, childcare and home-schooling was done by women, even in households where both a man and woman worked full-time from home. Women, who were already doing three-quarters of unpaid work in their households prior to the crisis, now found themselves in a situation where "everything we worked for, that has taken 25 years, could be lost in a year," according to UN Women Deputy Executive Director Anita Bhatia. "Employment and education opportunities could be lost, and women may suffer from poorer mental and physical health" (Lungumbu and Butterly). A study by McKinley and Company corroborated these fears, revealing that women were 1.8 times more likely to lose their jobs during the pandemic than men (Madgavkar). What a woman needs to combat this labour inequity, both professional and domestic, Chesler explains in her updated introduction, is a feminist therapist who will tell her that she isn't crazy for feeling angry or emotional about being "overworked, underpaid, underloved. [. . .] that it's healthy to harbour fantasies of running away when the needs of others threaten to overwhelm her" (30). While this notion of oppression as traumatic has been explored in recent fiction such as Mira T. Lee's *Everything Here is Beautiful*, Binny Kirshenbaum's *Rabbits for Food* and Lucie Britsch's *Sad Janet*, which depict the complex relationship between sex-stereotypes and mental illness, this thesis reveals that Chesler's desire for a feminist therapist has yet to come to fruition; instead, women continue to be let down by a male-dominated healthcare system that reinforces rather than challenges the gender norms that tear down women.

Women also suffer physical and emotional pain, which can cause symptoms that masquerade as madness, Chesler posits. The #MeToo movement that went viral in 2017 revealed just how pervasive sexual harassment and assault against women are. The constant state of terror endured by victims of domestic violence, the brutality and shame of rape, the manipulation and control women face in relationships – these injustices are traumatic and often lead to women being diagnosed with borderline personality disorder rather than treated as victims. Instead of garnering sympathy and support, when women get raped or attacked, the questions in the comment sections of news articles are always the same: ‘What was she wearing?’ ‘Was she drinking or doing drugs?’ ‘Why was she walking alone at night?’[1] This victim-blaming amplifies the trauma of the event itself and leaves women feeling isolated, ashamed and distressed. If women seek mental health help in the aftermath of sexual violence, they are, as Chesler argues, “diagnostically pathologise[d] [for] what might be a totally normal human response to trauma” (1). Is a survivor of rape mad? Or is she actually the antithesis of mad and displaying the most rational response of anyone in her situation? While Chesler raises these questions in regard to real-life women, I interrogate the link between trauma and mental illness in *fiction* and analyse how authors contribute to this debate by producing characters and stories that explore trauma – both sexual and otherwise – as a cause of pathologised mental illness. In Jacqueline Roy’s *The Fat Lady Sings,* for example, Merle’s mental distress is tied to a sequence of trauma including childhood rape, an abusive husband and a pregnancy loss, and she regularly hears voices calling her a “dirty girl” (81) and a “fucking whore” (82); while Merle’s erratic behaviour leads to her medical incarceration, Roy depicts Merle’s anguish with nonjudgmental empathy, and it is the compassion and companionship of fellow patient Gloria that aids Merle more than nurses and medication.

The external cause of mental illness is connected to Lisa Appignanesi’s argument in *Mad, Bad and Sad* regarding the “shallowness of sanity” (2), and the notion that everyone’s grasp on sanity is tenuous at best; we are all sitting on the edge of madness, teetering so precariously that it is not just unexpected and profound obstacles that may send one toppling, but also common, everyday predicaments. I explore this in Chapter Two, arguing that *Sad Janet*’s female friendships help contain her sadness within the affective realm, while the narrator’s social isolation in Ottessa Moshfegh’s *My Year of Rest and Relaxation,* contributes to her downward spiral. Appignanesi attributes the rise in mental illness to the fact that “unhappiness is medicalised” and society looks

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[1] A 2015 study on rape culture in the media found victim-blaming in 25% of online comments (Zaleski et al.).

for quick fixes to everyday life problems amid the “unstoppable growth [of] potential cures” (3) and the inflated promises of new drugs. Predictably, disenchantment quickly follows once patients realise that happiness doesn’t come in a single pill, a few weeks of therapy or a one-off session of cognitive behaviour therapy. What history has proven is that cures are rarely rapid, comprehensive or enduring. “There are many aspects of our lives,” Appignanesi argues, “which have ended up within the terrain of the mind doctors when they might more aptly belong in a social or political sphere either of action or of interpretation” (4). I examine this pathologisation of everyday emotion and abuse of psychopharmacology at length in the next chapter.

In addition to oppression and trauma, Chesler also discusses the clinical bias in the psychiatric treatment of women, notably that women are often wrongfully diagnosed and medicated by doctors who dismiss their physical pain as psychological, all in their head, imaginary. Anxiety and depression are real, but they can also be secondary symptoms of chronic pain and other underlying medical issues. This notion that women cannot even be trusted to evaluate their own physical pain supports Chesler’s idea that women are engaged in an unwitting, unwinnable war with men to prove that they are not innately predisposed to mental illness, hysterical, child-like, manipulative, hormonal, and either cold or smothering as mothers (2005 Introduction). Showalter agrees that women aren’t just mad but are actually seen as the physical embodiment of madness itself, citing the cultural tradition which has habitually conflated “women with irrationality, silence, nature and body, while men are situated on the side of reason, discourse, culture, and mind” (4). Appignanesi adds that the magazine *Psychologies,* which examines mental health and psychological issues in a publicly accessible, pop-culture format, nearly always has a woman on the cover, as if to suggest that women are the only ones interested in or experiencing mental health issues (7). I touch upon psychological gender stereotypes in Chapter Two with my analysis of Janet’s stoic demeanour, a coldness which, because she is a woman, is perceived as mental illness, whereas similar behaviour in a man would, I argue, likely be lauded as an asset.

Ultimately, women are damned if they do and damned if they don't. Either they are these things that men and society accuse them of being, in which case they are innately and unavoidably mad by the very definition of what a woman is, or they dare to rebel and push back against these strictures, in which case they are mad as well. Showalter contends that we must dismantle this connection between women and madness by subverting the very foundation of patriarchal society in which men determine the range of acceptable female behaviour. I address this in my thesis, evaluating the link between femininity and madness within fiction and the way that contemporary authors depict and then criticise this association, ranging from day patients claiming in Clare Allan's *Poppy Shakespeare* that the titular character – with her fashionable clothes, trendy makeup and well-groomed hair – can't possibly be mentally ill, to Lucia's male psychiatrist in *Everything Here is Beautiful* suggesting that she doesn't need a job to support her mental health because she already has one – mother.

These debates surrounding oppression, trauma and gender roles, as well as criticisms of the pathologisation and medicalisation of mental distress, are not just prevalent within the mental health community, but in the contemporary fiction that portrays situations of mental illness. Modern-day authors are attacking the many institutions that damage women's mental health – with Britsch condemning the pharmaceutical industry, Roy denigrating social expectations, Allan chastising modern mental health services – in a literary call to arms. These representations of female mental illness are not merely entertainment but empowering interventions that serve to unsettle stereotypes and ultimately, break down the barriers that break down women.

Asylums and Historical Treatment of Mentally Ill Women

The kind of gender inequity and sexism described by Chesler, Showalter and Appignanesi is far from new, and while the context surrounding the examples above – Covid-19, social media, the profusion of pills – may smack of modern-day culture, the messages of female oppression, abuse and marginalisation are pervasive throughout history. The nineteenth-century doctrine of coverture within English Common Law (Stretton and Kesselring), the longstanding English royal tradition of public labour and birth (Waxman), the lack of female voting rights in early 20th century America ("19th Amendment"), Chinese foot-binding (Foreman), Russia's current list of banned jobs for women ("Russian Federation") and the ongoing inability of sub-Saharan African girls to obtain an education ("Africa") are but a few examples of the gendered power imbalance that has for centuries extended beyond familial relationships to include occupational, political, educational and medical opportunities. This part of my thesis examines female inequality within the latter realm, specifically the medical branch of psychiatry, detailing the development of mental health discourse and care in the Western world; my research ultimately demonstrates that while trends in treatment, diagnosis and care continually shift and evolve, the medical disenfranchisement of women has been sadly, but not unsurprisingly, constant.

As Showalter explains, men's existing dominance over women was advanced by the psychiatric system in the nineteenth century, which allowed men to commit their perfectly healthy wives or daughters to mental institutions for whatever reason they fancied; perhaps their daughters were too wild and unrestrained, perhaps their wives were too outspoken, or perhaps the men wished to marry another. Male Victorian psychiatrists readily accepted these women as insane, as they believed women were more susceptible to insanity "because the instability of their reproductive systems interfered with their sexual, emotional, and rational control" (Showalter 55). To have a uterus was to be at risk. Puerperal insanity, which followed childbirth, was equally common in both wealthy and poor women, as no amount of money could thwart the horrors of non-medicalised childbirth, high proportions of stillbirths and the likelihood of young children dying from disease. Puerperal maniacs violated all of Victorian society's cherished ideals, argues Showalter, flaunting their sexuality, using obscene language, exhibiting suicidal tendencies and at times committing infanticide. Predictably, the psychiatrists didn't upbraid the mothers for these behaviours, as a woman's mind was naturally weak after childbirth and she was unable to control herself, like a rabid animal stuck in a trap. Though medical care during childbirth has vastly improved, motherhood continues to be entangled with mental illness, and both *Everything Here is Beautiful* and *Poppy Shakespeare* explore how this connection has evolved.

While “moral therapy” advocate Philippe Pinel was freeing patients from chains inside French madhouses and treating them with more humane “therapeutic confinement” (Appignanesi 70) in the 1790s, English women received no such reprieve and remained in prison-like asylums, describing them as hell, “worse than slavery,” “living death,” “a wholesale slaughterhouse” and “more of a place of punishment than a place of cure” (Chesler 4-5) during the early- and mid-1800s. Women, says Chesler, killed themselves to get out of the torture they experienced inside, including deprivation of food, exercise, sleep, sunlight and outside contact. Nineteenth-century Victorian psychiatry saw the causes of insanity as “worry, want, wickedness” and the cure as “method, meat and morality” (Showalter 30). Insanity was preventable through self-control and asceticism. Feelings and concerns were ignored and never discussed, with doctors focusing instead on keeping the mind too immersed in physical and communal activity to dwell on delusions. Women were busied with mindless needlework and tending gardens, activities which also helped line the asylum’s pockets. But these ‘cures’ were anything but, says Showalter, merely forms of “duplicitous control” and “exploitation” (Showalter 49) that failed to improve independence or self-governance. Without dialogue between patient and doctor, the root of the problem was never addressed. Clare Allan shows that too little has changed in 200 years, and *Poppy Shakespeare*, with its laughably inept doctors, lack of patient-centred care and happily incarcerated patients, is a testament to the ongoing ineffectiveness of institutionalisation.

By the late-1800s the idea of moral management had largely been replaced by Darwinian psychiatry, which focused on physical signs of insanity – with outer defects like head and face malformation signalling inward problems – and constitutional predisposition to mental illness. In essence, people went mad because they were fundamentally and hereditarily inferior, a point of view perpetuated by canonical works like *Jane Eyre* (Charlotte Brontë, 1847) and *Lady Audley’s Secret* (Mary Elizabeth Braddon, 1862) but dismantled by contemporary fiction, which configures mental illness as a social rather than biological or hereditary issue. This “psychological determinism” (Showalter 118) that was championed by controversial English psychiatrist Henry Maudsley saw the psychiatrist’s role shift from one of nurturing and kindness to a misanthropic one that bastioned “manliness, maturity, and responsibility” (120). Maudsley believed women were naturally inferior to men and displayed this “visceral misogyny” (Appignanesi 110) by urging men to scrutinise any potential wife for physical signs of madness prior to marriage. Showalter reveals that the social degenerates in Maudsley’s kingdom of disease were, unsurprisingly, middle-class women who refused to be bound by gender roles. These “nervous women” were also likely to be New Women, early feminists who refused to comply with the feminine ideal in an era of burgeoning vitality, and whose refusal to acquiesce was equally likely to “drive a woman to action or to the couch” (Appignanesi 115); as Appignanesi says, “The escape into illness was the mirror image of rebellion” (115), an idea that this thesis contends is complicated by contemporary literature. Rather than presenting mental illness as a justifiable rebellion, recent novels centre on the lived experience and the social, economic and medical institutions that propel mental illness and then configure it as problematic, calling for a more confrontational rebellion that directly addresses these damaging and restrictive practices. By depicting empowered female characters who refuse neoliberal values of individualism and frameworks of health, who refuse to make themselves smaller, who live alongside mental illness rather than despite it, these novels invite more overt, overarching social change that would deem the ‘madness-as-rebellion’ paradigm obsolete; escape isn’t necessary if the rebellion is won.

The Freudian model, which took hold in the early 1900’s, moved beyond psychological determinism to the idea of mental illness as a product of unconscious thought, repressed sexual conflict, and Oedipal fantasy, and focused on relief, not cure. In Austrian neurologist Sigmund Freud’s psychoanalysis, the patient was an active, albeit unequal, player in the process; while this did finally give women a voice, it was a private voice heard only by doctors and was ineffectual in cultivating a cultural change to the gendered social order. As Showalter explains, it was much safer for the patriarchy to simply tolerate women's hysteria, to allow women access to psychotherapists where they could deliberate their discontent, than it was to allow them to openly fight for political and social equality. Helen Oyeyemi engages with this notion of talking therapy in her 2005 novel *The Icarus Girl*, in which young Jess's parents approach their daughter's increasingly worrying behaviour from divergent angles, with her Nigerian mum employing African idols and mythology as a means of support while her British dad sends her to a psychologist; ultimately, neither version of treatment is sufficiently ameliorative, and Jess's diasporic turmoil must be tackled from within herself. The root of Jess's mental instability – subconscious generational suffering caused by precarious Nigerian-British relations – cannot be simply chatted away, much like the social inequality that damaged so many women's mental health during Freud's time.

It took *men* suffering from hysteria - hidden behind the more masculine name shell shock, but hysteria nonetheless - to finally usher in a new era of psychiatric modernism. The Darwinian idea that men and women are innately different was undermined by the influx of men coming back from World War I with neurosis; this directly counteracted the view of soldiers as ultra-masculine machines, able to persevere through the constant stench and threat of death, and hysteria as a primarily female disorder. Doctors initially turned to possible physical causes like brain damage or carbon-monoxide poisoning to explain the disturbing feminine characteristics of shell shock – crying, shaking, nightmares – but came up lacking. As it turns out, men aren't so different to women after all:

> Both men and officers had internalized these expectations [of courage, strength and fearlessness] as thoroughly as any Victorian woman had internalized her lesson about feminine nature. When all signs of physical fear were judged as weakness and where alternatives to combat [. . .] were viewed as unmanly, men were silenced and immobilized and forced, like women, to express their conflicts through the body. Placed in intolerable circumstances of stress, and expected to react with unnatural 'courage,' thousands of soldiers reacted instead with the symptoms of hysteria. (Showalter 171)

The ensuing methods of treatment ranged from Canadian-borne therapist Lewis Yealland's extreme physical and emotional abuse to English psychiatrist W. H. R. Rivers' more gentle Freudian approach, with the latter widening the acceptance of psychotherapy and the belief that mental illness could have an emotional origin. While psychoanalysis was certainly a step up from the shackles and isolation of nineteenth-century asylums, it was still a male-dominated effort in which the female mind had only been considered and probed by men, criticised German analyst Karen Horney in a series of papers written between 1926 and 1935. Horney condemned the concept of penis envy and derided Freud for downplaying the importance of motherhood on the female mind while ignoring men's potential envy of pregnancy and childbirth. Octavia Wilberforce was another woman at the forefront of psychiatry in the first part of the 20th century, and she very quickly surmised that women's social situation was tightly linked to mental breakdown. Despite some notable contributions to the field of psychiatry by women at this time, they were still vastly outnumbered by men, a "powerless minority" (Showalter 203) who were ultimately unable to change the methods of the asylums, which were still rooted in the past. This thesis shows that contemporary fictional women fare little better when it comes to receiving psychological care: the vast majority of medical practitioners portrayed in the novels within this thesis are male, and a great number of them – Allan's Dr. Diabolus, Lee's Dr Beige, Roy's Nurse Don, to name a few – perpetuate misogynistic stereotypes, display professional ineptitude and offer a notable lack of compassion, revealing a need for more female medical professionals who can offer the empathy and encouragement that their male counterparts seem to lack. That said, *MYRR* suggests that gender isn't enough to guarantee this much-needed support, and the incoherent Dr Tuttle serves as further criticism of modern psychiatry.

Following World War I, schizophrenia replaced hysteria as the female malady, and even though men and women were diagnosed in comparable numbers, it was the women who were more largely subjected to the 'cures' of insulin shock, electroshock and lobotomy. Women, after all, didn't need their brains, and the pliability and docility that resulted from these procedures was often seen as success; Allan satirises this in *Poppy Shakespeare* with inpatient Dawn, whose short-term memory has been fried due to a trainee doctor's carelessness with the ECT machine. The cultural link between schizophrenia and femininity was strengthened by the number of autobiographical books and journals written by women between the 1920s and 1960s, such as Hannah Green's *I Never Promised You a Rose Garden* (1964), Marguerite Sechaye's *Autobiography of a Schizophrenic Girl* (1951) and Jennifer Dawson's *The Ha-Ha* (1961) which, far from romanticizing the condition, says Showalter, were "guilt-ridden accounts of institutionalisation as a punishment for transgressing the codes of feminine behaviour, docility, and affection" (211). Have representations of schizophrenia changed since this time? While Showalter argues that "modernist literary movements have appropriated the schizophrenic woman as the symbol of linguistic, religious, and sexual breakdown and rebellion" (204), this thesis argues that contemporary fiction has moved beyond presenting mental illness as purely transgressive, no longer utilising schizophrenia as primarily metaphor or women as symbols but rather directly upbraiding the complex social, cultural, gender and medical issues that negatively impact women's mental health.

A study by British psychiatrists Aaron Esterson and R. D. Laing – *Sanity, Madness, and the Family* (1964) – changed the perception of schizophrenia by concluding that it wasn't a biological condition to be treated with drugs and electroconvulsive therapy, but rather a social disorder borne from lack of autonomy and unliveable home situations. This idea triggered a new mental health movement called 'antipsychiatry,'[2] which attacked the powerlessness of women in institutions and within the doctor-patient relationship and the ineffectuality of shock therapy and surgery. Instead of treating schizophrenia from within, it should be treated from the outside, with the social contexts of families, relationships and repression all taken into account. Laing's "humanizing reform of psychiatric practice" (Showalter 228) included his belief that schizophrenia was simply a label applied to those who were unable to reconcile the conflicting expectations of a mad society, and perhaps schizophrenics were the sanest of all in an increasingly mad society. This echoes Chesler's

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[2] The term was first used by psychiatrist David G. Cooper in 1967 (Chapman).

belief that madness following trauma isn't madness at all, but simply a sane reaction to an unbearable situation. Another cog in the resistance to psychiatry, Thomas Szasz's *The Myth of Mental Illness* (1960), aimed to delegitimise the power of psychiatrists and mental health agencies by claiming that people don't have mental illness but rather "problems in living" (70), and that since diagnoses are judgmental rather than scientific, the ensuing treatment is oppressive and unethical. The French pushback to psychiatry came in the form of Michel Foucault's *Madness and Civilization* (1961), which condemned the asylum as a "fortress of confinement" (64) that focused on increasingly restrictive ideas of Reason and morality and failed to recognise passion as not simply a cause of madness but rather intrinsic to the very mechanics of it. Madness, Foucault argues, *is* logical, but logic based on a falsehood that exists only to the mad. Despite this reformation of the nature of schizophrenia and mental illness, its view of *"*madness as a female strategy within the family" (Showalter 246), antipsychiatry offered little solution and no new treatment plan. The best hope for the future, wrote Showalter in 1988, is the "feminist therapy movement" (249), which would see women as an integral part of their own mental healthcare, overseen by female medical professionals with first-hand experience of the hardships, inequities and discrimination faced by their patients. Many contemporary novels – including *Poppy Shakespeare, Rabbits for Food*, *The Fat Lady Sings* and *Everything Here is Beautiful* – interrogate twenty-first-century mental health services; this thesis contends that, as a whole, these works reveal that Showalter's "feminist therapy movement" has yet to be realised and instead, women continue to be let-down by a male-dominated, quick-fix, recovery-driven system of care, or, as Moshfegh shows, female practitioners who remain heavily aligned with the medical model of disability.

The development of new drugs in the 1970s meant madness could now be treated in outpatient facilities, and, coupled with decreased government funding and public outcry over institutionalisation, drove asylums in both Europe and America to shut down. The medicalisation of mental illness sky-rocketed in the 1990s with the development of Prozac and was chronicled by memoirs like Elizabeth Wurtzel's *Prozac Nation* and Lauren Slater's *Prozac Diary.* The very existence of the drug spurred the proliferation of depression diagnoses at the time, as Appignanesi argues that doctors are more apt to diagnose conditions that they can treat; this contention is supported by Britsch and Moshfegh, whose inept medical professionals are more concerned with pushing drugs than actual care. The World Health Organisation ranked depression as the fourth "leading cause of burden" among all diseases in its *Global Burden of Disease, 2000*, causing "the largest amount of non-fatal burden"(Üstün et al.); sadness is now classified as an illness that can be mitigated by a prescription of more than sixty different kinds of drugs ("Antidepressants"), which rather than giving a few people a definitive cure, give a lot of people a little relief. Cognitive Behaviour Therapy (CBT) grew in popularity alongside Prozac in the 1990s and is now the go-to therapy for mental illness like depression and anxiety and often goes hand-in-hand with the acronymic pharmacology – SSRIs, MAOIs, SNRIs, TCAs, etc – that American television adverts tell the public they need and that 17% of the world population now takes ("Prescribed"). Contemporary fiction like *My Year of Rest and Relaxation* and *Sad Janet* serves as modern-day commentary on psychopharmacology, and I examine these texts as criticisms of the pharmaceutical industry and the medicalisation of sadness in the following chapter.

The evolution of mental illness treatment, while seeing women freed from literal shackles, is marked throughout by the absence of women's agency in their own health. The mental asylum wasn't freedom or acceptance, but a locked-door substitute for familial patriarchy, run by men like Henry Maudsley, W. H. R. Rivers and R. D Laing. Both Showalter and Appignanesi present mental healthcare in the nineteenth and twentieth centuries as ineffectual, callous and patriarchal. The psychotherapy and antipsychiatry movements in the 1900s didn't solve the problem either. Simone de Beauvoir's *The Second* Sex, first published in 1949, found that throughout history, any period's definition of madness was directly connected to its expectations of female behaviour. Transgression meant madness. Is that still true today? This thesis uses fiction to investigate where we are now, in the twenty-first century, in relation to where we have been in the past, and examines the failure of Showalter's feminist therapy movement to come to fruition. Does the fiction of today show mental institutions as therapeutic and constructive, or are they still a segregated holding ground for society's most marginalised? Do they signify hope or death, or something in between? Does modern psychotherapy engender cure? Does, as Chesler questions, good mental healthcare even exist – in real life, or in fiction?

Canonical Literature: Reinforcing and Confronting Mental Health Trends

From Ophelia to Bertha Mason, to Miss Havisham to Anna Wulf, female characters with mental illness have been portrayed in fiction for centuries. As Appignanesi, Showalter and Gilbert/Gubar note, the trends of mental illness within historical time periods are mirrored in the fiction, with female characters serving as microscopes through which the fears, expectations and rebellions of each era can be dissected and analysed. Mary Elizabeth Browning's *Lady Audley's Secret* and Charlotte Brontë's *Villette* and *Jane Eyre* portray mentally ill women as lunatics with bad hereditary lines, a genuine fear of Victorian society. Mental illness had evolved by the fin-de-siècle era, and works like Kate Chopin's *The Awakening* show women fighting back against restrictive gender roles and Weir Mitchell's rest cure. By the 1960s and 70s, the women's liberation movement was in full force, and novels such as Doris Lessing's *The Golden Notebook* attack Freudian patriarchy and blame women's breakdowns "on the limited and oppressive roles offered to women in modern society" (Showalter 213). This thesis continues the discussion started by these scholars by analysing the fiction from 2000 to present to determine how it contributes to and reflects current cultural debates on mental illness as well as the aims of this intervention; to accurately unpick the literature of today and the empowering mental health messages within, one must first understand the fiction that precedes it and the various ways in which these novels both support and subvert the social, medical and political ideas of their times. This section is essential toward building an answer to one of this thesis's overarching questions: What is contemporary fiction doing differently, and to what end?

Some of literature's earliest and arguably most famous madwomen were written by William Shakespeare, whose murderous, obsessive Lady Macbeth has been diagnosed by modern psychologists as having OCD, depression and PTSD (Herbert; Minton; da Mota Gomes and Nardi, respectively).[3] When Macbeth asks his wife's doctor how she is, the physician replies: "Not so sick, my lord, as she is troubled with thick-coming fancies that keep her from her rest" (Act 5, Scene 3, 46-48). Shakespeare recognised the link between mental anguish, in this case over King Duncan's murder, and physical symptoms, like Lady Macbeth's sleepwalking, despite the lack of actual medical knowledge on mental illness and neurology at the time. *Hamlet*'s Ophelia, whose madness is driven by her inability to reconcile her grief from her father's death with the demands of courtly society, establishes the link between mental illness, social expectations and powerlessness that will not only play a significant role in subsequent literature but will go on to be used by Victorian psychiatrists as an archetypal model of mental illness in their own practices.

The connections between Sir Walter Scott's *The Bride of Lammermoor* (1819) and Emily Brontë's *Wuthering Heights* (1846) have been well-documented by critics like Q. D. Leavis and Lakshmi Krishnan. While Scott's work serves as a cultural critique in which Lucy and Ravenswood's mental illnesses and ultimate deaths are triggered by a cruel and unforgiving society, it nonetheless serves to reinforce the Victorian medical belief that mental illness was caused by a feeble will and moral decay. Brontë challenges this notion in *Wuthering Heights* by portraying Heathcliffe and Cathy as instrumental in their own illnesses through strength of character, recklessness and force of will. It is not weakness but fortitude that impels both towards their deaths. Brontë defies Maudsley's view that mental illness and physical deterioration were linked by presenting both Cathy and Heathcliff as healthy and passionate, which, as Krishnan explains, "represents a prolongation of existences that are incomplete and agonizing because of their mutual separation" (Krishnan 36). The characters' illnesses engender strength and serve as their means to escape a life in which they cannot be together; while this thread of empowerment is an early example of fiction pushing back against public attitudes of mental illness, the 'resolution' of mental illness through death is one that

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[3] This kind of literary diagnosis, which further disempowers women by removing their involvement in health discussions, is pervasive in scholarship, and one that I avoid in my thesis.

contemporary authors reject, preferring instead to depict the possibility of living a meaningful and passionate life alongside mental illness.

Perhaps the most analysed madwoman in literature is Charlotte Brontë's Bertha Mason, whose animalistic mental illness hurtles the plot in *Jane Eyre* (1847) toward its fiery climax. The titular character in Sandra M. Gilbert and Susan Gubar's feminist classic *The Madwoman in the Attic*, Bertha serves as a flamboyant double for the more reserved Jane, whose financial, emotional and social powerlessness drives her first mental breakdown in the red-room at Lowood. The attic in which Jane's "secret self" (348) Bertha hides at Thornfield is also the setting for her own self-examination, where Jane relentlessly paces, trying to reconcile her desire for freedom and passion with her job as a Victorian governess. It imbues her with the strength to stand up to Rochester and assert that "it is my spirit that addresses your spirit; just as if both had passed through the grave, and we stood at God's feet equal, - as we are!" (Brontë 223). Jane's own fears over her marriage are embodied in Bertha's trampling of her wedding veil; in fact, as Gilbert and Gubar note, each of Bertha's appearances in the novel is related to Jane's own anger. It is Bertha's death – the liberating demise of Jane's double – that causes Rochester's disfigurement, solidifies Jane as his equal and finally allows them to marry. Brontë fuelled the embers of Victorian fears by portraying Bertha's madness as not just frenzied and demonic, but also hereditary; Bertha serves as validation for Victorian asylums and a warning of the punishment for unbridled female sexuality and lack of morality. Bertha must be "purged from the plot" (Showalter 69) before Jane is allowed her happy ending, for there is no room for happiness when madness is afoot. Bertha is more than just a cautionary tale, functioning as a symbol of the Victorian wife who is doomed to a life of domesticity and grows increasingly hysterical when denied an outlet for her frustration. Left unchecked, this failure to conform to gender roles or desire to live outside them leads to madness. While such metaphorical readings allow for a positive spin on Bertha's madness, Brontë's depiction of female mental illness as animalistic, dangerous and terrifying is a damaging stereotype that modern-day fiction – with its more humanising and empathetic portrayals – seeks to overturn; regrettably, Bertha-esque characters continue to be prevalent in Young Adult Literature (YAL) like Alyssa Sheinmel's *A Danger to Herself and Others* and Kelley Armstrong's *The Summoning*, discussed in Chapter Five, and much work still must be done to eradicate this stigma.

The mid-nineteenth century saw the rise of the modern penitentiary, and along with it, and increase in the use of isolation in psychiatry, and many works of this period challenge the effectiveness and morality of the controversial treatment. Charlotte Brontë's *Villette* (1853) chastises solitary confinement as a cause, not cure of mental illness. Showalter explains that at the time, prisons and asylums touted solitary confinement as a nonviolent method of regulation that allowed them to reform inmates through mind control, despite the fact that those subjected to it suffered from hallucinations, suicide attempts and nightmares. While Brontë's Lucy Snowe isn't an actual prisoner, she is very much ostracised and alone and spends the novel surrounded by the equally confined women – Miss Marchmont, Madame Beck, Madame Walravens. When Lucy starts seeing an apparition of a faceless nun – a symbol of her sexual repression and celibacy, her physician, in the vein of Victorian moral management, recommends "happiness and a cheerful mind" (70). Lucy's mental illness and withdrawal from society are not simply caused by external issues and the "destructive strictures of patriarchy" (Gilbert and Gubar 400) though, as Brontë portrays her as complicit in her own confinement and madness through her choice to work and provide for herself. Charles Dickens explores social alienation as a symptom of mental illness in *Great Expectations* (1860) through the lovelorn character of Miss Havisham, who remains bedecked in her rotting wedding dress and tarnished jewels, unable to move past the heartbreak and social stigma of being left at the altar twenty years prior. Dickens, who was well-acquainted with Hanwell Asylum physician John Conolly and visited asylums in both Britain and the US, uses Miss Havisham to illustrate the fine line between eccentricity and hysteria; he validates Conolly's belief of the socially well-off as being specifically vulnerable to mental illness while challenging Victorian psychiatry's desire to pin mental illness on physical rather than emotional causes. As Akiko Takei discusses, Miss Havisham's self-imposed isolation in her dark, dusty house mirrors the solitary confinement within an asylum and reveals Dickens' growing disenchantment with modern psychiatry (Takei), one that Allan echoes in *Poppy Shakespeare* with her condemnation of contemporary institutionalisation.

Women across the ages weren't listened to by their doctors, husbands, fathers and society at large, and instead they turned to writing and other forms of expression to share their voices. Founder of modern nursing Florence Nightingale compares the "prison which is called a family" (qtd. in Showalter 63) to the confinement of a mental institution and blames madness on women's "mental atrophy" and "moral starvation" (Showalter 62); Showalter describes Nightingale's 1852 essay *Cassandra* as a "scathing analysis" (63) of how the suffocation of Victorian conventions and society's deluded moral compass quashed women's passions and rendered them passive and silent, ultimately leading to their depression, illness, institutionalisation and death. When women are denied autonomy, death is freedom. While Cassandra does view her death as a welcome release, Nightingale believed that depression as feminine protest was less successful than actual action; I argue that recent novels build on this idea, not simply making the connection between social inequities and mental illness, but depicting women who take charge of their mental health and challenge this injustice and oppression. At the close of *The Fat Lady Sings*, Merle defies her doctor's orders to take a taxi to her husband's house, and Gloria almost immediately breaks her promise to pacify her distinctly non-British boisterousness: "I open up my mouth and I just sing and sing" (Roy 283). In 21st century fiction, when women are denied a sphere of action, they demand one and they take it, and this reclamation of power is a more active and more powerful form of protest than illness itself.

This contrasts with Wilkie Collins's 1860 novel *The Woman in White,* which gives justification to the Victorian fear of mistaken incarceration with his lookalike heroines Anne Catherick and Laura Fairlie and perpetuates the powerlessness of mad women. While Collins does seem to suggest that madness is dangerous, both for the mad and those in her vicinity, he condemns the asylum as an inefficient prison in which sanity can be mistaken for madness just as easily as one woman can be mistaken for another. Collins also validates the cultural concern that madness is difficult to refute once doctors and society have decided otherwise. Appignanesi uses analysis of the novel to corroborate her earlier notion that sanity can easily be unhinged by a number of external causes like abuse, suggestion from stronger personalities or institutionalisation itself, and that women are particularly susceptible to madness due to the “malevolence of men and the marital, hereditary and mental institutions” (101) of the era. The fear of mistaken confinement is still very real today; this thesis explores the notion in contemporary novel *Poppy Shakespeare,* in which the titular and very-much sane Poppy loses her grasp on reality and sanity once unwarrantedly institutionalised.

Lady Audley’s Secret (1861) provides a destabilising feminist perspective on puerperal mania by echoing a Conolly case study of a women with inherited mental illness. Mary Elizabeth Braddon’s Lucy doesn’t love her newborn child, instead viewing her as a burden and thus abandoning the child with her father while she changes her name and seeks employment as a governess. Her ensuing engagement to another man, her employer, is a symbol of her freedom from the oppression of motherhood and domesticity from which she, and many of her contemporaries, were so desperate to escape. When her first husband returns, Lucy attempts to kill then blackmail him, and when confronted with her crimes pleads insanity with the dramatic declaration: “You have conquered - A MADWOMAN! (Braddon 20)” Lucy blames her puerperal insanity on a bad hereditary line and is committed to a madhouse rather than a prison. As Showalter asks, is Lady Audley’s secret that she carries a maternal line of insanity, or that her mental illness is “simply the label society attaches to female assertion, ambition, self-interest and outrage” (72), which saw so many Victorian women locked away in asylums and so many modern women pathologised? I argue that contemporary authors are advocating for an openness and acceptance within mental health that removes the need for secrets altogether; by normalising a spectrum of experiences, these novels work toward eradicating the shame and stigma that continue to envelop mental illness. Reframed by this modern-day perspective, Braddon’s novel might be called *Lady Audley’s Freedom* rather than *Lady Audley’s Secret* and focus not on the titular character’s dangerous behaviour but instead on the restrictive social environment that compelled such actions.

As Appignanesi explains, the late 1800s were "a nerve-wracked age" of "restlessness and constant change, of speed and shifting perspectives" (113), which is reflected in the conflicting literary representations of mental illness at the time. Charles Reade's *A Terrible Temptation: A Story of the Day* (1871) features Rhoda Somerset's faked hysterical seizure and validates the Victorian practise of withdrawing the audience (and sympathy) to both establish the doctor's authority and punish any maligners. While Reade's work narrativizes the effects of feigned mental illness, Joseph Sheridan Le Fanu's *The Rose and the Key* (1871) depicts the genuinely ill Maud Vernon, who mistakenly thinks she is at a party, not an asylum, and only becomes aware of the truth when a fellow party-goer is placed in a straitjacket and doused with water. Read in conjunction, these stories – notably both written by male authors – reveal that whether legitimately ill or only bogusly so, women are disciplined; despite "shifting perspectives" within mental health, women emerge the losers time and time again. Further building on notions of female powerlessness, memoirs of wrongful confinement like Georgiana Weldon's *How I Escaped the Mad-Doctors* (1878) and Rosina Bulwer-Lytton's *A Blighted Life* (1880) fostered the late-Victorian's distrust in asylums and exposed the unmitigated power of men to institutionalise their wives against their will.

While Weldon and Bulwer-Lytton turned to non-fiction to condemn mental healthcare, fin-de-siècle writer Charlotte Perkins Gilman's personal experience with mental illness – she experienced fatigue and depression after giving birth in 1885 – found its way into her fictional work. Gilman's short story *The Yellow Wallpaper* is a sharp rebuke of Silas Weir Mitchell's rest cure, based on her own encounter with the treatment, in which women were prescribed to live a simple, domestic life free of any mental stimulation. This 'cure,' which demanded that Gilman "never touch pen, brush or pencil as long as [she] live" (Chesler 69), damaged Gilman more than it helped her, and the author only started to emerge from her post-partum depression after she left her husband and baby to spend time with friends and start writing again. In Chapter Two, I discuss *My Year of Rest and Relaxation* as Weir Mitchell's rest cure in extremis, a 21st century version of social isolation that sees the protagonist embarking on a drug-fuelled period of hibernation; while the narrator emerges believing her mental health has improved, the ending of the satirical novel is far more ambiguous, and the absence of any ambition, companionship or interests calls the longevity of her emotional development into question, and instead advocates for community and purpose as integral to mental well-being.

By this turn-of-the-century period, the madwoman had broken free from the Gothic subplot and “taken up residence in the front room” (Showalter 52). The primary storyline in Kate Chopin’s *The Awakening* (1898) correlates Edna Pontellier’s increasing demand for freedom and individuality with her declining mental health and diminishing domestic and maternal abilities, a social commentary that is still prevalent in contemporary literature like *Everything Here is Beautiful*. Edna’s inability to reconcile her desire for freedom – her awakening – with societal expectations leads to her ultimate escape in suicide, foreshadowing the deaths of women like Plath and Woolf that would come in the following century. While Perkins Gilman’s *The Yellow Wallpaper* condemns Weir Mitchells’s rest cure as destructive and problematic, Elizabeth Robins’ *A Dark Lantern* (1905) depicts a version of it in which the heroine, Katharine Dereham, is allowed to continue writing her poetry; Robins’ version of the rest cure provides financial, sexual and creative freedom and features the “doctor-lover” as a “saviour” (Showalter 143). As Showalter argues, these fin-de-siècle novels signify the emergence of female mental illness from the literary shadows, leading to a series of questions posed by this thesis: Where does the fictional madwoman reside today? Is she still front-and-centre, or has she retreated to the background? Is she a caricatured sideshow employed as a character foil or plot device, or is she more complex, with her own goals and needs beyond her mental illness?

Zelda Fitzgerald is yet another woman writer whose individuality, ambition and desire for autonomy were quashed and ultimately transmuted into madness. Fitzgerald was institutionalised on two occasions and in and out of health clinics for most of her life, and her psychiatric fate was always in the hands of male practitioners; her unhappiness with life and marriage were so profound that she told husband Scott she would rather be in an asylum that at home, explaining that there “is no difference to being hospitalised and being married” (Chesler 74). Zelda’s largely autobiographical novel, *Save Me the Waltz* (1932), was written from within the walls of a psychiatric institution, not unlike Allan's *Poppy Shakespeare*. Appignanesi compares Zelda to Virginia Woolf, whose "racing highs" marked by hallucinations, followed by suicidal lows and "total absorption in the world of her madness" (270) parallels Zelda's schizophrenic condition. Woolf's early breakdowns were sparked by the deaths of her mother, brother and father, while her later episodes tended to follow submissions of manuscripts, with her suicide in 1941 coming on the heels of *Between the Acts*, following at least two previous attempts and several stays at mental institutions. Woolf was originally averse to psychoanalysis, fearing that her madness fuelled her creativity and that vanquishing the madness would come at the expense of her writing, instead choosing to face her demons *through* her writing and thus release them: "In expressing it I explained it and then laid it to rest" (Appignanesi 274). This is an interesting point that Allan and Kirshenbaum explore in their novels, with N's life writing constituting a freeing purge similar to what Woolf describes, while Bunny's anecdotal writing – with its more journalistic, stoic style – serves to challenge the nature of such a healing catharsis.

Following the fin-de-siècle era, literature began to take aim at emerging psychiatric trends, including Freud's new practice of psychotherapy. A series of papers published by psychiatrist Karen Horney between 1922 and 1937 overturned Freud's idea of penis envy and configured environmental and social factors – not just biological ones – as integral to personality formation, validating women's growing disillusionment with psychiatric practices and influencing the literature of the time period. Millen Brand's 1937 novel *The Outward Room*, for example, details Harriet Demuth's nervous breakdown following her brother's death and her subsequent stay in a mental hospital. The novel serves as a strong denunciation of both the mental institution and Freudian psychotherapy, neither of which help the protagonist, who only recovers once she escapes the asylum and finds romantic love; while one can understand Brand's intention to depict recovery outside of psychiatry, this 'love conquers all' *deux ex machina* is an equally damaging, misinformed trope that pervades YAL today, including Julia Hoban's *Willow* and Jasmine Warga's *My Heart and Other Black Holes*, novels that I examine in Chapter Five.

While twentieth-century fiction explored a variety of new and provocative mental health issues, it repeatedly and regularly returned to the role of female social expectations in generating and perpetuating poor mental health. *The Bell Jar* (1963), for example, chronicles Sylvia Plath's own struggle as an "artist with the female condition" (Chesler 69) through the fictional Esther Greenwood, whose mental health deteriorates as she is torn between succumbing to domestic requirements or eschewing them in favour of her ambition. Esther is prescribed shock therapy by a male psychiatrist to revive her deadened emotions, but this only further exacerbates her mental illness. Esther's ensuing suicide attempts land her in an asylum. While Plath presents social expectations and personal goals as conflicting in a way that breaks down women and begets mental illness, contemporary literature complicates this relationship. What of Kirshenbaum's Bunny, who not only shuns a domestic life, but also fails at her desire to be a successful writer? What are we to make of *Sad Janet*, whose indifference to romance and eccentric life goals are both at odds with society, or Moshfegh's narrator, who epitomises haughty Manhattan ideals but is nonetheless unhappy? This thesis interrogates how recent fiction reflects the evolving relationship between social and personal success and the implications on women's mental health.

The establishment of second-wave feminism in the 1960s saw a resurgence of female mental illness in literature, perhaps most notably Jean Rhys's *Wide Sargasso Sea* (1966), which examines Bertha Mason's madness from a feminist and postcolonial perspective. Rhys's novel garners sympathy for the madwoman in the attic by giving her the voice, name and history that Brontë denied her, portraying her illness as a reasonable and inevitable symptom of her powerlessness within an imperialist and patriarchal world. This turns the tables on her animalistic portrayal in *Jane Eyre*, which can now be read as Bertha, née Antoinette, finally discovering her strength and self-sovereignty, even at the expense of her life. Similarly, Doris Lessing's *The Golden Notebook* (1962) and *The Four-Gated City* (1969) represent mental illness as an "intelligible response to harrowing existential conditions, nurtured in the family and in a troubled society" (Appignanesi 412) and deduce that break*downs* can sometimes be break*throughs.* Heavily influenced by R. D.

Laing's antipsychiatry movement and his endgame of destigmatising madness, Lessing's Anna Wulf signifies the limitations of psychoanalysis, while *The Four-Gated City* criticises the medical model, which induces a "zomboid, controllable normalcy" (Appignanesi 412) that must be adamantly avoided. These novels shift the basis of poor mental health from women's naturally weak composition to the unforgiving, brutal society in which they live and stand as early literary examples of self-acceptance. Moshfegh brings this commentary into the 21st century in *My Year of Rest and Relaxation*, in which the narrator's existential ennui stems from disenchantment with the materialism of Manhattan and the cookie-cutter women who thrive in it; while the protagonist's self-prescribed treatment of extended hibernation is outlandish and dangerous, it nonetheless reveals the desire of contemporary women to seek help outside of traditional psychiatric routes as well as a resistance to the normalised diagnosis-treatment-recovery paradigm.

Responding to the counterculture movement of the late-60s, Marge Piercy's *Woman on the Edge of Time* (1976) contrasts the racist, homophobic, classist, patriarchal 1970s with a distant utopian future that finds all of the movement's goals fulfilled. Connie's institutionalisation in an abusive 1970s asylum is sharply juxtaposed against the psychiatric treatment of 2137 in which individuals have full autonomy over their own mental health, checking themselves in and out of sanatoriums as they wish, embarking on various forms of therapy and taking mental breaks as and when they need them. Piercy's speculative novel, like satires *My Year of Rest and Relaxation* and *Sad Janet*, allows for exaggerations and fantastical situations that make the reality of current care seem all the more grim; *Woman on the Edge of Time* mirrors the growing societal criticism of asylums and precedes the widespread deinstitutionalisation that would come in the next decade.

Writers like Nightingale, Perkins Gilman, Lessing and Rhys gave women a voice within the sphere of mental health and showed the power of fiction to come closer than statistics and facts to the truth of a lived experience in which the 'cure' was unbearable, inimical and rendered women powerless. These female characters evoked sympathy, rage, fear, grief, sorrow – a coalescence of emotions that moved beyond the black and white page to expose the true colours of female mental illness, a veracity that was too often hidden from public view by men – doctors, husbands and politicians alike. Literary geniuses Zelda Fitzgerald, Virginia Woolf and Sylvia Plath all saw the insides of asylums, and despite their notoriety, beauty and privilege, none of them was helped; inspired by their own lived experiences, these authors' fictionalised accounts were free to exaggerate or invent or obscure in an effort to better convey the mental health problems facing women of the time. I argue that fiction still holds this power today, with contemporary novels shedding light on the shortcomings of mental healthcare and the resulting impact on women with a candour far more compelling than that of facts and figures. Poppy's decline, Bunny's public breakdown, Lucia's death – all are powerful and shocking and heartbreaking – but perhaps most importantly, they are memorable.

These fictionalised accounts of Plath, Woolf and others spawned the birth of a new literary genre in the late-20th century, in which a deluge of women's memoirs chronicled real-life psychiatric hospitalisations and 'descents into madness.' Jill Johnston's *Paper Daughter* (1985); Kate Millett's *The Loony Bin Trip* (1990); Susanna Kaysen's *Girl, Interrupted* (1993); Kay Redfield Jamison's *An Unquiet Mind* (1995); Elizabeth Wurtzel's *Prozac Nation* (1995), Lauren Slater's *Prozac Diary* (1998) all revealed conflicting ideas about medication, symptoms and institutionalisation, with some authors claiming they were never mentally ill at all. If the psychiatric memoir was the new genre in the late-1900s, psychiatric *fiction* is the new genre of today, with fictional characters exploring the same themes that their real-life predecessors did in their autobiographies, but without the restrictive faithfulness to fact. As discussed in the introduction, the resulting freedom allows for a more pointed, purposeful criticism of the social structures that impede mental health, and contemporary authors use this opportunity to stage widespread attacks on aspects of mental health ranging from the pharmaceutical industry to government regulations to cultural stereotypes. While 20th century autobiographies chronicled mistreatment, misdiagnosis and drug abuse, the fiction of today seeks to inform the public, draw out empathy and identify roadblocks in an effort to prevent these kinds of experiences from occurring in the future. Today's fiction exists so that future memoirs need not.

In addition to the copious memoirs of the 1980s and 90s, fiction like Wally Lambs *She's Come Undone* (1992) served to shed light upon the lived experiences of those with mental illness. Dolores Price's depression is self-reinforcing; she overeats because she is depressed and then gets further depressed at her weight gain. She is institutionalised for seven years after a suicide attempt and, while she does find therapy helpful, she is frustrated by the slow-moving nature of it. Dolores's ultimate recovery is predicated upon finding authentic romantic love and the realisation that her life is enough. While many of the autobiographies of the time chronicle drug-induced stupors within autocratic institutions, *She's Come Undone* depicts an alternative and more delicate remedy to mental illness in which the ill need to find acceptance and happiness within. Despite being selected as an Oprah Book Club novel in 1997 and topping the *New York Times*' bestsellers chart, the novel was chastised by some readers as perpetuating dangerous clichés about love and depression that suggest unhappiness is a choice and can be overcome through the adoration of a good man ("She's Come Undone"), damaging tropes that continue to pervade YAL and are discussed further in Chapter Five.

For centuries, the depiction of mentally ill women in fiction has been tied to the social, political and medical views of the time, with some characters, like Brontë's Bertha Mason, serving to substantiate the callous treatment of the mad while others, such as Anna Wulf, function as criticism of psychiatric trends in an effort to evoke social change. While the impact of any individual work is difficult to ascertain retroactively, it is safe to say that fictional works did play a part in moulding the views of their contemporary audiences and that some of them – *The Bell Jar* and *The Awakening*, for example – did empower woman to live their lives outside the box of social expectations. This thesis takes these ideas into the 21st century not only by evaluating how contemporary literature contributes to debates on mental illness and its connection to feminist, disability, literary and cultural theory, but by showing how recent fiction subverts the normalised diagnosis-treatment-recovery model – which has been adopted by many medical outlets, including England's NHS – to diversify the notion of what it means to be mentally ill. While contemporary fiction is certainly a lens through which to view the many barriers to female mental health and the stigma and challenges surrounding mental illness, novels like *The Fat Lady Sings*, *Sad Janet* and *Rabbits for Food* do more than simply inform – they are meant to enrage, to frustrate, to shock, to disturb, all in an effort to initiate real, meaningful change that will prevent the plights of these fictional protagonists from becoming a reality for future women. Whereas in the past, depictions of female mental illness in fiction were – even when subversive and empowering – largely one-dimensional, direct responses to the limited cultural, social and medical views of mental illness at the time, as the discourse has broadened and become more mainstream in the last two decades, we are now beginning to see a representational shift in which women and their mental illnesses are written in increasingly complex, varied and intriguing ways which not only destabilise stereotypes, but aspire to completely annihilate them.

Chapter Two: "There's a pill for that":[1] Medicalising Sadness in Ottessa Moshfegh's *My Year of Rest and Relaxation* and Lucie Britsch's *Sad Janet*

Ottessa Moshfegh's 2018 novel *My Year of Rest and Relaxation* (*MYRR*) and Lucie Britsch's *Sad Janet*, written in 2020, explore the medicalisation of sadness and the complexity of navigating private emotions in a 21st-century society that revels in spectacle and exhibitionism. Moshfegh's unnamed narrator faces a debilitating sadness that she medicates with a precarious combination of drugs, eager to lull herself into an extended hibernation that she hopes will serve as a spiritual rebirth; conversely, Janet embraces her perpetual sorrow as an integral part of who she is, unwilling to medicate away what she deems a normal response to an unjust world. Though the two protagonists diverge on their opinions about pill-popping, with Moshfegh's narrator self-medicating herself into oblivion and Janet standing firm on her resistance to any such prescription, both novels deliver satirical plots that put the pharmaceutical industry in their crosshairs. In addition to this timely criticism of Big Pharma,[2] *MYRR* and *Sad Janet* intervene in a number of ongoing discussions within the mental health community surrounding contemporary female sadness, using narrative to explore the muddled line between ordinary affective response and incapacitating despair as well as the social conditions – ignored by neoliberal feminism – that both drive and ameliorate these psychological states. Rife with brutally honest inner dialogue and emotional introspection, these novels offer a front-line, inside-out view of mental illness that highlights fiction's ability to connect with readers in a way that engenders understanding, empathy and indignation.

While the financial and political power of the pharmaceutical industry may be commanding,[3] it is not without controversy, particularly in areas involving mental illness, and both novels position themselves quite firmly within this opposition. In recent years, the mental health community –

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[1] *Sad Janet*, page 92

[2] A collective term used to designate the trillion-dollar global pharmaceutical industry

[3] Statista reports the global pharmaceutical industry to be worth $1.48 *trillion* in 2022 (Statista).

patients, medical professionals, scholars, social workers – has raised concerns over the commercialisation and overprescription of antidepressants,[4] as well as the lack of integrity and openness in the research and regulatory phases of medication.[5] Moshfegh and Britsch contextualise these criticisms, highlighting, respectively, the alarming ease with which one can obtain prescriptions – as well as the dangerous consequences of this abuse – and the blatant corruption of a shockingly unapologetic drug company. Moshfegh's eccentric psychiatrist, Dr Tuttle, has a pill for everything, trying desperately to whittle down the narrator's existential dread to a treatable condition, "because if it's suicide, I can give you something for that" (Moshfegh 111). Britsch's scathing portrayal of the fictional MedsForLife takes jab after jab at Big Pharma, parodying the proliferation of antidepressants – 60 different drugs, currently ("Antidepressants") – that continue to saturate the market despite an absence of concrete biological markers for depression[6] and ambiguous (at best) evidence surrounding the effectiveness of these medications.[7] In this chapter, I investigate how contemporary fiction adds to recent mental health discourse by offering carefully

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[4] The World Health Organisation estimates in 2019 that 280 million people worldwide have depression, around 3.8% of the population, including 4% of adult men and 6% of adult women ("Depressive Disorder"). Numbers in both England and the United States skew higher, with around 10% (Office for National Statistics) and 8.3% ("Major Depression") of each respective adult population affected by depression. Interestingly, the usage of antidepressants in both countries exceeds these numbers. The Center for Disease Control found that during 2015-2018, 13.2% of adult Americans were prescribed antidepressants, with more women reporting usage in every age group (Brody and Qiuping). The UK government states that in 2017-2018, 7.3 million adults in England received antidepressants, representing 17% of the adult population ("Prescribed"). Post-pandemic numbers suggest these figures may have increased, with 16% of adults in Great Britain self-reporting moderate to severe depressive symptoms (Office for National Statistics) and 12.9% reporting severe depression in the United States (Ettman et al.).

[5] Meta-studies conducted by Irving Kirsch et al (Kirsch et al.) and Arif Khan et al (Khan et al.), and discussed at length in James Davies' *Cracked,* reveal the extent of this data manipulation; America's Food and Drugs Administration and Britain's Medicines and Healthcare Products Regulatory Agency require only *two* clinical trials to show that a drug is more effective than placebo before approving it, with negative results allowed to be discarded (J. Davies).

[6] A 2022 article in *The Guardian* highlights a recent review led by Joanna Moncrieff, a professor of psychiatry at University College London and consultant psychiatrist at North East London NHS foundation trust, which found "'no clear evidence' that low serotonin levels are responsible for depression." Moncrieff adds, ""It is always difficult to prove a negative, but I think we can safely say that after a vast amount of research conducted over several decades, there is no convincing evidence that depression is caused by serotonin abnormalities, particularly by lower levels or reduced activity of serotonin," adding that patients "should not be led to believe that antidepressants work by targeting these unproven abnormalities" (Gregory).

[7] Several recent meta-analyses, most notably American psychologist Irving Kirsch's 2008 study, find that antidepressants work no better than placebos for the vast majority of patients (Kirsch et al.).

crafted and nuanced insights into the medicalisation of sadness that paint the pharmaceutical industry in an overwhelmingly negative light.

Both novels indict society as equally embroiled in modern-day misery in a direct affront to neoliberal individualism; mental illness is not a personal failure but a systemic one. Addressing the potential over-prescription of antidepressants, Dr James Davies, author of *Cracked: Why Psychiatry is Doing More Harm Than Good*, explains in a 2014 interview with Channel 4's FactCheck, "Most people taking antidepressants are not mentally ill. They are suffering from natural, normal – albeit painful – human responses to the different things they have got themselves caught up in – things that these medicines were never designed to treat;" this resulting sadness from what Davies refers to as "common life problems" (Worrall) is increasingly viewed as intolerable, leading to GP visits and, in turn, medication. While Davies doesn't elaborate on what these "common life problems" might be, both *MYRR* and *Sad Janet* elucidate how the social expectations of a capitalist, patriarchal 21st century might be complicit in the unhappiness of modern-day women, suggesting that perhaps it isn't "things they have got themselves caught up in" that have led to the female protagonists' sadness, but rather situations they cannot avoid and a cultural mould they are pressured to fit. Both novels advocate for a situational approach to illness, with their investigations into the cultural and social sources of sadness reinforcing criticisms of the *DSM-V* – psychiatry's "Bible" (Jabr) – that chastise it for ignoring context.[8] To what degree has society created the unhappiness that it markets as problematic?

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[8] In the mid-1970s, a group of US clinicians lobbied for the use of specific diagnostic criteria mapped against symptom patterns, and their term Major Depressive Disorder (MDD) was incorporated into the *DSM-III* in 1980, where it remains largely unchanged today (Surís et al.). The most recent version, the *DSM-5-TR* (2022), divides depressive disorders into eight subgroups – "disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder" – noting that "the common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual's capacity to function" (*"*Diagnostic" 178). To be diagnosed with MDD, the most severe form of depression, an individual must present five or more specific symptoms during a two-week period with one of these being "depressed mood" or "loss of interest or pleasure" ("Diagnostic" 184). While the *DSM*'s criteria for MDD have been criticised for their lack of social and personal context and their failure to acknowledge depression as a changing continuum, the *DSM-V* is nonetheless the standard classification system used by healthcare professionals throughout the United States.

In a field dominated by statistics and diagnoses, recent fiction tends to resist this quantification and pathologisation, focusing instead on the affective experience of mental health, the everyday emotions, interactions and thought processes that constitute sadness, and the role of drugs in managing feelings. This marks a deviation from mental illness memoir, which often relies on medical terminology, explanations of diagnoses and intricate treatment plans to build a story arc of recovery.[9] These novels do no such thing; in fact, any mentions of drugs or mental health conditions serve to challenge the normalisation of this kind of narrative. Moshfegh's narrator self-treats her sadness not with antidepressants as one might expect, but with powerful sedatives that knock her out, garnering prescription after prescription from a psychiatrist whose medical advice is laughably horrific. She seeks not cure from a specific illness but simply change. Janet leans into her sadness, embracing it as part of her personality and refusing to medicate it away. While the novels in Chapter Three challenge more explicitly the recovery aspect of the diagnosis-treatment-recovery paradigm, *MYRR* and *Sad Janet* confront the diagnosis and treatment components, showing alternative mental health journeys that sidestep diagnosis altogether and further disrupt the recovery pathway by portraying non-traditional approaches towards medication.

Analysis of each novel's form and style is equally pertinent in unpacking their approaches to mental illness. Moshfegh's use of an abrasive, unlikeable narrator exemplifies what Sianne Ngai calls the aesthetics of "ugly feelings" (3), creating difficulty for readers who might otherwise expect a narrative of recovery or redemption; by making the reader privy to the narrator's inner thoughts – horrid as they are – Moshfegh invites a claustrophobic closeness that challenges sentimentalised depictions of illness. Meanwhile, Britsch deploys deadpan humour and narrative flatness, strategies that resist empathy in conventional terms, instead engendering a form of intimacy predicated upon alienation. Both protagonists refuse wellness culture, resist normative recovery and actively withhold the kinds of vulnerability that might invite sympathy, unsettling expectations of female

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[9] Elizabeth Wurtzel's *Prozac Nation* (1994); Lori Schiller's *The Quiet Room* (1994); William Styron's *Darkness Visible: A Memoir of Madness* (1989); Susanna Kaysen's *Girl, Interrupted* (1993) are a few of the more widely known examples.

resilience and positivity associated with neoliberal feminism. Taken together, these novels demonstrate how formal experimentation can upend the novel's traditional association with empathy and recognition, replacing it with a more ambivalent intimacy that mirrors the complexity of mental illness itself. By doing so, they reveal how the genre is being reconfigured in the early twenty-first century to challenge the therapeutic, redemptive and inspirational imperatives that dominate neoliberal cultural narratives of female illness.

At their core, *MYRR* and *Sad Janet* are satirical narratives that denounce pathologised sadness through exaggerations of self-medication and toxic positivity, and, when read together, argue for a shift in attitudes toward naming and treating sadness. "What sort of world is it when parents are proud that their kids are considering getting medicated?" (Britsch 74), wonders Janet. With modern society's increasingly low threshold for tolerating sadness, coupled with its burgeoning reliance on psychiatric medication, Janet's rhetorical question hits dishearteningly close to reality. Janet and Moshfegh's narrator have contrasting opinions on medicalising their sadnesses – one takes all of the pills and one takes none – but when read in conjunction, they serve as a convincing condemnation of both cultural expectations and the pharmaceutical industry, challenging medication as a one-size-fits all cure for sadness and instead configuring community, acceptance and social change as more robust and enduring antidotes.

Socially-Driven Sadness in My Year of Rest and Relaxation

Moshfegh's *MYRR* features two discontented women – an unnamed protagonist who epitomises Manhattan ideals of beauty, poise and wealth, and her best friend Reva, whose perpetual quest to mirror this success leaves her waning in the narrator's shadow. Reading these characters together is essential to achieving a holistic view on how the novel situates mental health within the broader social issue of gender-based cultural expectations. One woman belongs on a magazine cover – she suggests as much herself[10] – while the other can only peruse the pages, if she can afford it – and yet both are unhappy. Thus, Moshfegh suggests that contemporary female mental illness has less to do with whether or not one fits in and more to do with the powerlessness and burden that comes with the existence of a rigid neoliberal paradigm predicated upon productivity, resilience and consumerism.

The novel centres around a stunningly beautiful but deeply unlikable narrator who seeks to treat her perpetual disgust and misery with an extended, drug-fuelled sleep; while the narrator's anger and apathy have manifested in a society that has perpetuated them, they took root within a small family unit that modelled this destructive mind-set. The narrator references her childhood as biding time "until I could move out and grow up and feel normal, I hoped" (66), away from parents who treated her as an afterthought at best and shamed her for showing any kind of emotion. While the memories of the narrator's parents are limited in the novel, her mother in particular is portrayed in an overwhelmingly negative light, as a woman existing – not living – in a boozy, drugged up haze, immune to guilt and shame and quick to ruthlessly criticise her daughter. When the narrator's father dies of prostate cancer her junior year in college, her mother kills herself six weeks later:

> And I'd feel sorry for myself, not because I missed my parents, but because there was nothing they could have given me if they'd lived. They weren't my friends. [. . .] They barely even knew me. They were too busy to want to imagine my life in Manhattan. My father was busy dying [. . .] and my mother busy being herself, which in the end seemed worse than having cancer. (69-70)

While the narrator's upbringing has contributed to her mental state, Moshfegh indicts modern-day society for stoking these negative emotions, utilising her protagonist's despondency to condemn contemporary American standards of beauty and success for stifling happiness, even among those who manage to fulfil them. The narrator, who critic Sofie Behluli refers to as "the anti-hero of

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[10] The narrator compares herself to Lauren Bacall, Joan Fontaine, Kim Novak (235), Amber Valetta (144) and Kate Moss (143)

contemporary decadence" (Behluli), has intelligence, wealth, status and desirability, and yet she is untethered to the world, an orphan without any meaningful relationships, and not privilege nor beauty can buy her out of a life of ennui. Prior to her decision to sleep for a year, the narrator does what she thinks the young and rich and gorgeous are supposed to do: she gets colonics, facials, massages, frequents the gym and parties in expensive clothes. But it doesn't bring her the joy that society, magazines and adverts tell her it should: "I thought that if I did normal things – held down a job, for example – I could starve off the part of me that hated everything" (35). She is going through the motions, doing what she thinks she is meant to, and she feels dead and empty inside; the narrator has everything, and yet she has nothing, and she struggles to come to grips with this disconnect. The narrator's life is perfect, so why is she so sad?

This is the crux of the narrator's ongoing unhappiness, the divide between neoliberal values and the narrator's personal beliefs, the disjoint between the person the world tells her to be and the person she truly is. The narrator finds this confusing and unnerving: "Since adolescence, I'd vacillated between wanting to look like the spoiled WASP that I was and the bum that I felt I was and should have been if I'd had any courage" (35). On the surface, she aligns perfectly to Manhattan ideals of wealth and beauty; yet, rather than enjoying herself, the narrator feels pigeon-holed into pretending to be someone she isn't sure that she wants to be. The cost of this social acclimatisation is the narrator's psychological wellbeing, the disparity between her internal turmoil and external perfection resulting in an anger, despair and disdain that coalesce to form a debilitating mental health condition; though not officially diagnosed in the novel, the narrator's mental state prevents her from living her life, interfering with her job, her relationships and her day-to-day activities. The narrator certainly looks the part, but she finds herself unwilling and unable to play it; by highlighting this discord, *MYRR* suggests that fulfilling cultural expectations doesn't guarantee happiness and that promoting such a link might instead compromise mental health.

While the narrator's frustration emanates from effortlessly fitting into a world that she rejects, her best friend Reva's futile pursuit of such social acceptance results in alcoholism, bulimia and sadness; by closely tying each woman's emotional state to the society and conditions that have produced it, Moshfegh makes a convincing argument for the inclusion of context in discussions of mental illness. Though the narrator's misery is complex, predicated upon a variety of factors ranging from the death of her parents to her failure as an artist, these negative feelings are exacerbated in a city that has no time, no use, no sympathy for self-pity. The narrator may only rarely leave her apartment, but New York City – arguably the pinnacle of early twenty-first-century neoliberalism – functions as a tertiary character in the novel, and it is hard to imagine the narrator suffering as she does in small town Nebraska or rural Texas; the "overpowering affective economy" of Manhattan, the "media, capitalism, neoliberalism and other socio-political forces" that are unavoidable in America's largest city complicate the narrator's goal of "re-affection" (Behluli). It is her rejection of the glamour of New York City juxtaposed against her own narcissism and beauty that makes her existential crisis so captivating. She chastises Reva for being a "slave to vanity and status," noting that while this superficiality is the norm in Manhattan, "I found her desperation especially irritating" (9). Reva fights for that which comes naturally to the narrator: "Nothing hurt Reva more than effortless beauty, like mine" (10). The narrator is the embodiment of everything New York socialites crave – Reva included – and thus everything she hates. As a precursor to her Infermiterol-driven hibernation, in an effort to fabricate a tabula rasa, the narrator donates all of her expensive clothes and jewellery to Reva, rejecting the consumerism inherent to late-capitalism. "I want to forget it all existed" (255), she explains. It is a metaphysical bargaining tool that the narrator believes will instigate an emotional change, privately admitting her hope that "[Reva's] greed would unburden me of my own vanity" (256). But the reader can see that this will not be enough; the narrator requires metamorphosis not just within herself but within society at large, and while she can instigate the former with a drug-fuelled sleep, the latter is out of her control; the outside world –

driven by neoliberal greed and commodification – will still be there, unchanged and unforgiving, when she wakes up, and this will inevitably continue to chip away at her mental wellbeing.[11]

While most critics, like Behluli, focus on the narrator's condition, Reva's downward spiral – driven by her desperation to adhere to Manhattan ideals and exacerbated by her mother's death – is equally compelling and deserving of critical attention.[12] Reva has spent her adult life in tiresome pursuit of physical beauty, professional success and requited love, a trifecta of perfection paraded across magazine pages, television screens and the fast-paced streets of New York City, and her constant comparison to the naturally beautiful narrator only feeds her insecurity. When Reva covers her body up at a bathhouse, the narrator claims that she shouldn't care because it isn't a contest. "Yes it is," snaps Reva. "You just can't see it because you've always been the winner" (44). Reva has to watch the narrator squander the privilege and beauty that she is so desperate to have. "She saw my struggle with misery as a cruel parody of her own misfortune" (14), explains the narrator. The true extent of Reva's mental illness is revealed when the narrator goes to her apartment in search of her stolen meds. It reeks of vomit and is brimming with evidence of Reva's bulimia and poor mental health: dried-out sheet cake with finger gouges, a cupboard filled with laxative teas, cut-outs of fashion models taped around the mirror, a bed covered in food stains.

Reva's illness is a departure from the portrayals of female mental illness in much of twentieth century literature; it isn't a protest against restrictive female roles within a manipulative society, a notion propagated by antipsychiatry and prevalent in works like Sylvia Plath's *The Bell Jar*

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[11] Not even the events of 9/11 can bring about this social change. While many critics contend that the carefree, superficial American attitude came to a grinding halt as the towers fell, critic Ariel Saramandi suggests that *MYRR* mocks the idea "that the 90s in all its frivolity imploded the day of the attack" (Saramandi) and was forever changed. The narrator's privilege is a bubble that protects her from the events of the world, and she has no interest in that which doesn't directly impact her. Accordingly, the narrator speaks of 9/11 not as a devastating event, but as a voyeuristic piece of art; she watches the video of 'Reva' jumping over and over again for comfort, feeding into Saramandi's argument that "the attacks were just a violent continuation of our spectacle-obsessed culture" (Saramandi). While 9/11 may have dominated the news cycles for months, the truth (that I experienced first-hand living in Manhattan in early 2002) is that many people returned to processes of consumerism – shopping, cinema, going out – quite quickly thereafter as a way to 'get back to normal,' and the hastily hung American flags in the windows lasted longer than any meaningful shift in cultural attitudes.

[12] One such article devalues Reva's experience so much that it actually misspells her name as 'Riva' (Keeble).

and Jennifer Dawson's *The Ha-Ha*, but rather the revelation that some women actually *aspire* to fulfil these feminine ideals, and their unending desire for cookie-cutter perfection can be as equally damaging as eschewing it altogether. Not fitting the mould has led to 'othering' for centuries, with Appignanesi noting that "not conforming to a norm risks the label of deviance or madness" (7). While this is certainly true, it fails to acknowledge that desperation to conform is psychologically injurious as well. As Sarah Louise Bennett explains, "professional success and economic independence are often highlighted as the ultimate goals of feminist empowerment" (49) within a neoliberal regime; accordingly, Reva accepts a new job at the World Trade Center in the name of career progression, clinging desperately to capitalist ideals of self-management, ambition and optimisation. Her death on 9/11 due to this job-shift exposes the fragility of neoliberal feminism's promises; her relentless pursuit of self-optimisation, career mobility and empowerment through productivity are abruptly nullified by an event beyond her control. In contrast to the narrator's withdrawal from these imperatives, Reva's fate illustrates the emptiness of neoliberal assurances of safety and fulfilment.

Reva's depression is a result of living in a society in which fantasies are fraying, including, as cultural studies scholar Lauren Berlant explains in *Cruel Optimism*, fantasies of "upward mobility, job security, political and social equality, and lively, durable intimacy" (3). Reva gets transferred to the Trade Towers against her will, she pines after her married boss who is using her for sex, her best friend cannot stand to be around her. Reva is an example of what happens "when the ordinary becomes a landfill for overwhelming and impending crises of life-building and expectation whose sheer volume so threatens what it has meant to 'have a life' that adjustment seems like an accomplishment" (Berlant 3). Reva's coping mechanisms – most notably alcoholism and bulimia – are the "adjustment[s]" that she has made in order to tolerate a disappointing and dictated life that is far from the fantasy sold to her by beauty magazines and romantic comedies. Reva is a victim of Berlant's notion of "cruel optimism," unwaveringly attached to the misguided idea of true love and a perfect life, so focused on "a concept of the later*"* that it has allowed her "to suspend questions about the cruelty of the *now*" (Berlant 28). Reva accepts her present unhappiness because she believes it is a necessary evil that she must endure if she is to achieve the life she desires. Berlant questions why "people stay attached to conventional good-life fantasies – say, of enduring reciprocity in couples, families [. . .] and at work – when the evidence of their instability, fragility, and dear cost abounds" (2), and Reva's struggles expose the price of embracing this fairy-tale ideal. Why is Reva so desperate to mimic the narrator's external perfection when the pursuit is quite literally killing her?

Moshfegh portrays Reva's mental health deterioration as culturally and aesthetically driven, the product of a failed twentieth century neoliberal culture that values sameness and flawlessness, of a society "whose violence takes the form of systematically making us feel bad" (Cvetkovich 15) when we inevitably fall short of perfection. Moshfegh has successfully constructed a world that, while resembling our own, more explicitly shows this connection between society and mental health, and thus invites readers to interrogate their own relationship with social expectations and the impact it may have on their wellbeing. Reva's sadness might be the result of what Davies calls "common life problems," but these problems – and consequences – are not a choice but part of an unspoken social contract that contemporary women have no choice but to sign. While the narrator rejects and lashes out against this notion, Reva embraces it, puts on a smile and willingly plays the game, desperately clinging to the hope that she will emerge a winner. Both attitudes – denunciation and blind acceptance – are mentally exhausting. Both women are miserable.

Drugs + Sleep = Self-Care?

Moshfegh's narrator's solution to her woes – her contempt for the world, her disdain for any kind of human interaction, her anxiety over social situations – is to hibernate for a year. This extended rest and relaxation will, the narrator truly believes, rejuvenate her and change her outlook on a life that she deems intolerable. While the narrator emerges from her metaphorical cocoon feeling that she has succeeded, the novel in no way portrays this approach, and the narrator's reliance on more than two dozen drugs, as commendable or cogent; the narrator's unethical, dangerous and cavalier use of drugs is a last-ditch attempt at a semblance of normality, and it comes at such a price – the physical and mental side effects, the destruction of her remaining relationships, the loss of her job – that the novel ultimately serves as a very strong, satirical rebuke of the pharmaceutical industry and an eye-opening testament to the lengths those facing mental illness are willing to go to improve their quality of life.

The narrator knows what she wants – pills, sleep, change – and the ease with which she fills her medicine cabinet, under purview of the scatter-brained Dr Tuttle, undergirds Moshfegh's condemnation of modern-day psychiatry. When the narrator attends her first appointment, Dr Tuttle is wearing a fake neck brace as part of an insurance scam, goes on a tirade about microwaves and radio waves damaging the brain, and immediately asks the narrator if she works for the police or FBI. None of this clearly questionable behaviour deters the narrator, who recognises that Dr Tuttle isn't a good doctor and gives "terrible advice," but praises her as a "pharmaceutical shaman" (25). Dr Tuttle knows how to work the insurance game[13] and doesn't balk at the narrator's endless requests for more pills, and this is the only aspect of the doctor-patient relationship that matters to the narrator, who isn't looking for guidance or solutions, but simply access to drugs to fulfil a self-care plan of her own device. Before long, the narrator boasts an overflowing medicine cabinet of drugs to treat her "existential anxiety" (111) and plays a game of pharmaceutical Tetris with her medicines, carefully calculating how much of each she can take for a desired outcome, for example, taking Trazodone with Ambien "so if I dreamt, I'd dream low to the ground" (252). It's a risky game with potentially life-threatening consequences, but one the narrator is willing to play to see her endgame to fruition; it exposes a dark and dangerous side of psychiatry and medicalisation that profits from the desperation of mental health patients who are willing to lie and put themselves at risk in order to get better. As Davies explains in *Cracked*, "Psychiatry, in the name of helping others, is now in

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[13] Eventually, the doctor turns to "ecoscripting" (42), the practise of prescribing medicines for their side effects in order to evade insurance questions.

serious peril of better helping itself," motivated by "pharmaceutical riches and medical status" (3) rather than patient health; Dr Tuttle may be more driven by professional ineptitude than wealth or status,[14] but her inclusion in the novel is nonetheless a purposeful denunciation of contemporary psychiatry.

Dr Tuttle doesn't offer the talking cure in any sense of the term, repeatedly forgetting major details about the narrator's life like her mother's death, and at no point suggesting any kind of lifestyle changes that might aid her mental health. Their relationship is more drug dealer-client than doctor-patient, but the narrator wouldn't have it any other way. Dr Tuttle is an integral cog in her self-care plan; in fact, the only time (prior to her extended sleep) that the narrator shows any emotion whatsoever is at the thought of losing Dr Tuttle, of her dropping dead or losing her license. For once, the narrator actually needs someone, can't just rely on herself or her money or her looks, and the thought of this essential, life-altering relationship disappearing is enough to bring tears to the narrator's eyes. Everyone else in her life has been disposable or replaceable or superfluous – her mother, Reva, boyfriend Trevor – but she *needs* Dr Tuttle on a visceral level, and this unfamiliar feeling of dependence has for once imbued her with emotion, albeit unintentional. Human connection, despite its predication upon a precarious and unethical chemical dependency, has cracked the narrator's icy and misanthropic disposition, even if only for a second.

The narrator's excessive pill-popping isn't without side effects. As her long-term self-care plan escalates, the narrator's actual physical self-care deteriorates. She stops brushing her hair and showering regularly, stops shaving and moisturising altogether, stops eating. Her muscles turn soft and wither away, and both her pulse and blood pressure plummet. Eventually she stops menstruating. Her ribs protrude, her collarbones jut out and she has wrinkles on her hips from loose skin. The mental repercussions of the drugs, particularly Infermiterol, are extreme as well. In November 2000, the narrator realises that she is starting to do small things while 'sleeping' –

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[14] Her usage of a fake neck brace as part of an insurance scam does, however, reveal that she is motivated at least in part by money.

rearranging furniture, going to the local bodega, buying and gorging on food. It's anathema to her hibernation project and annoys the narrator, largely because if she commits a crime or gets hit by a bus "the chance for a new and better life would be lost" (86). She starts ordering sexy lingerie in her sleep and making appointments with beauticians, a few weeks later waking up to AOL chatroom conversations and nude photos that she has sent. The narrator's stress level rises and she realises she can't trust herself: "It seemed that while I was sleeping, some superficial part of me was taking aim at a life of beauty and sex appeal" (86). Her blackout escapades continue to escalate, and she awakens with slick panties, surrounded by pictures she has taken while clubbing. She is giving life to a completely different self in her sleep, the life she used to think she was supposed to live, a life that her waking self would undoubtedly deride. Her year of rest and relaxation has seen her social calendar busier than ever. "One Infermiterol had taken days of my life away. It was the perfect drug in that sense" (120). But at what cost?

These conflicting personalities – one cold and isolated and awake, one vibrant and social, but asleep – are reminiscent of the frequently analysed dissociated doubles that marked the fin-de-siècle era, including the timid Miss Beauchamp and her counterpart, rambunctious and free Sally, who were under the care of American neurologist Morton Prince, as well as Felida X, chief Salpetriere surgeon Eugene Azam's patient who was suffering in unbearable pain but fell into daily trances where she was healthy and happy. While the similarities are striking – the narrator does, after all, seek "liberation from the indeterminate, hypnotized state into which the customs and morality of the times have penned [her]" (Appignanesi 168) – the narrator's dual personas aren't the result of a psychic split, but rather an unwanted side effect of the drugs she is abusing. The narrator is engaged in a battle between the glamourous allure of New York high society, a subculture into which she so effortlessly fits, and her inward desire to live her life on her own terms, a showdown between outward appearance and inner self that the medication renders her unable to fight. While her sleepwalking, or rather, sleep-living is, a "waning of the disciplinary will," (Appignanesi 168) it isn't a Freudian dream in which she is living out repressed desires, but rather the very opposite; the narrator is leading the life she wants to while she is awake, but under the cloud of medication, she reverts to the life she is familiar with, one of frivolity and excess and beauty magazine standards. The narrator's sleepwalking shows just how potent the tension is between the "spoiled WASP" she is and the "bum" she wants to be (35). The narrator has finally found the courage to be free, but it withers as she takes an ever-increasing number of pills and slides back into a life of shopping and sex and superficiality. Old habits do, after all, die hard. It's as if she needs to give life to this part of herself in order to purge it and fully move on; until she is able to confront the discord between self and culture, decide who she really is and make peace with it, she cannot wholly transform, cannot truly be happy.

This dichotomy between who the narrator is and who she becomes on the pills is also redolent of a situation in psychiatrist Peter D. Kramer's *Listening to Prozac*, in which he describes radical changes in patient Tess after she begins Prozac. Tess's shift from being weary and depressed to "vivacious and fun-loving" (Kramer 11) is accompanied by a more gregarious circle of friends and a burgeoning love life. Tess becomes unrecognisable to Dr Kramer, not an improved version of her former self but a new person altogether. This change alarms Kramer, who notes that "for a drug to have such a pronounced effect is inherently unnatural, unsafe, uncanny" (13). How, asks Kramer, "were we to reconcile what Prozac did for Tess with our notion of the continuous, autobiographical human self?" (14). Which version of Tess is the 'real' one? These are issues to which Moshfegh alludes with her presentation of the narrator as two antithetical people. Though Infermiterol isn't an antidepressant like Prozac, it nonetheless precipitates a personality change in the narrator that she cannot control, leaving the reader to question whether the drugs are too powerful, too risky, too "unnatural," and to what extent the qualities that make us 'us' are biological constructs that can be tinkered with in a lab.

The narrator's drug-induced, sleep-focused self-care regime is not just a pathway to improved mental health, but a purposeful affront to the New York society with which she holds so much contempt. In the capitalist economy of America, where productivity is a major marker of success, sleep has become associated with laziness and lack of ambition, and white-collar employees wear their lack of sleep like badges of honour. The narrator attempts to opt out of neoliberal imperatives of self-optimisation by sleeping for a year — a radical refusal of productivity, consumerism and relationality; to this end, the narrator's sleep becomes a political act of resistance.[15] Sleep is, as Jonathan Crary, author of *24/7: Late Capitalism and the Ends of Sleep,* says, "one of the great human affronts to the voraciousness of contemporary capitalism [. . .,] an uncompromising interruption of the theft of time" (10) by a workaholic, consumer culture that only sees dollar signs. Working to the brink of collapse is rewarded and applauded, and self-care is seen as selfish and wasteful. Taking a sick day is a sign of weakness. The narrator turns this entire philosophy on its head with her year of rest and relaxation; exhibiting the very "entrepreneurial spirit" (Orgad and Gill 16) and "boldness" (15) that neoliberalism prizes, the narrator recasts them as strategies for orchestrating her retreat into sleep, thereby weaponising neoliberal ideals against themselves. It may be true, as Crary argues, that "within the globalist neoliberal paradigm, sleeping is for losers" (14), but the narrator isn't using the same tape measure to gauge her success. She is marking progress not by her yearly bonus or billable hours or professional success, but by hours of sleep, time spent inert. She turns her back on the rat race that causes so much burnout and stress, seeking solace through sleep instead. The very fact that she has chosen this route of self-care, the antithesis to the formidable work ethic on which Manhattan thrives, demonstrates personal growth, shows that she is on the road to leaving behind her closet of designer shoes and a life of doing what is expected. She has taken the first step in the right direction before her project even begins.

That said, the narrator's extended sleep regimen is borne of privilege; she doesn't *need* to work, to earn money, to participate in society in order to survive, thus creating a paradox: her ability to opt-out of neoliberal imperatives of productivity and resilience is secured by the very structures of wealth and privilege that neoliberal feminism serves. The narrator can comfortably live on her

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[15] This aligns with Hedva's "Sick Woman Theory" which configures illness and incapacity as politically significant in their resistance to comply with neoliberal demands for productivity, visibility and participation.

inheritance for the foreseeable future, imparting her a level of freedom unavailable to most of her peers – her friend Reva included – who live pay check-to-pay check, struggling to make ends meet. Reva cannot remove herself from society and embark on a lengthy self-help journey like that of the narrator, and the narrator's drug-fuelled sleep – like her Bloomingdale's shopping sprees – is yet another luxury that Reva simply cannot afford. The juxtaposition between the narrator's outlandish attempt to alleviate her existential despair and Reva's tacit acceptance of her own deteriorating mental health reveals a healthcare divide rooted in class differences. Those who can afford to get help, whether it be expensive wellness clinics or intensive therapy or, as in the narrator's case, months-long hibernation, are granted more opportunities to improve their mental health than those at the other end of the social spectrum. "Lucky you," sighs Reva. "I wouldn't mind taking time off from work to loaf around, watch movies, and snooze all day" (12). While the narrator has high hopes for her self-help scheme, the very nature of her plan is so entangled with her privilege that it is hard to imagine it begetting a completely fresh start; it is only possible because of the very life that she is trying to leave behind.

The narrator's hibernation project reaches its pinnacle in March 2001 when she endeavours to sleep for three months straight, only waking for one hour every three days, 40 conscious hours in 120 days. It's Silas Weir Mitchell's rest cure[16] in extremis. She has a locksmith add a lock to the outside of her door so she cannot leave, vowing that if her project doesn't work, she will jump out of the window in June. One way or another, it will be the end. The narrator enlists the help of artist Ping Xi, who will bring her pizza once a week and make sure she is alive, in exchange for filming her experience as part of his newest installation. While she begins with a ritual cleansing, gifting her designer clothes to Reva, throwing her cell phone in the river, donating all non-necessities to charity, even her beloved Whoopi Goldberg tapes, she stops short of burning her birth certificate and cutting

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[16] The physician's cure was famous in the late 19th century; its aims were "to take the patient away from familiar surroundings, to enforce rest and distance from any forms of stimulation other than those provided by doctor and nurse, to feed and feed some more" (Appignanesi 137). While the narrator eats only minimally and secludes herself in her own apartment, she most certainly takes the "rest and distance from any forms of stimulation" to the extreme.

up her passport and license, despite Ping Xi's explanation that it would be a shocking signification of rebirth. She wants to be changed from within, wants to start over, but she won't give up the identity and wealth that have made her life easier; she refuses to squander the privilege that forms the foundation of her self-worth, and this is a sign that any change she experiences will have its limits.

The narrator is hopeful that her project will work, but not unafraid:

> But I was terrified. It was lunacy, this idea, that I could sleep myself into a new life. [. . .] But now I was approaching the mouth of the cave. [. . .] Something had to be burned and sacrificed. And then the fire would burn out and die. The smoke would clear. My eyes would adjust to the darkness, I thought. I'd find my footing. When I came out of the cave, back out into the light, when I woke up at last, everything – the whole world – would be new again. (260-1)

Up until this point, the author has been zealously living in Plato's cave, avoiding the "garish and hostile" (4) outside world, preferring the darkness and shadows of the cavern, where she is willingly chained to her bed in a life of solitude. The reality from which she hides is inauthentic and unwelcoming, a place where truth and individuality take a back seat to plastic conformity, where the Revas and Trevors of New York cling desperately to the rungs of the social ladder. The narrator is hopeful that sleep will curate her personality in a way that makes this previously intolerable world seem fresh and beautiful, not just bearable but desirable. Sleep is both anaesthesia and cure, with the narrator craving both the emptiness and the transformative power of sleep. She wants to feel alive:

> I knew in my heart – this was, perhaps, the only thing my heart knew back then – that when I'd slept enough, I'd be okay. I'd be renewed, reborn. I would be a whole new person, every one of my cells regenerated enough times that the old cells were just distant, foggy memories. My past life would be but a dream, and I could start over without regrets,

> bolstered by the bliss and serenity that I would have accumulated in my year of rest and relaxation. (51)

And it seems to work.

Ambiguous Success

The narrator wakes on June 1st, 2001, and immediately leaves her self-implemented comfort zone, walking to Second Avenue and the next day all the way to Lexington. She sits on a park bench watching dogs, finds some books, unfamiliar and new, on the curb and reads them all. She has no trouble sleeping, no dreams. She replenishes her wardrobe and refurnishes her house with items from Goodwill rather than Bloomingdale's, listens to music, gives up coffee, feeds the squirrels in the park. She calls Reva on her birthday, a notable shift in her desire to cultivate a relationship, and for the first time doesn't want Reva to leave, describes her as beautiful, tells her she loves her. Yet despite all of the narrator's claims that she is changed, claims that her plan has been successful, embers of her former self still linger in the ashes. The narrator is quick to criticise Reva's "pornographic" (280) appearance and gives her unsolicited advice on where to get her too-long jeans hemmed. She tunes out Reva's reading of a *The New Yorker* article that is clearly important to her. While this version of the narrator is softer and kinder, her hibernation does not mark a complete metamorphosis.

But how exactly has the sleep managed to change her? While the narrator isn't a fan of scientific understanding or questioning why something works, admitting that "reading up on a drug sapped its magic" (25), there are a few possibilities for how the sleep has transformed her. There is a potential link with a 1980s study conducted by The National Institute of Mental Health, which set out to evaluate the effectiveness of antidepressants and psychotherapy. The study found that regardless of which treatment a participant underwent – drugs, therapy or a placebo – improvement was tied to expectations more than anything else. As Davies explains, "Those who expected to feel better improved the most, while those who expected little or no improvement received the least benefit from treatment" (J. Davies 82). It may simply be that the narrator expected her sleep project to work, so it did. The narrator's improvement may also be related to target-setting: she has set a goal, albeit the unorthodox goal of sleeping for months on end, and she has achieved it. Sleeping has given her purpose, perhaps for the first time in her life, and she is doing it for herself – not for her parents, not for Reva, not for Trevor, not because society has pressured her to or because it would be the easy thing to do. The narrator is sleeping because she *wants* to sleep. It is perhaps this new sense of accomplishment, the significance of setting herself an objective and surmounting it, that has imbued her with a fresh lease on life and left her "like a newborn animal" (278). She has finally found, as Andrew Solomon, author of *The Noonday Demon: An Anatomy of Depression*, explains, "the vital sense of purpose that is the opposite of depression" (15). She knows she is capable not just of success, but of doing something for herself and only herself. She is free.

This learned self-governance is an example of Michel Foucault's "technologies of the self," or what the French philosopher describes as strategies "which permit individuals to effect by their own means [. . .] operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection" (225). By controlling her daily habits and focusing on self-care, the narrator is able to shift her way of thinking and affect emotional change. Sleeping has become for the narrator a "ritual of purification" (Foucault 240), not unlike more palpable forms of asceticism like fasting or celibacy, through which she purges her pain by harnessing her focus on a single element. As Megan Brown says in "Taking Care of Business: Self-Help and Sleep Medicine in American Corporate Culture," "Even self-training that seems primarily physical in nature is frequently posited as simultaneously attitude training; when one's body is in better shape, so are one's moods and one's ability to think clearly" (176). Rest for her body is rest for her soul, and it has served as a psychological re-boot that has freed her from past trauma.

The psychological, emotional and physiological benefits of sleep are well documented. Sleep is not just rest, but also a form of connection, "a world in common, a shared enactment of withdrawal from the calamitous nullity and waste of 24/7 praxis" (Crary 126). Sleep is simultaneously personal and collective; like throwing away trash, which the narrator describes as an enjoyable task that fosters a sense of community (Moshfegh 114-115), it is a banal and unavoidable social norm that begets a sense of belonging for the narrator. It is also a remission from the society she detests, a postponement of the future, and forced disengagement from a life in which our every move is dictated by an external force. It is during this period of darkness and inactivity that our bodies metabolise not just the food, drink and medications that we have ingested during the day, but as Crary argues, "also the flood of anxieties, fears, doubts, longings, imaginings of failure" (127). Sleep is an extradition of emotional baggage. Neuroscientist Matthew Walker explains in *Why We Sleep: The New Science of Sleep and Dreams,* that "sleep is the single most effective thing we can do to reset our brain and body health each day" (8). It "recalibrates our emotional brain circuits" and facilitates dreaming, which is "a consoling neurochemical bath that mollifies painful memories" (Walker 7). The narrator has finally slept long enough to digest and extricate all of her pain and has woken up to an unforeseen future in which she is unafraid, her sleep allowing for "a possibility of renewal and hence of freedom" (Crary 127).

The novel ends with the narrator watching a recording of Reva's death in 9/11, specifically the scene of a woman she believes is Reva jumping to her death from the North Tower. The narrator is "overcome by awe" (289) at the thought of Reva, who was sleepwalking through her life and constantly succumbing to the expectations of a flawed society, finally choosing her own path, "diving into the unknown [. . .] wide awake" (289). While the language of this short chapter is markedly different from the rest of the novel, more flowery and emotional and insightful, it reveals once again that the narrator is not completely changed. She continues to tacitly embrace both privilege and consumerism, rushing out to buy a new TV/VCR on the day of the events. She is yet again watching a VHS tape on repeat, relying on her old coping mechanism to process her trauma, perhaps seeking a reminder of the emotional connection, the shared experience that 9/11 signifies. She treats the events of 9/11, which took the life of her only friend, as more art than fact, watching the tape in the very same way that she watched *Star Trek* and *Working Girl*. Though she truly believes she is a changed woman, it is clear that the narrator still hasn't learned to cope with sorrow and pain in a meaningful way; bad things will continue to happen throughout her life, and the novel doesn't leave the reader with a sense that the narrator can necessarily overcome these future woes without retreating into her anxiety and misery to at least some degree.

The narrator's apathy and disdain function as "ugly feelings" (Ngai 3), affective states that refuse resolution and prohibit the cathartic sympathy typically extended to tormented protagonists. As Ngai explains, "Unlike grand passions or emotions with clear objects, ugly feelings point less to action than to the blocked conditions of life under late capitalism" (14), and the narrator's affective state helps register the psychic toll of neoliberal feminism. Rather than inviting identification or compassion, the narrator's indifference unsettles traditional modes of empathy by making her difficult to like or even tolerate. In doing so, the novel resists the solace of recognition and instead demands a more uncomfortable form of engagement – one that, as Rita Felski suggests, moves beyond the familiar logic of "recogni[sing] oneself" (37) in the character and toward identifying the social and cultural conditions that produce the narrator's withdrawal. By creating a protagonist whose "ugliness" frustrates easy connection, Moshfegh challenges the reader to confront the limits of empathy and to reckon with the neoliberal pressures that render apathy itself a mode of resistance.

The novel doesn't mask the messiness of mental illness, doesn't romanticise the narrator's relationship with drugs, nor does it leave the reader with a sense that the narrator has completely overcome her debilitating sadness. While she certainly does appear better at the end of the novel – or at least different – it is an unsettling ending that very much belies the narrator's confidence in her cure; she hasn't learned to deal with her emotions, hasn't cultivated new and healthier coping mechanisms, hasn't shown any real ability to form and maintain relationships. Her medication may have bought her a year of rest and relaxation, but it doesn't seem to have bought her lasting peace; to this extent, the novel calls into question the usefulness of drugs in managing emotion. To begin with, the narrator utilises medication not as a direct treatment for her unhappiness but as a means to an end, as a way to achieve extended sleep. It is the hibernation, not the pills, that the narrator believes will help her, and this break in the link between medication and recovery undermines the capacity in which drugs can treat sadness. Additionally, while Dr Tuttle may be a scathing representation of modern psychiatry, the pharmaceutical industry is equally portrayed as ineffective and complicit in the narrator's precarious self-care plan. The narrator's growing cache of drugs goes unchecked throughout the novel, with neither the pharmacy nor the insurance company questioning the need for such an accumulation of prescriptions. The narrator sets out with the plan to abuse drugs to aid her sleep, with no interest in recommended dosages or possible drug interactions, and at no point is she prevented from doing so. It isn't quality mental healthcare, it's a caustic lampoon of a profit-driven industry that has gone awry and put its patients, or rather, customers, at risk. While the novel sends a variety of nuanced messages about the power of self-care, the nature of unhappiness and the damaging expectations of modern society, the point it makes around medication is quite simple: drugs, like beauty and money and power, are no guarantee of lasting happiness.

An Argument for Non-Pathological Sadness in *Sad Janet*

While *MYRR* features a singular character with a hyperbolic proclivity for pill-popping, Lucy Britsch's *Sad Janet* imagines an equally sardonic world in which this blasé attitude toward medication is the norm, where nearly every character is on antidepressants, where interventions are staged not because of addiction to pills but because of a refusal to take them. Like Moshfegh's novel, *Sad Janet* carves out a world of believable exaggeration that serves to criticise both Big Pharma and contemporary social values; Britsch's tongue-in-cheek writing layers rage with levity, anger with humour, resulting in a narrative whose message is a subtle yet trenchant warning of a toxically positive, overly medicated future best avoided.

Britsch's Janet isn't just sad, she's "bone sad" (5), or has *malaise* or *melancholia* or *mono no aware* ("the sadness of things") or any of the other fourteen words the Japanese have for "this feeling that staying afloat is almost impossible" (6). But she isn't depressed, and she certainly isn't a Goth. She's just Sad Janet. As Britsch says in an interview with Electric Literature, "Depression is something clinical that can be treated whereas sadness is a feeling, [and] for Janet it's a natural one we should embrace" (Lou). Many scholars – Ann Cvetcovich, Lewis Wolpert, Andrew Solomon, Kay Redfield Jamison, to name a few – have written eloquently and powerfully about their own depressive periods, and all describe depression as a frightening and debilitating illness that permeates every aspect of their lives, rendering them unable to participate in the world in any meaningful capacity. While Moshfegh's narrator arguably satisfies these conditions, Janet's condition lacks this all-encompassing destructiveness, and she describes her more subtle sadness as a "manageable melancholia," in which her days "are no worse than grey" (16), and Janet stands firm in her assertion that her sorrow isn't pathological. "I'm borderline so many things," Janet says. "I'm on every spectrum. But I will not have them tell me it's something that needs correcting. Being on a spectrum just means being human" (20). Janet's sadness isn't an illness, but simply a natural response to a broken society that values conformity and has turned everything, even Christmas, into a commercially-driven competition. Janet isn't embracing her fault but trying to convince those around her that it isn't a fault at all.

To this end, *Sad Janet*, like *MYRR*, functions as pushback to the neoliberal regime that demands happiness, productivity and emotional positivity. Janet's resistance – choosing sadness in the face of social and familial pressure – undermines the neoliberal feminist mantra that women must "lean in" (Rottenberg 420), be cheerful and manage their own wellbeing in a way that makes them more efficient workers, partners and consumers. Where Hedva suggests that sickness exposes the limits of neoliberal frameworks, Janet's deliberate melancholia functions as a critique of enforced wellness and compulsive positivity.

In Allan Horwitz and Jerome Wakefield's 2007 *The Loss of Sadness*, the two sociologists argue that the line between depression and sadness comes down to context. They critique the *DSM*'s approach to diagnosing Major Depressive Disorder (MDD), which hinges entirely on symptoms and "fails to take into account the *context* of the symptoms and thus fails to exclude from the disorder category intense sadness, other than in reaction to the death of a loved one, that arises from the way human beings naturally respond to major losses" (Horwitz and Wakefield 14, emphasis mine). This echoes feminist psychotherapist Phyllis Chesler's chastisement of modern psychiatric medicine for its propensity to "diagnostically pathologise what might be a totally normal human response to trauma" (1). While these statements rightfully help situate sadness outside the medical realm, they don't account for Janet's own emotional state. She hasn't suffered any gratuitous trauma or great loss: "My sadness wasn't caused by any one horrific unspeakable incident. [. . .] It's more an accumulation of tiny sadnesses, ones I've been collecting for as long as I've known the value of pockets" (24). Janet's stressor isn't the loss of her boyfriend or the death of a relative; it's the divide between the life she set out to live and the life she is living, the gradual, unrelenting loss of hope that eats away at one until sadness takes over. It is her failure to thrive in a capitalist, misogynistic world that regulates everything – even emotions – that both generates and perpetuates her sorrow, and Britsch's intimate glimpse into Janet's day-to-day life, her relationships, interactions and reflections, authenticates this kind of sorrow in a way that medical terminology and psychological jargon cannot.

Janet quips, "The whole world is too sad, really, but no one wants to admit it because they made it that way" (10). As Dr Paul Keedwell explains in *How Sadness Survived*, "The media fills our heads with unfulfilled dreams and the need for perfection in all aspects of our lives" (ix), like the Christmas adverts that suggest planning begin in October, the unrealistic film romances held up as ideal, glossy fashion magazines that feature far-too-skinny models in far-too-expensive clothes, and it is a set-up for failure. It is the same expectation of unattainable perfection that drove *MYRR*'s Reva to bulimia and alcoholism. Not only does Janet lack the cultural markers of success – she has no money, no impressive career, no children, no mansion in the suburbs – there is a notable disconnect between her interests (post-feminist science fiction and nachos, for example) and what society values. The dog shelter she works at lies deep in the woods, mirroring Janet's life on the outskirts of society. Like Reva, Janet is losing a competition she never even wanted to enter, faced with daily reminders that she isn't good enough, and it propels her into a spiral of sadness that pushes her even further away from being one of the "shiny people" (146) that society rewards; when read alongside *MYRR*, in which Moshfegh's narrator is "shiny" yet miserable, it is easy to see the social construct itself as the problem rather than an individual's alignment with it. Unfortunately for Janet, society isn't changing, nor is she, and her sadness is clearly here to stay. She is at an impasse in which she has no choice but to embrace her unhappiness, and yet society punishes her for this as well.

There is a permanence to Janet's sadness that makes it difficult to ascertain whether it is best categorised as feeling or mood. In *Malignant Sadness: The Anatomy of Depression*, Lewis Wolpert argues that every basic emotion "is characterised by being initiated by a distinctive signal of rapid onset, short duration and unbidden occurrence" (76) and this helps differentiate emotions from mood. He goes on to explain, "Moods such as contentment, or feeling low over longish periods, are not considered to be basic emotions as they are not initiated by distinctive signals" (Wolpert 77); but one could argue that in Janet's case, her sadness *is* brought about by distinctive signals, but these signals are so ubiquitous and effusive that they blend together in a way that makes them nearly invisible – an ad for anti-depressants on the radio, a comment about her attire, a suggestion from her boyfriend that she look into grad school, her mother's criticism of her job. These events happen with such regularity in Janet's life that she never has time to escape the sadness. Wolpert adds, "Depending on its duration, sadness can be either an emotion or a mood" (77), but in Janet's case it is both. The incessant bursts of small sadnesses are so prolific that the sensation lingers even in the absence of stimuli. Janet is perpetually down, in what one might call 'a bad mood,' and this is punctuated by additional sadness brought on by the constant reminders from her family and society that she needs to be fixed.

When Horwitz and Wakefield discuss normal sadness, they refer to it as temporary, ending when "natural coping mechanisms allow an individual to adjust to the new circumstances and return to psychological and social equilibrium" (16). This concept is problematic in its underlying assumption that equilibrium is happiness. Is it possible for a person's default setting to be, like Janet's, a delicate sadness? The stress causing Janet's sadness is a society that refuses to change, one that she cannot escape, and it makes sense that her natural state is one of sorrow. When life gives you nothing to be happy about, how can one be expected to find it within? As social psychologist Margaret Wetherell explains, an emotion isn't a 'thing' that exists solely inside a person, but rather "a relation to others, a response to a situation and to the world" (24), and Janet's sadness is predicated upon her incompatibility with the world around her. Similarly, Dr Robert L Spitzer[17] writes in the forward to *The Loss of Sadness*, "To be human means to naturally react with feelings of sadness to negative events in one's life" (Spitzer vii), and in Janet's case, the "negative events" are the whole of her life.

To fully understand Janet's sadness, one must explore not only what causes her sorrow, but also what prevents her happiness. In Sara Ahmed's *"*Happy Objects," she explains that "happiness puts us in intimate contact with *things*" (31, emphasis hers) and "objects that give us pleasure take up residence within our bodily horizon" (32); hence, Janet surrounds herself with dogs. "Dogs make me the closest to happy I've ever been" (Britsch 33), she surmises, and she spends as much time as possible at the shelter, even on days off. Ahmed extrapolates this notion by adding that "if something is close to a happy object then it can become happy by association" (33). Janet loves both

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[17] Spitzer, the architect of the third edition of the *DSM* (released in 1980), has since admitted the fallacy of utilising a tick-list rather than context to diagnose depression and has been quoted here and in an interview published in Davies' *Cracked* suggesting that depression is over-diagnosed and over-medicated. He suggests that many of those who are diagnosed and treated are not "psychiatrically unwell," with Davies adding that "what Spitzer told me, in other words, is that when clinicians ignore such contextual factors, they'll see mental disorders where there are none" (J. Davies 46).

the seemingly fun aspects of her job – cuddling the dogs, taking them for walks – but also the tedium – cleaning the cages, mopping up dog vomit. Janet even tolerates the perpetually peppy Melissa, her co-worker who embodies everything that Janet is not, because she is in close proximity to Janet's happy place. The Janet who works at the shelter is not quite Sad Janet, but a Quasi-Happy Janet who can finally be herself and be accepted for it. The problem is that this is the only joy Janet has in her life, and her network of happiness is restricted to those people and objects within this realm. Janet says as much when she has to leave the shelter on Christmas to go see her family: "I'd already left behind the best part of myself, with Debs and the dogs at the shelter" (103). Outside of her workplace is the world she loathes, yet it remains unavoidable.

Ahmed states that part of happiness is moving away from things we do not like: "Awayness might help establish the edges of our horizon; in rejecting the proximity of certain objects, we define the places that we know we do not wish to go, the things we do not wish to have, touch, taste, hear, feel, see, those things we do not want to keep within reach" (32). While this is certainly true, Ahmed assumes that one is physically able to avoid that which is unpleasant, and in Janet's situation that is impossible. It is society as a whole – at least, everything outside of the shelter – that brings Janet unhappiness, but she cannot wholly extricate herself from the neoliberal regime she wishes to escape. While Moshfegh's narrator can sleep away her sadness in isolation, her wealth and lack of family allowing for a total break from the outside world, Janet has no such luxury. Janet must earn an income, partake in the everyday social tasks of living – going to the grocery store, for example – and interact with her family, who insist on being an active part of the life, despite their differing viewpoints inciting regular arguments. Moshfegh's narrator can escape from the society that triggers her despair, seek solace in extended slumber, whereas Janet's lack of privilege renders her stuck in an inescapable cycle of sadness.

Throughout the novel, Janet takes issues with the patriarchal nature of society and the proclivity of men to both make the rules and punish those who break them, and this is intertwined with her sorrow as well. Janet has faced a lifetime of men trying to fix her, to convince her that her sadness is a character flaw that can – and should – be eradicated. Even Janet's boyfriend, who was once charmed by Janet's dark demeanour, starts to take issues with it once she loses interest in sex. "I've always been sad, but now it didn't fit his needs" (20), she laments. Janet's negative encounters with the opposite sex extend beyond just romantic ones. Her doctor lures her to his office under false pretences, telling her she is due for a pap smear, when in reality, he wants to pitch her the new Christmas drug, which is amusingly called Santa's Little Helper in an effort to increase its marketability. He promises it is the answer to all her problems, but the doctor only has his own self-interests in mind, "like all men who want to fix me" (28), complains Janet. At the mandated meetings for Santa's Little Helper, Janet notices a man in a suit taking notes in the corner: "Men medicating women – just as it's always been" (116). The meeting is a microcosm of the psychiatric world in which men – Silas Weir Mitchell, George M. Beard, Morton Prince, Charles Fayette Taylor,[18] to name a few – have been setting the boundaries for female behaviour for centuries and then pathologising those who dare cross them.

Janet speaks for many modern women when she says, "It's almost impossible to be a woman. All I really want to be is a person anyway" (259). Society has tied womanhood to identity in such a way that they cannot be separated, and this is complicit in Janet's ongoing sadness. Women face challenges and assumptions tied to their gender on a daily basis, and Janet is no exception. Debs' brother tells Janet that she's "not that fuckable" (259) even though Janet made no indications that she was interested in him; men regularly come to the dog shelter to ogle the strange women in the woods like they are a sideshow exhibit; Janet is routinely chided for hiding her body underneath layers of sweaters and a giant coat; she can't avoid envisioning motherhood because "as a woman [she's] hard-wired to always be thinking about babies" (109). As Chesler explains, women have been

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[18] Weir Mitchell's notorious rest cure requires complete disengagement from activities, family and peers, and he speaks of his patients "with the vivid impatience of a practical misogynist" (Appignanesi 136); Beard suggested women's "incursion into the masculine sphere of intellectual labour together with the 'exhausting sentiment of love' were responsible for their nervous depletion" (Appignanesi 115); Taylor believed women's emotions led to poor mental health and "too much education in a woman made her more emotional" (Appignanesi 132)

oppressed for centuries, oppressed in the expectations of them, oppressed in the control men have over them and their bodies, oppressed in the avenues of life that are closed off to them merely because of gender, and as she concludes, “Oppression is traumatising” (1). When Horwitz and Wakefield consider the stresses that lead to sadness, perhaps they should expand their thinking to include the notion that simply being a woman in the twenty-first century is an on-going and unrelenting stress, and a baseline of sadness may not be inappropriate. Would Janet’s sadness be more acceptable if she were a man? Would it be construed as seriousness or lauded as emotional control rather than seen as a flaw that needs fixing? How can a woman be truly happy in a world constructed by men?

By presenting Janet’s sadness as a fundamental part of who she is, and one that she has tacitly accepted, Britsch gives a voice to those who contently live outside social norms and challenges the notion that mental health is one-size-fits-all. Where Moshfegh’s narrator goes to extremes to change who she is, Janet clings to her sadness like a badge of honour. As Britsch explains, “There’s this idea of the happy existentialist, someone who sees the void at the heart of existence but accepts it and is free” (Lou); this is the blood and guts of her titular character. It is a break from late-20th century mental health narratives – both memoir and fiction – in which happiness is currency. Janet isn’t Wally Lamb’s Dolores who spends the majority of *She’s Come Undone* craving joy, feeling worthless and broken, or the arguably narcissistic Elizabeth Wurtzel, whose *Prozac Nation* is bursting with self-pity over her misery. Happiness isn’t Janet’s endgame, and this is a liberating shift that opens up the concept of ‘normal’ to include shades of sadness and champions for a self-acceptance based on personal values, not public acceptance. “Happiness is not on my radar,” explains Janet. “I want other things. Like control over my life, my body. Like being able to get through a day without feeling like I’m doing it wrong. I want to *feel* all my feelings, not swallow them, and if they swallow *me*, so be it” (25, emphasis in text). While everyone else supresses sadness with pills or denial, treats it as an embarrassing rash that needs immediate treatment, Janet embraces it and rages at those who shame her for this – her mother, her brother,

her doctor, her boyfriend. Janet is desperately trying to live her life on her own terms but is increasingly made to feel that this simply isn't good enough. Like the smelly Dumpster she purposely leaves near the entrance to the dog shelter, Janet doesn't hide her sadness but puts it on display and demands acceptance for who she truly is, and this is an empowering message.

A Pill for All That Ails You

"What our culture once viewed as a reaction to failed hopes and aspirations it now regards as a psychiatric illness" (4), explain Horwitz and Wakefield, and Britsch's satirical *Sad Janet* is a prime example of the pathologisation of sadness. As modern pharmacology produces more and more medications that solve life's niggling problems – baldness, acne, restless legs, dandruff, body odour – the less adversity society is willing to accept. Sadness is no longer a simple human emotion but a disease that must be treated and eliminated. Solomon adds, "We pathologise the curable, and what can easily be modified comes to be treated as illness, even if it was previously treated as personality or mood" (27). Janet explains her predicament: "I *should* be happy, apparently. Not because we've just won the war on terrorism, or survived a near-fatal collision with an asteroid, or found the cure for cancer, but because happiness is right there for the taking, if I would only take my butt down to my doctor and then to the pharmacy" (7). Why wallow in sadness when happiness is only a prescription away?

Nearly everyone in Janet's life is medicated, and they are rather unperturbed by it. "Melissa is on Lexapro. Debs is on good old-fashioned Prozac. [. . .] My best friend, Emma, started taking Zoloft because she got a free hat" (7), Janet explains. Her brother and mother are both on a bevy of pills, with Janet clarifying their rationale: "They think if there's something wrong and there's a pill, then why not? They take a dozen different ones" (8). Janet applauds the fact that the proliferation of pill-poppers has eradicated the stigma of medication, but she fails to realise that the judgement has only shifted, and it is now those who refuse to exterminate their sadness that are pilloried. This becomes clear when her family and boyfriend stage an intervention to try to convince her to take medication, which they hope will encourage her to engage in more “normal things” (17). Janet is urged to take the pill – an act of conformity in itself – so that she can further conform to the expectations of a woman in modern society. Marriage. Babies. “A nice pretty dress” (5). Janet must “fix” (5) herself, change who she is, to better adapt to the world, and the possibility that the problem is society and not her is never considered by those closest to her. The sadness is easier to repair, after all.

While the pills seem to do as promised – Emma ended up feeling better and moving to Ibiza, Janet’s mother is always in a good mood, her brother went from a bedraggled loner to a married father – Janet argues that the result isn’t true happiness but a flattening of *all* feelings, even the good ones, which were never good enough anyway. “I think people got tired of waiting to feel things, because when they did, it was disappointing. Instead, they started taking pills that promised them they’d feel *different*, at least, and sometimes that’s enough” (23, emphasis in text), argues Janet. There aren’t happiness pills, but rather “everything’s ok pills” (23), and many studies corroborate Janet’s accusation of emotional blunting (Balon, Goodwin et al.; Marazziti et al.; Opbroek et al.; Price et al.; Read and Williams). The pills promise a life in the middle – not too high, not too low – and for many people, certainly everyone in Janet’s life, this is sufficient. But not for Janet, who resists, explaining, “Most of the time I go around a little numb, but sometimes I feel things pretty hard, and these flashes of feeling are why I don’t want to be medicated” (77). Janet’s prolonged sadness is a gateway to feeling more, and taking a pill would mean closing off this part of her altogether.

Janet reveals that “it was the pill for shyness that cemented my feeling that pills were garbage, that we were one step away from a pill that would make you straight, when all most of us wanted was to be allowed to be crooked, broken, flawed” (65). Shyness isn’t a disease any more than sadness is, and eradicating it means losing part of what it means to be human. This ties into Kramer’s apprehensions about his formerly withdrawn patient Tess, mentioned earlier in the chapter, who became a seemingly different person – outgoing and passionate – under Prozac. Janet argues that the pills promote sameness, not happiness, and medicating away character flaws is tantamount to creating a society devoid of humanity. What Britsch is advocating for is an acceptance of human emotion as a spectrum that is better off felt in its entirety, for better or for worse, and for the glorification of difference, not the suppression of it. It is a powerful message that resonates with anyone who has been urged to mask their true self – dress a different way, smile a bit more, change their interests – and it gives strength to those who might be tempted to conform by showing the power of self-acceptance.

Sad Janet functions as a protest against toxic positivity, the injection of happiness into every situation to the detriment of authentic experiences. Positivity becomes poisonous when it exists in excess and limits the gamut of feelings to those that are deemed acceptable. Janet is expected to grin simply because it's Christmas; her boyfriend prefers her drunk because she is nicer to his family; group leader Karen smiles and says, "Okay, well, it'll take a few weeks" (135) when no one at the second drug meeting immediately announces that they feel better. Toxic positivity is the denial of reality, a smothering of sadness. It is the rally cry of everyone in Janet's life. Sadness inarguably slows us down, and in a capitalist society that rewards professional success, there is simply no time for this; the solution is to perpetuate a toxic positivity that demands we medicate away the sadness "so we can get back to earning a living and consuming" (Keedwell x). But Janet resists, and through her refusal to join the ranks of the pill-popping emotion-evaders, Britsch encourages her readers to embrace sadness as natural, not medical, and advocates leaning in to all emotions, even the negative ones. Happiness isn't always best, especially if it means denying the truth of who Janet really is, and toxic positivity is a naïve avoidance of reality that tries to fix a systemic problem with a superficial smile.

Sad Janet is equally a criticism of the pharmaceutical industry that both advertises sadness as a disease and then offers the solution in the form of a pill. As Keedwell suggests, "The notion of depression as a disease has been reinforced and perpetuated by biologists, psychiatrists and pharmaceutical companies, all of whom have a vested interest, consciously or unconsciously, in the clinical perspective" (x). Janet is known as a resister, one of the last holdouts who refuses to take a daily pill, and Santa's Little Helper is specifically designed for people like her, the last population subgroup that the pharmaceutical industry has yet to crack. Her doctor literally says, "It was made for you, Janet" (28). The pill is designed to be taken for eight weeks starting in November with the promise of allowing the user to enjoy the Christmas season. It's "a pill to get you to Christmas with a smile" (29), explains Janet's doctor. When news breaks in February that the drug was a sham, the true goal of the pill is revealed – it was never about making people feel better for the holidays, but rather about creating a gateway drug that would lure the resisters into trying a daily pill once Christmas was over. It is Britsch's critique of a Machiavellian medical industry that is focused on money and profits instead of emotions and people and will do anything – even unabashedly lie – to increase its client base. While the events in the book read like satire, the dishonesty and exploitation portrayed is surprisingly close to truth. For example, in 2000, Eli Lilly marketed their new drug Sarafem as a treatment for premenstrual dysphoric disorder, promising women that the pink and purple pill would bring them relief from their monthly mood swings, but they failed to reveal that the medication was actually just repackaged Prozac.[19] Similarly, manipulation is so prevalent in drug trials that a bevy of slang terms – cherry-picking,[20] salami-slicing,[21] washing out[22] – have arisen to delineate the various ways that researchers tweak data to make their drugs seem successful.

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[19] In addition to the rebranding allowing Eli Lilly to extend the patent on Prozac by marketing it under a new name, it also solved the problem of women not taking Prozac for PMDD because it is associated primarily with depression (J. Davies 76-80).

[20] the practice of concealing evidence that disproves one's goal and publishing only that which proves it (J. Davies 150-2)

[21] As Davies explains in *Cracked*, "This is when companies not only keep negative studies hidden from professionals and the general public, but also publish positive studies many times over in different forms and locations. The problem with this practice is obvious: it creates the false impression that many studies have been conducted, and all showing positive results, when in fact all the positive studies stem from only one 'data set' or piece of research" (J. Davies 153).

[22] A term referring to the practice of first putting all patients on a placebo and then removing those who improved on the placebo from the actual drug trial. This artificially inflates the number of patients who responded better to the drug than the placebo, making the drug look more effective than it actually is (J. Davies 154-5).

Janet's disdain for the medicalisation of the human condition is rooted in her own experiences, which reveal a deep mistrust for the medical community as a whole, one that Britsch corroborates through her narrative. Janet describes Diane, an old housemate who "hadn't even seemed that sad" (47), especially in comparison to Janet, and yet begins taking Citalopram after the campus doctor prescribes it. When it starts to make her agitated and paranoid, her doctor, in a very Dr Tuttle-esque manoeuvre, doubles the dose. Diane further unravels to the point where the housemates are worried that she might stab them, and rather than stop the medicine, the doctor adds Mirtazapine to counter the reaction; this calms Diane down to the extent that she cannot get out of bed, and her parents ultimately have to retrieve her and take her home from school. Despite all the evidence to the contrary, the parents refuse to blame the medicine: "She had a prescription" (48). Britsch uses Diane's experience and her parents' reaction to condemn the level of trust that is placed in the medical and pharmaceutical industries as well as the over-diagnosis of general sadness as depression.

Doctors are not infallible, and the social, political and economic pressure increasingly applied to their profession have led to a superfluous increase in both MDD diagnoses and the prescription of antidepressants. While many doctors and organisations deny the overprescription of antidepressants, including The Royal College of General Practitioners, whose chair Maureen Baker argues that GPs "prescribe medication only when necessary and where other alternatives have been explored" (Worrall), Britsch, and the statistics, disagree. Even Spitzer, chief architect of the *DSM-III* admits that "we have to some extent" medicalised "much ordinary human sadness" (J. Davies 44). A 2013 *BMJ* article written by Christopher Dowrick and Allen Frances cites not only an overabundance of clinical MDD diagnoses compared to community prevalence of the disorder, but also an increase in the number of patients prescribed antidepressants without any psychiatric diagnosis at all,[23]

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[23] William Davies cites in *The Happiness Industry* that 80% of antidepressant prescriptions in the US are written by medical doctors and primary care physicians rather than psychiatrists (W. Davies 175).

mirroring the disjoint between disease and medication mentioned earlier in the chapter. The pair argue that doctors and patients are equally complicit in medicalising normal sadness:

> For GPs a diagnosis of depression may be an attractive instrument for managing uncertainty in the consulting room, especially as its commonest treatment comes in the form of a once daily pill and is encouraged by clinical guidelines and indicators. Patients often request treatment for symptoms of sadness, and doctors and patients can feel obliged to offer and accept a diagnosis of major depressive disorder. (Dowrick and Frances 3)

Glòria Durà-Vilà, author of *Sadness, Depression and the Dark Night of the Soul*, agrees that sadness is being inaccurately diagnosed as depression and wrongly medicated; yet, she explains that this is expected within the current medical landscape, which is increasingly pressured by economic interests and social expectations. Society is more extensively conceptualising negative emotions as psychological problems, and doctors are being pressured by “overstretched health services that tend to favour the use of antidepressants rather than more costly psychotherapeutic treatments” (Durà-Vilà 21), a pressure that “augment[s] the use of medication as a response to emotional difficulties” (Durà-Vilà 21). Doctors are inadvertently promoting the pathologisation of sadness by complying with patients’ requests for drugs to help them navigate their very normal, yet unwelcome, feelings, and this normalises the treatment of sadness with pills.

The advertisements for anti-depressants only exacerbate this effect, and Britsch chastises these as well; *Sad Janet* further elucidates the duplicitous nature of the pharmaceutical industry by showing how increased commercialisation encourages people to self-diagnose and then self-medicate. Ads for the Christmas drug are everywhere – Facebook, TV, radio, on the sides of busses – and are diverse enough to represent a cross-section of modern society, to appeal to all the Janets of the world. The one that speaks to Janet the most features a woman that looks eerily similar to her but is clearly a “better version” (90), with shinier hair, a svelte figure and a nicer apartment. “Do you want a happy Christmas, says a voiceover lady, but feel like you’ll never have one? Are you currently resisting everyday antidepressants but still want a joyful holiday?" (90). It is Janet's exact situation. Faux-Janet's world starts out black-and-white, but quickly shifts to colour once she takes the pills, and the commercial cuts to a montage of the woman happily engaging in typical Christmas activities. The ad employs an oppositional paradigm of depression as black and white and 'normal' life as full colour that exaggerates the effect of the drug as well as the speed with which it works. Another advert says, "Life is hard. We get it. Just look at the news. But that shouldn't stop you enjoying your least favourite time of year. You deserve it. You deserve Christmas" (97). The commercial casts a wide net with generalisations about life and the news, and then homes in on the individual with its use of "you" to make the reader feel that the drug is personalised for him. The ad's repetition of "you deserve" links the drug to self-care and implies that if someone chooses not to try the drug, she doesn't value herself. These are tried and true advertising techniques, but given the nature of what they are selling, the tactics toe the line of morality.

In a 2007 analysis of television ads for prescription drugs, Dominick L Frosch et al. found that on the whole, drug commercials featured emotional appeals that downplayed health risks in favour of promoting a product and "were often ambiguous about whether viewers might legitimately need the product" (Frosch et al. 10). This is certainly true about the ads for Santa's Little Helper, which hinge on generalities that will apply to many people, whether they are depressed or not, and whose potential side effects "fill the screen" (Britsch 100) in the last seconds of the ad. Frosch et al. discovered that the majority of ads "show characters that have lost control over their social, emotional, or physical lives without the medication, and they minimize the value of health promotion through lifestyle changes" (Frosch et al. 6). The commercials for the Christmas drug insinuate that the pill is a quick fix that allows the user to live life to the fullest and make no mention of alternatives to improve mood such as therapy or exercise. MedsForLife, the very appropriately named company behind Santa's Little Helper, has created a solvable problem and then advertised the solution; there are even Kwanzaa and Hanukkah versions of the pill available, just to make sure that no facet of the target audience is left out. Equally problematic, some ads for the Christmas medicine feature cartoon elves called Dopamine and Serotonin, configuring depression as a purely chemical issue to which MedsForLife has a chemical fix; not only does this conceal the social aspects of depression, but it centres entirely on a biological component that science has yet to substantiate. While the novel is a satirical look at medicated sadness, the ads for Santa's Little Helper smack of late-capitalist realism and serve as Britsch's denunciation of a pharmaceutical industry that claims to promote health but whose advertising does anything but.

Janet's wariness of medicating her sadness is further validated when the Christmas drug turns out to be a sugar pill; while one would expect the controversy to lead to an increase of support for her anti-drug stance, the aftermath reveals a surprising outcome. The CEO of MedsForLife, Richard Grossman, holds a press conference that mitigates the social backlash with a bit of PR magic: "The world needed something to bring people together, he says. And we did that. Does it really matter how? [. . .] Don't you see? he says. *It worked.* People all over the country had a happy Christmas. They found the real Christmas spirit – right there inside themselves. And it was all thanks to our pill" (268, emphasis in text). Soon, Grossman (whose name is a bit too on-the-nose) is being lauded instead of condemned, and the manipulation of the pharmaceutical industry has not only been forgiven but touted as genius. The general public's susceptibility to persuasion by televised appeals clearly extends beyond drug advertisements, and Britsch attacks this willingness to overlook the lies and accept the contrived apology. Earlier in the novel, Janet admits that she loves stories of drug trials gone wrong, because "who can resist a fairy tale where Big Pharma is exposed as the wicked witch?" (118). The ending of *Sad Janet* offers a depressing answer – apparently everyone. With so many people reliant on the pharmaceutical industry to medicate away their problems, it turns out that they will forgive anything in order to keep the pills coming.

A Social Placebo Effect

While Janet doggedly opposes her family's request to medicate her sadness, professing that she is "happy in [her] sadness" (25), there are hints throughout the novel that this is not quite the case, and her resistance wanes with the unveiling of the Christmas drug. Janet admits to struggling with "crippling self-awareness" (212), "self-doubt" (157) and overthinking: "I lie awake most nights now thinking about everything that has ever happened to me. I can't switch it off – switch *me* off – but I want to" (67, emphasis in text). There are clearly aspects of Janet's personality that eat away at her and cause distress, and while she doesn't want to erase them altogether, she welcomes the opportunity to feel 'different' for a short period of time. "I don't really want to take any pills, because life is sad and I don't want to forget that. But maybe a few weeks off at Christmas wouldn't be so bad" (120). Santa's Little Helper offers Janet a non-committal glimpse at an alternative life, an intriguing psychological makeover without the feeling that she is completely giving in. And, as Janet bemoans, "resistance is exhausting" (23).

Sad Janet's twist is that while everyone believes Janet is taking the drugs – the reader included – she isn't; yet, November and December Janet is notably more upbeat and tolerant than normal Sad Janet. The change isn't a chemical one but a social one, with those in Janet's life softening their approach to her in the belief that she is taking the medicine, and this in turn imbues Janet with the desire to shift from a passive participant in her life to an active one. It is a placebo effect not within Janet, but within her friends and family; they expect a change in Janet that in turn influences their own behaviour toward her. Janet's mother invites her to go Christmas shopping, a request she would never have levied prior to Santa's Little Helper. This small action broaches a line that has separated mother and daughter for years, and to everyone's shock, Janet willingly accompanies her mother to the mall. Her mother's expectation of change – due to the drugs – has manifested in an actual change in Janet. It has opened the lines of communication between the two, even if only for a short time. New Janet returns on Christmas Day, when Janet uncharacteristically offers to help her mother with the preparation and then gratefully accepts her present of a gift card. Prior to this year, Janet would have "screamed something about capitalism [and] consumerism" (227), but the glimmer of acceptance from her family has increased her tolerance for the society that previously rejected her. Janet considers the Christmas a success ("I didn't make anyone cry or call anyone an idiot (229)), and her mother claims that the "pills are a godsend" (230).

Janet's Christmas experience is proof in the power of community to manage negative emotions, echoing the findings of a range of sociologists who have shown that social integration and identification support psychological well-being and offer protection from stress and detrimental life events (Cassel; Cobb; Durkheim; Leighton; more recently, Boardman et al.; Leigh-Hunt et al.; Link and Phelan; Perry and Pescosolido). Janet's family, for once, treats her as a person instead of a blight, and this offers the same temporary reprieve of gloom that the actual drug promises. She feels included in a way that her sadness has previously rendered off-limits, activating a sense of belonging that allows her to drop her guard. Janet feels lighter, freer: "I was opening myself to something, to feeling something different. Ever so slightly, but it was a start. An offering" (234). Janet has achieved the goal of Santa's Little Helper without actually taking the pill; her family's belief in the existence of New Janet has willed her into life. This transformation – achieved without medication – not only reveals the role of social acceptance in mental health, but also helps contextualise Kirsch's findings regarding the power of antidepressants versus that of placebos, as well as those of the NIMH study involving expectations of improvement.

These are the very notions that Grossman invokes when he is forced to admit that Santa's Little Helper is a sham. People *did* have a happy Christmas, despite the fact that the drug wasn't real, because the people taking the drug believed they would be happy, and those in their social circle approached them as such. But Britsch is not suggesting the placebo effect as a solution to sadness, but rather advocating for more tolerance for those who are sad. Welcoming the Sad Janets into society, albeit under the false pretences of being medicated, has lifted their veil of sorrow by removing the sense of ostracism that drove their sadness. The required weekly meetings also provide Janet with proof that she isn't alone in her melancholy, and this new sense of community is soothing. "I wonder if all those people in the meeting were really happier, or if they just liked having someone acknowledge they were sad" (262). This is Janet's wish – to be heard, to be seen – and the group has facilitated this by offering a sense of social acceptance.

Janet quickly reverts to Sad Janet after the holidays: "Everyone is quietly disappointed in me. I tried, but the change they saw over the holidays didn't stick" (243). The effort was too much and too far from the person she truly is, and she couldn't hold onto it. "I am getting back on track. It's not the track anyone wants me on, but it is mine. Sometimes just moving is ok, even if it's not in any particular direction" (243). Though Janet claims to be "back on track," her behaviour becomes more and more unhinged. She is sent to collect the dog of a deceased woman, and she imagines the dead woman is Vyla, Richard Grossman's ex-wife, the original Sad Janet for whom he designed the Christmas pill. Vyla is reported to have left her husband and run off with a mall Santa, and nothing has been heard from her since. Janet imagines that Vyla tried to start over but found it too hard, began taking the Xanax that Janet finds in the bedside table, but still "couldn't keep going" (249) and ultimately killed herself. Janet's deepest fear is that she will give into the drugs, and they still won't be enough. She further connects herself to this imagined version of Vyla by trying on the dead woman's clothes, drinking her vodka, dancing to one of her CDs. She *is* Vyla, and now Vyla is dead. "It feels like some bullshit Ghost of Christmas Future moment" (251), Janet says; yet Vyla isn't just representative of Janet, but also "the only person in the world who could understand [her]" (251). The woman isn't actually Vyla, of course, but this begins Janet's unravelling by suggesting a dark path ahead in which Janet either ends up completely alone or dead, and Janet can't figure out which option is worse.

It is at this stage where Janet's sadness shifts into an arguably pathological depressive episode, as Debs has to retrieve her from the apartment after her breakdown. "I realise I'm losing my mind a little" (258), Janet says after being told the dead woman wasn't Vyla, but rather a girl named Louise who died by slipping in the bathtub. Janet worries that the "madness is coming" (259) for her, and the news that her ex-boyfriend has a new girlfriend with whom he is expecting a baby only solidifies this fear. "I feel like I need to do something dramatic, to stop me from doing something stupid to myself" (260). And she certainly does, releasing all of the dogs from their kennels before driving to a motel to hide. Janet's descent from quiet sadness to contemplation of self-harm is foreshadowed at the start of the novel when Janet hints, "Most of my life is reining shit in. When I finally let it all go, have my breakdown in the grocery store, it will be spectacular" (29). And while she has the location of her breakdown wrong, it certainly is spectacular. And Janet is right; she has spent her life trying to regulate her feelings, noting several times over the course of the novel that she "want[s] to be in control of my emotions" (167), and imagining the death of Vyla triggered a release of pent-up worry. She is forced to face the truth, that she was resisting drugs in part because she was afraid they wouldn't work, that trying and failing is considerably worse than not trying at all. This revelation, coupled with the image of her psychological doppelgänger dying alone, open Janet's emotional floodgates and overwhelm her in a way she can no longer ignore.

Janet eventually speaks to Debs on the phone and unloads her fears and grievances in what resembles a much-needed therapy session. "Everyone leaves me" (262), Janet cries. "I haven't got anyone in my life who can give me everything I need" (263). Debs-cum-therapist says that no one has someone who can be everything, but offers herself as a consolation prize. "I'm here" (264) says Debs, and the two embrace in a rare moment of physical affection for Janet. At this point, *Sad Janet* becomes somewhat disappointing in its representation of mental health. Janet has clearly benefited from unloading to Deb, who has in turn given her helpful advice; yet, at no point in the novel does Britsch suggest that Janet might profit from actual therapy. Instead, she portrays Janet's options as black and white: either take the pills or don't. The reality is that there are significantly more options, and psychotherapy is certainly one that could be explored. Chesler's notion of a feminist therapist, one who approaches the patient-therapist relationship with the understanding that "it's hard to break free of patriarchy [and] the struggle to do so is both miraculous and life-long" (30), would undoubtedly serve to validate Janet's on-going sadness. "A feminist therapist does not label a woman as mentally ill because she expresses strong emotions or is at odds with her feminine role" (Chesler 30) and this meshes well with Janet's insistence that neither her sadness nor failure to fall in line with social expectations are pathological. Britsch is obviously under no obligation to include therapy in her novel, but it seems like a missed opportunity in which Janet could have found another female ally.

The novel ends with the revelation that the Christmas drug was fake, and Janet further feeling that she has lost control, and yet she begins to realise that there are people in her life who do understand her: Debs, her neighbour Min-Seo, Melissa, and the woman who knocks on her door at the end of the novel: the real, very much alive Vyla. “Debs told me there comes a time when you need to stop thinking about the people you don’t have and start thinking about the people you do” (272), explains Janet. Solomon indicts the estrangement of modernity for its role in the ubiquity of 21st century sadness: “The pace of life, the technological chaos of it, the alienation of people from one another, the breakdown of traditional family structures, the loneliness that is endemic [. . .] have been catastrophic” (Solomon 32) for mental health, and he suggests community and love as potentially palliative. Janets realises she does have a support system, and together they have “three hundred and forty-seven days to work out what to do about Christmas and all the stuff in between” (273). The final lines of the novel are a feminist battle cry: “We’re women. We’ll work it out” (273).

Sad Janet is a testament to the strength of friendship and support, a subversive attack on the neoliberal configuration of mental health as a personal issue that must be addressed privately and individually. The novel ends with an unexpected community of women forming in what becomes the support system Janet so desperately needs. She cannot navigate her sadness alone and has finally realised that she doesn’t have to. As Hedva argues:

> The most anti-capitalist protest is to care for another and to care for yourself. To take on the historically feminized and therefore invisible practice of nursing, nurturing, caring. To take seriously each other’s vulnerability and fragility and precarity, and to support it, honor it, empower it. To protect each other, to enact and practice community. A radical kinship, an interdependent sociality, a politics of care.” (10)

Women are problem-solvers, and while neither Janet's family nor society have ever given the acceptance she craved, Britsch shows that female friendship offers perhaps a better level of understanding. Despite never taking the pill, Janet has changed, and is bolstered now by the women around her. "Sometimes people have just had enough – of other people, yes, but also of themselves. We all spend our lives pushing and pulling in a million directions, until we're too tired to push another inch. Whatever's left is the life we all share. A new life of sorts, but built on the ruins of the old one. It's change, at least, and sometimes that's enough" (256), Janet muses. But Janet's Christmas experience has left her less than satisfied with this notion of tacit acceptance: "I'm not sure it's quite enough for me, though. Not yet, anyway" (256). Janet no longer wants to live but wants to thrive. She had a momentary period of acceptance from her family and has transmuted this feeling into a permanent one by creating a cohort of like-minded women. Lifted by this, Janet is now considering graduate school, and having been fired from Joe's Shelter for releasing the dogs, must now come back from the woods and re-join society, this time accompanied by a tiny but undaunted feminist legion who love her for exactly who she is: Sad Janet.

Concluding Thoughts

Both *Sad Janet* and *MYRR* are satirical commentaries on real-life issues of mental health, social expectations and psycho-pharmacology, exaggerations of the truth that underpin the complicity of twenty-first century consumer culture in the contemporary mental health crisis and expose the danger in promoting conformity as the hallmark of success. As Solomon suggests, "There is no life that does not have the material for despair in it, but some people go too close to the edge and others manage to stay sometimes sad in a safe clearing that is far from the cliffs" (48). Janet and Mosfegh's narrator are the epitome of this mental health divergence, with the former (mostly) content with her sorrow, and the latter self-medicating in extremis to escape her rage and sadness. Both women are inherently unhappy but for opposing reasons. Moshfegh's narrator – beautiful, young and rich – is welcomed into society with open arms, yet she despises who she is; Janet accepts herself, having made peace with her sadness long ago, yet is spurned by a society that desperately wants to fix her. When read in conjunction, the novels demonstrate the need for both social *and* self-acceptance within the sphere of mental health. They advocate for empathy and tolerance toward those who struggle with mental well-being and offer differing perspectives on sadness, which coalesce to show the all-encompassing nature of sorrow, whether pathological or affective. Those who don't fit society's mythical notion of 'normal' – productive, conformist, happy – are Othered in a way that further removes them from the public domain. Mental health is an uphill battle, and a messy, protracted, personal one at that. The novels are a campaign for living life on one's own terms. Even terrible people deserve happiness, if that's what they want. But sadness is ok, too.

Together, the novels show that mental well-being is at its pinnacle when the onus of recovery – whatever that might look like – rests not on the shoulders of an individual but is shared among a community of support. As Solomon argues, "Depression will only intensify in the private cocoons we spin at our lowest" (453). *MYRR* is a version of *Sad Janet* where the protagonist is truly alone, and this absence of external encouragement not only facilitates the narrator's descent from wieldy sadness into an incapacitating illness, but also accounts for the schism between the narrator's perception of her newfound happiness and the reader's less optimistic outlook on her future. While Janet's family views her as an outcast, Janet has Debs and Melissa and the dogs, and at the end of the novel, she realises the importance of this small but growing community in managing and softening her sadness. Moshfegh's narrator still has only herself, and as a result, has no one to throw her a buoy when she inevitably sinks back into her existential despair. Both novels conclude on tenuous footing, appropriate endings for narratives that deal with a weighty, complex topic rife with recidivism, yet *Sad Janet* is arguably more hopeful. Yes, Janet is still sad, but now she is Sad Janet With Friends, and this creates a microcosm of acceptance that will foster her mental health; Moshfegh's narrator may have convinced herself she has changed, but her bad habits prevail, and without any meaningful relationships to aid her well-being, it is only a matter of time before her mist of happiness evaporates. Her problems are not solved, only shelved. While the novels differ in their protagonists' levels of support, both convey the notion that community and relationships are vital for mental well-being.

This reliance on others is anathema to the neoliberal focus on self-empowerment and individualism that dominated the early 2000s. As Hedva contends, illness and incapacity are not merely private conditions but political states, challenging neoliberal demands for visibility, resilience and productivity. Neoliberal feminism in particular enjoins women to self-optimise through self-care practices and consumer choice, promising empowerment while leaving structural inequities unaddressed. In *MYRR*, the narrator's year-long withdrawal from work, relationships and the demands of late-capitalist New York constitutes a refusal of this imperative to remain healthy, productive and socially functional. Yet her resistance is complicated by her privilege: she is able to retreat precisely because of her financial security. *Sad Janet*, by contrast, stages resistance in the form of wilful unhappiness: Janet refuses the pharmacological management of her emotions, rejecting the pressure to embrace positivity, productivity and wellness as markers of successful womanhood. Together, these novels illuminate the limitations of neoliberal feminism's insistence on empowerment through self-care, revealing how female refusal – whether through sleep or sadness – becomes a radical, if ambivalent, mode of resistance within contemporary culture.

MYRR and *Sad Janet* show a trend in recent fiction toward exploring the emotions within mental health rather than rushing toward an endgame of diagnosis and treatment, taking time to delve into the protagonists' feelings of hopelessness, desperation and rejection that better encapsulate their mental state than a catch-all term from the *DSM-V*. The inner dialogue that drives the novels reveals more about the characters' mental states than defining their unhappiness as 'major depressive disorder' or 'dysthymia' or 'social anxiety disorder.' When Moshfegh's narrator explains that "it was better to be alone than to be stuck with people who were supposed to love you, yet couldn't" (64), or Janet laments that "all the tiny sadnesses will build up until they make you into whatever monster you are that keeps you up at night" (132), these small but honest admissions expose a complex, intimate side of mental health that pre-packaged medical terms cannot. While psychiatry focuses on commonalities, looking for symptoms that align to those of a certain condition, fiction depicts a diversity of experience that defies this reductive view. As Ngai observes in *Ugly Feelings*, abrasive or unlikeable narrators can provoke a more complicated form of empathy – one that resists sentimentality by demanding readers reckon with irritation, discomfort or ambivalence. The narrators of *MYRR* and *Sad Janet* function in this way, their sharp edges amplifying rather than diminishing our capacity to engage with their mental states. These novels provide the insight and empathy that medicalisation removes, the nuance and individuality that pathologising resists.

Similarly, both authors investigate help-seeking outside of the traditional medical pathway, with Moshfegh's narrator constructing her own self-help regime and Janet eschewing treatment altogether, giving voice to those whose experiences of mental illness are situated outside of the diagnosis-treatment-recovery paradigm. The novels show that there is not simply one kind of sadness, and, most certainly, there is no 'right' way to be sad.

Both novels highlight the pernicious practices that undergird the pharmaceutical industry, with *MYRR* depicting drug abuse and damaging side effects and *Sad Janet* showing the overmedicalisation of sadness by a duplicitous market sector. Britsch centres her narrative around a manipulative drug company that manufactures and advertises a fake pill, while Moshfegh focuses on what happens next, showing an incompetent psychiatrist prescribing drugs, followed by a young woman abusing them. Together, the novels paint a picture of a pharmaceutical system that is broken from beginning to end, built upon layer upon layer of lies and exploitation, leaving the reader with a bevy of lingering thoughts: What is the pharmaceutical endgame – health or money? Is the very existence of mood-altering pills damaging to mental health? Is sadness a disease or a normal emotion? These are the debates circulating within the mental health community, and Britsch and Moshfegh's narratives have extended the conversation beyond academia and hospitals, offering perspectives outside of those on drug brochures, ones that ultimately encourage readers to reflect, understand, empathise and perhaps most importantly, to question.

Chapter Three: "But how do they know if you're better?":[1] Reframing Recovery in Clare Allan's *Poppy Shakespeare* and Binnie Kirshenbaum's *Rabbits for Food*

Clare Allan's 2006 novel *Poppy Shakespeare* and Binnie Kirshenbaum's *Rabbits for Food,* written in 2019, follow two women through their contrasting experiences of institutionalised mental illness, intervening in ongoing debates within the mental health community about the nature – and necessity – of recovery within twenty-first century, post-asylum society. As psychiatrists Larry Davidson and David Roe argue, there is "increasing global interest in recovery as *the* expectation of people living with mental illness;" yet, "there is little consensus on what recovery means in relation to mental illness or what is to be entailed in transforming mental health services to promote it" (Davidson and Roe 460, emphasis theirs).

Poppy Shakespeare highlights the problematic nature of this recovery agenda within Britain's National Health Services (NHS), condemning policymakers for invoking recovery as an excuse to curtail public spending, resulting in a quick-fix, "garage repair"[2] (Taylor 251) model of healthcare that hijacks the patient-centred notion of recovery for monetary and political gain. Allan chides mental health services for creating a culture of institutionalised minds, leading to highly dependent patients stripped both of identity and constructive social skills. *Rabbits for Food*, set in a posh, private Manhattan hospital, illustrates that even without this top-down bureaucracy, even with first-rate medical care, recovery is difficult and complex, a slow, non-linear process that can be derailed by feelings of powerlessness, despair and fear. When read together, *Poppy Shakespeare* and *Rabbits for Food* reveal that both England's public model and America's privatised system, vastly different approaches to healthcare, fall short on their management of mental illness, suggesting that the fundamental issue with recovery isn't national, bureaucratic or operational but rather

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[1] *Poppy Shakespeare,* page 91

[2] Barbara Taylor, in *The Last Asylum*, succinctly referencing psychoanalyst Darian Leader's notion of quick-fix psychiatry in *What is Madness?*

conceptual. It isn't just *how* recovery is achieved that needs interrogating and challenging, but *what* recovery even is.

Both novels add breadth and depth to mainstream depictions of recovery, breaking with the diagnosis-treatment-recovery paradigm[3] normalised by the Recovery Narrative, memoir[4] and popular culture[5] to offer representations of recovery as unstable and uncertain. By penning narratives that refuse to glamourise recovery – configuring it as "ordinary" (Cvetkovich 12) rather than grandiose, fuelled by self-empowerment rather than medication or professional help – Allan and Kirshenbaum challenge the "compulsory positivity" (Woods et al. 222) prolific within life-writing and add to the discussion raised by Davidson and Roe in a new and meaningful way. Together, the novels offer a subversive depiction of recovery that emphasises alternative pathways to mental health – many of which occur *outside* of mental health services, including narrative writing and social connection – as well as a spectrum of recovery predicated upon individual needs and goals. Recovery is not an objective outcome achieved within the walls of a doctor's office or hospital, but an ongoing process marked by nuanced progress and setbacks. By diversifying representations of mental illness and broadening the concept of what recovery is, *Poppy Shakespeare* and *Rabbits for Food* underscore the power of fiction to constructively contribute to current mental health discussions, politicise readers and ultimately, evoke real social change.

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[3] Depictions that begin with a person receiving a medical diagnosis, followed by medical treatment in the form of pills, ECT, therapy, etc, and then ending with improved mental health

[4] Many well-known memoirs like Susanna Kaysen's *Girl, Interrupted*, Elizabeth Wurtzel's *Prozac Nation*, Lori Shiller and Amanda Bennett's *The Quiet Room: A Journey Out of the Torment of Madness* and Kay Redfield Jamison's *An Unquiet Mind: A Memoir if Moods and Madness* follow this paradigm to at least some extent, as do celebrity memoirs from Brooke Shields and Portia di Rossi; one only need read the synopses in Sarah S. Davis's 2019 article "50 Must-Read Memoirs of Mental Illness" to see just how pervasive this paradigm is (S. Davis).

[5] Many celebrities have publicly spoken about their experiences of mental illness; while opening up this dialogue is important and certainly does move to destigmatise mental illness, more often than not, the experiences that garner the most attention are those that fit into this diagnosis-treatment-recovery paradigm (Katy Perry, Lady Gaga, Chrissy Teigen, Kristen Bell, Selena Gomez, Rachel Bloom, Lena Dunham, Cara Delevigne, Sarah Silverman) (Michelson). Some televisions shows feature a character working through all three stages of the paradigm in a single episode, with their mental health issues never (or rarely) mentioned again – Randall in *This Is Us* and Ted in *Ted Lasso*, for example.

These are not novels that offer solutions, nor are they narratives driven by a benevolent desire to educate the medical profession on the lived experience of mental illness or improve the doctor-patient relationship; rather, Allan and Kirshenbaum's works are actively intervening in second wave medical humanities by responding to Anne Whitehead and Angela Woods' call "to address difficult, more theoretically charged questions, and to claim a role much less benign than that of the supportive friend" (2). *Poppy Shakespeare* and *Rabbits for Food* are provocative and defiant, attacking larger issues of necessitated recovery, bureaucratic red-tape and data-driven care in an effort to challenge perceptions of what mental illness is and propose how it can be – not cured, not eradicated, not hidden – but traversed and managed.

Brief History of the Recovery Movement

The modern recovery movement in the United States and United Kingdom – where *Rabbits for Food* and *Poppy Shakespeare* are set, respectively – has its roots in the deinstitutionalisation that took place in the 1960s and 1970s; this shift away from long-term mental asylums was complex and drawn-out, brought on by the introduction of antipsychotic drugs, public outrage over patient conditions and a governmental effort to cut healthcare outlay.

Historian Barbara Taylor writes of her own experience with deinstitutionalisation in her memoir *The Last Asylum*, situating it within the larger history of mental health services in the UK. Asylums were doomed, explains Taylor, from the inception of National Health Services in 1948 by Labour Minister of Health Aneurin Bevan, who was "determined to end the ghettoization of mental health care, which he regarded as 'a source of endless cruelty and neglect'" (113); the old mental hospitals had no place in this new regime. The Mental Health Act of 1959 put further pressure on the removal of asylums by encouraging the mentally ill to seek support from community care and social services rather than long-term in-patient care. Exposés of neglect and the growing antipsychiatry movement both near[6] and far[7] instigated a public shift in the perception of mental illness, sparked outrage over the treatment of the institutionalised and served as the final nail in the coffin of British asylums.

Deinstitutionalisation occurred in the United States within a similar timeframe. President John F. Kennedy's personal experience with sister Rosemary's mental illness led to his creation of the Community Mental Health Act in 1963, which granted federal funding to community-based care centres and emphasised alternatives to asylums. Bolstered by the success of the Civil Rights movement, mental health service users began to fight for their quality of life and demand equality, and new advocacy groups like National Alliance on Mental Illness and Project Release began to fight on their behalf. This growing criticism of asylums, coupled with judicial decisions against involuntary confinement,[8] led to the closure of many longstanding mental institutes. By the early 1980s, the large-scale shuttering of asylums was well underway in both the United States and the United Kingdom, paving the way for a new era of rehabilitation and recovery.

The vacuum created by deinstitutionalism was quickly filled with community care facilities whose aim shifted away from containment and stabilisation and toward a new idea of rehabilitation. Davidson and Roe cite a 1969 WHO study on schizophrenia as the spark that fuelled this notion of recuperation; it was the first of its kind to show that 'getting better' was a possibility and that mental illness wasn't by definition a life-long debilitating sentence. This idea gained traction in the 1970s when the same survivors' movement that criticised asylum conditions began arguing that "people with serious mental illnesses can, and should be entitled to, have a life beyond that of a 'mental patient'" (Davidson and Roe 461). Advocates reasoned that the line between abnormal and

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[6] Michel Foucault's criticism of 'The Great Confinement' (Foucault); a journalist's accusation of patients treated as "human trash" following Barbara Robb's 1966 report into elder care (Taylor 116); antipsychiatry condemnations by Franco Basaglia in Italy and R D Laing and David Cooper in Britain (Taylor 115)

[7] Erving Goffman's 1961 *Asylums* referring to American asylums as "storage dumps for inmates" (73); Rosenhaun's famous 1973 experiment showing mental hospitals failing to discharge fake patients (Appignanesi 400); a 1972 TV broadcast exposing neglect at Willowbrook State School, "the largest institution for the treatment of people with disabilities" (Klacik), in New York; Thomas Szasz's *The Myth of Mental Illness*

[8] 1975 *O'Connor v. Donaldson*; 1975 *Rogers v. Okin;* 1978 *Addington v. Texas*

normal, healthy and ill was not as clear-cut as previously believed and that improvement was possible. This rehabilitation model focused on, as psychologist William A. Anthony explains, “treating the consequences of the illness rather than just the illness” (523) and reconfigured the by-products of mental illness as impairment, dysfunction, disability, and disadvantage, equally important facets that needed treating along with symptoms.

While in theory, community care based on eradicating these notions is a positive move, the bureaucratic chaos and uncertainty following the abolition of asylums resulted in a dearth of actual care; Taylor chronicles her own tumultuous experience with mental health services during this time, quoting UK MPs who declared community care a “catastrophe” and UK mental health figure Baroness Elaine Murphey who referred to community care between 1962 and 1990 as “The Disaster Years” (116). While deinstitutionalisation failed to meet the needs of the mentally ill, it did give rise to the realisation that people wanted more than just symptom relief, and it is this move toward person-centred care and a more holistic treatment of mental illness that ultimately gave way to the more conceptualised vision of recovery that took foot in the 1990s.

Writing in 1993, Anthony claimed that “recovery from mental illness is the vision that will guide the mental health system in this decade” (521), foreseeing a mental health revolution that would usher in a new “decade of recovery” (536). Anthony and Lori Ashcraft cite a burgeoning repertoire of writing from service users who had themselves experienced recovery (Deegan; Houghton; Leete; Unzicker) as well as the work of Courtenay M. Harding, who reviewed a number of long-term research studies in the 1980s and 90s that “suggested a deteriorating course for severe mental illnesses was not the norm” (Anthony and Ashcraft 466) as the impetus behind this policy shift. What was only a vaguely conceptualised pipe dream in the 1980s began to influence services and policy in the decade that followed. Psychologist David Pilgrim corroborates this, noting that recovery was absent from government documents and academic analyses of service reform prior to the 1980s but had gained traction by the end of the twentieth century due to the “resonance of antipsychiatric ideas, which were incorporated into the new social movement of disaffected service users” and “growth of consumerism in health care reforms” (296).

By the beginning of the twenty-first century, recovery had officially become policy, with recommendations of the President’s New Freedom Commission on Mental Health (“Achieving the Promise”) and *Federal Action Agenda* (“From Exclusion to Belonging”) resolving that “recovery has been mandated as the overarching aim of mental health care in the United States” (Davidson and Roe 460). Recovery as the overt goal of government policy in England first emerged in 2001, with the publication of *The Journey to Recovery: The Government’s Vision for Mental Health Care*, which stated that the creation of “safe,” “sound” and “supportive” recovery-oriented services would encourage the agenda that had been detailed in the *Mental Health National Service Framework*’s (*The Journey to Recovery; National Service Framework*) 10-year modernisation programme.

While the term ‘recovery’ has certainly become a mental health buzzword, both in policy and in services, what exactly it entails is far more ambiguous. Anthony’s 1993 definition of recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles, [. . .] a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness” (527) is still widely cited in academic journals and governmental policy today. Pilgrim simplifies Anthony’s definition of recovery by explaining, “What cannot be ‘cured’ might be endured” (296), stressing the overarching idea that recovery is not absence of symptoms, but rather life alongside mental illness. Davidson and Roe take this conceptualisation a step further by specifically delineating between the two notions of recovery, the stereotypical “recovery from” mental illness and the emerging notion of “recovery in,” with the former referring to an absence of symptoms and the latter involving the process of “living one’s life, pursuing one’s personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse” (464).

The “deeply personal” and “unique” aspects of recovery pervade most definitions, making a universal claim to what exactly recovery looks like impossible, complicating the issue of how best to foster and recognise recovery. Psychologist Mary Leamy adds that with recovery conceptualised as "a vision, a philosophy, a process, an attitude, a life orientation, an outcome and a set out outcomes," it has the tendency to "make a cow-catcher on the front of a road train look discriminating" (449). While there is merit to the breadth of recovery – it allows for personal definitions that validate a range of experiences while acknowledging mental illness as shifting along a spectrum – it is equally problematic in that it makes pinning down a definition that doctors, therapists and patients can make sense of and apply unnervingly complex. With a volume of interlinking definitions on what recovery might entail but little investigation into what services might best promote it, it is no wonder that in 2011 Leamy cited a "need for conceptual clarity on recovery" (445) ahead of policy overhaul. How can the means be justified – or even initiated – when the end is so unclear?

Intertwined with the growing discussion of recovery is the emergence of the Recovery Narrative (RN), a short, prescribed piece of writing written and performed by a service user involving her experience with mental illness, treatment and recovery; capitalised and singular, the Recovery Narrative is "an overarching category" distinguishable from the "myriad of individual testimonies which speak of recovery" (Woods et al. 223). Medical humanities researchers Angela Woods, Akiko Hart and Hel Spandler critique the RN as generalising recovery by promoting homogenous narratives of positivity and inspiration as told by white, middle-class men and women, thus ignoring more chaotic and adverse experiences as well as those of marginalised groups (Woods et al.). A study conducted by Fiona Ng et al. in 2021 gives credence to this criticism, finding that "less articulate and polished narratives or ones where the narrative is not fully resolved or is expressed metaphorically" are needed to "maximise the likelihood of impact," going on to suggest that mental health services should "refrain from only using narratives of individuals who are fully recovered"[9] (Ng et al.). While the RN "testifies to an individual's experience of recovery as something which has already been achieved" (Woods et al. 231), fiction can broaden this constrictive view by including narratives of

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[9] This begs the question of what exactly "fully recovered" means

individuals still undergoing recovery, still negotiating the balance between life and symptoms, both successfully and less so. By expanding the cast of characters with whom readers can become invested, fiction, more than the RN, exposes readers to a spectrum of recovery that, in turn, allows for a wider range of conclusions to be drawn and a multiplicity of experiences to be elevated.

In this chapter I argue that fiction is adding to the discussion of what recovery is and how it can be achieved by offering critical, personal perspectives that challenge the dominant diagnosis-treatment-recovery paradigm and subvert the normative narratives of the RN and those within popular culture. *Poppy Shakespeare* and *Rabbits for Food* bring the notion of recovery in the twenty-first century to life, shedding light on the shortcomings of the recovery agenda and RN, highlighting the gap between policy and reality and above all, revealing that recovery – whatever it may look like – happens *within* an individual, not *to* her.

Poppy Shakespeare: Truth in Exaggeration

While *My Year of Rest and Relaxation* utilises satire and dark humour to tackle issues of self-care and psychopharmacology, Allan's *Poppy Shakespeare* uses a similarly sardonic approach to deprecate the mental health services that Moshfegh's narrator deliberately bypasses, focusing predominantly on community day hospitals and the bureaucracy surrounding outpatient treatment. Through its depiction of an enabling medical environment that exacerbates more than cures mental illness, a caricature of institutionalisation that drives the titular character mad, *Poppy Shakespeare* serves as antipsychiatry-inspired literature of protest; it is a pushback to the highly politicized, data-driven recovery movement that Allan condemns for prioritising accolades and targets over meaningful support. Allan's Abaddon hospital, situated in North London, is a segregated word of "dribblers" (day patients), "flops" (ward patients) and "sniffs" ('normal' people) (7), cordoned off by the red tape of welfare money and yearly assessments and devoid of empathy and person-centred care. Rather than improving social integration and fostering recovery, the mental health services in Allan's novel have resulted in a separate and unequal – and tragically comical – mentally ill cohort that not only doesn't know how to get better, but isn't particularly interested in it either.

Allan's use of satire to convey the absurdity of bureaucratised mental health services and its link to the institutionalised mind reveals a broken system that not only hinders recovery but exacerbates mental illness. As Dustin Griffin explains in *Satire: A Critical Reintroduction*, "A satire is single-minded and clearly focused on its target. [. . .] Every formal decision is ideally designed to sharpen the ridicule on the object of the satire" (36), and Allan's attack of mental health services is strengthened by her choice of character names, her over-the-top portrayal of in-hospital antics and her exaggerations of governmental red tape.

The names of both Dr Diabolus and Abaddon hospital evoke images of hell, with Allan depicting the very infrastructure of mental health services as not just anti-recovery, but rooted in evil and darkness. *Diabolus*, a Latin word meaning 'devil,' is linked to the more common word *diabolical* meaning evil, fiendish or cruel, while *Abaddon* is the "underworld abode of lost souls" ("Abaddon"), or more succinctly put, hell. Allan's hospital is not a place of hope but a prison for those who have sinned, with Allan suggesting that despite decades of advocacy on behalf of the mentally ill, the Victorian view of mental illness as a moral failing has yet to be fully eradicated. Here in their hell of mental health services, patients must answer to the Devil himself, who strives not for their rehabilitation – moral, mental or otherwise – but rather lures them further into their 'sin' of mental illness. This is certainly the case with Poppy, whose mental health rapidly deteriorates within the walls of the hospital. By linking both the building and the head doctor to negative imagery of hell, Allan makes it clear that mental health services are far from the beacon of hope that they purport to be.

As Charles A. Knight explains in *The Literature of Satire,* "Although satiric characters are actual, satire treats them as examples of broader problems" (204), and Allan uses the names of the patients to further elucidate the shortcomings of the recovery agenda. Slasher Sue, Marta the Coffin, Verna the Vomit – all are caricatures of their conditions, reduced to their symptoms with humorously alliterative names. Slasher Sue self-harms, Marta the Coffin is morbidly depressed, Verna the Vomit is bulimic. The recovery movement hinges on treating those with mental illnesses as more than just their illnesses, with Davidson and Roe arguing that mental health conditions are merely one facet of an "otherwise whole person" (462); yet, the characters in *Poppy Shakespeare* are their conditions and nothing more, their diagnoses and symptoms so integral to the characters that they cannot be identified without them. This is anathema to the "person orientation" that psychiatrist Marianne Farkas describes as essential to successful recovery policy. Her belief that each person must be treated as an individual, not just a "'case' exhibiting indicators of a disease" (145) is common among recovery scholarship, with Pilgrim agreeing that one of the first steps to recovery is "knowing that you are a person not a diagnosis" (298). The names of Allan's characters function as a direct attack on this notion, clear evidence that despite policy suggesting otherwise, patients are still treated as 'cases' and not individuals. With names like Verna the Vomit and Slasher Sue, Allan takes this conflation between patient and diagnosis and makes it tangible, leaving the reader with witty, memorable names that serve to invalidate the recovery agenda's person-centred intentions. Allan's use of names can also be read as an affront to the decision-making power allocated to policy-writers; the recovery movement dictates a person-centred view of patients, but how is this complicated by the way that patients view themselves? If Verna the Vomit's identity is so entangled with her eating disorder that she cannot be identified outside of it – but *willingly* so – who are policymakers to tell her that this self-conceptualisation is wrong?

The outrageous anecdotes that fill the pages of *Poppy Shakespeare* exemplify satire's function as a "distorting lens" that "magnif[ies] actualities" (Knight 204) in an effort to both mock and expose the failures of institutionalisation. When N first describes her fellow dribblers, she reveals that Dawn's short-term memory is quite literally blown due to an ECT mishap: "They got her all wired up on the bed, and all of these students stood around, who was s'posed to be learning how to do it [. . .] and this one he leant on the thing by mistake, and they hadn't set the dial or nothing, so Dawn she got this massive electric shock" (13). It blew every fuse in the hospital and left Dawn with an inability to form new memories. The silver lining, explains N, is that Dawn loves making wooden tables in the wood workshop and never gets bored, her brain unable to remember that she has ever made one before. With this simple, yet outlandish, anecdote, Allan calls into question the professionalism and aptitude of mental health staff and their proclivity to do more harm than good. White Wesley jumps through a window to avoid discharge, N signs her government forms in blood to prove her madness, Elliot bleaches himself "so the snipers wouldn't recognise him" (183) – all serve to signify the hospital as a place where mental illness is not alleviated but exacerbated. N describes assessments as the "MAD Olympics" (185) where, rather than focusing on recovery and discharge, improvement and independence, the dribblers prepare by "pissing theirselves or rolling in shit" (184), attempting to outdo each other, earn a high rate of welfare money and stay within the system. The absurdity of these situations underpins Allan's effort to challenge the efficacy of institutions and the recovery agenda, serving as damning – and unforgettable – evidence that the recovery movement has not just failed, but backfired, resulting in patients who have been institutionalised so long that they want nothing else.

Allan portrays the jargon within mental health services as a dangerous deterrent, an intentional roadblock to getting the necessary support. When the hospital institutes classes for the dribblers, they are merely a tick-box exercise to help earn the Beacon of Excellence award, with courses like Relaxation and Normality Group led by former-patient Roberta, whose mental health is no more intact than the dribblers'. They come with an immensely confusing, Kasfkaesque set of rules:

> 1. If clients wish to attend, groups are voluntary.
> 2. If clients do NOT wish to attend, groups are NOT voluntary.
> 3. Voluntary or otherwise, clients must attend all their groups.
> 4. Clients who do NOT attend groups will NOT remain clients. (179)

The language is purposely convoluted, an effort to make patients think they have a choice when the reality is quite the opposite. Farkas explains that self-determination and individualisation are key to promoting recovery, and language like ‘must’ is directly contrary to this, as is a blanket policy of group attendance that covers all patients regardless of personal need. Poppy’s MAD money rejection letter is similarly complicated, adding months for various appeals and explanations to the point where getting a final answer could takes years. The language and system are prohibitively complex, designed to confuse and frustrate the patient to the point of giving up, contradictory to Anthony and Ashcraft’s belief that the language within recovery-orientated mental health programs must be “non-clinical and optimistic” and focused more on “listening than directing, [. . .] inspiring than controlling, [. . .] choices and options than direction and coercion” (471). The group rules and the MAD money letter, while laughably incoherent, are an exaggeration of the red tape that impedes actual recovery, Allan’s allegation that the language of mental health services fails to connect patients to the services they are using and further alienates them from the process of which they are a part. This language is distancing and yet another aspect of the recovery movement that exists in policy only, not reality.

N’s use of language equally contributes to the novel’s hyperbolic depiction of mental health services. While the reader is drawn into N’s world through her unfiltered first-person narrative, offering an unusual closeness, N’s unfamiliar, non-standard dialect – rife with abbreviations and slang – is simultaneously distancing. It slows comprehension, causing one to read, and often re-read, carefully, forcing intimacy through effort. N’s language is frequently tinged with paranoia predicated upon her fear of release; yet, this paranoia is not simply delusion but a rational response to ambiguous bureaucratic systems, echoing Ngai’s view of paranoia as “a way of registering powerlessness in systems that are both omnipresent and opaque” (226). N’s narration, unreliable and redolent with swearing, resists easy sympathy, but this isn’t necessarily anathema to Allan’s condemnation of the mental health system; rather, N’s linguistic style makes the reader work to understand her reality, echoing the marginalisation of psychiatric patients in a way that invites further contemplation.

“Satire is often an ‘open’ rather than a ‘closed’ form, that it is concerned rather to inquire, explore, or unsettle than to declare, sum up, or conclude” (95) explains Griffin, and Allan’s unresolved ending is a refusal to terminate her attack on mental health services. The novel ends with a role reversal between N and Poppy, with N discharged from the hospital amid a newfound sense of hope while Poppy is moved to the Floor of No Return after a suicide attempt. “There is no ‘natural’ end to the satirist’s anger” (Griffin 112); there is always another example of systemic failure, further proof that the recovery initiative is ineffective. Though N is better, Poppy is worse, leaving the story lingering in a way that parallels the lack of finality and assurances in mental illness. By concluding N’s narrative in a satisfactory way while refusing to grant Poppy the same closure, Allan leaves the reader to speculate and carry on the story in her own mind, and the reader’s thirst for justice – like Allan’s – is left unquenched.

Knight discusses the complexities of narrative satire, explaining that “when personal consciousness and the sympathy of readers are replaced by social awareness and by a mixture of analysis and anger, it becomes difficult to continue reading the work within the broad conventions of the novel” (205); Allan mitigates this propensity to lose the “novel”-ness of her story by writing in N’s distinctive voice. Allan’s attack on institutionalisation and the recovery agenda is clear and undeniable, but her ability to structure this attack through N’s vernacular keeps the reader tethered to the narrative. N’s use of slang, her incessant swearing, her long, rambling sentences and incorrect grammar constantly remind the reader that she is getting a view from the inside, a personal experience, and it builds a connection to N’s character that only strengthens Allan’s attack. The reader’s “sympathy” for N is not replaced by “social awareness” but rather further fuelled by it, the reader’s anger over the broken system only growing as we see N navigate mental health services that have failed her.

As Knight mentions, satire is “designed to pose questions and raise problems” (14), and *Poppy Shakespeare* is Allan’s literary battle cry, her attempt to ignite passion for change in her reader through her candid depiction of mental health services at their worst. In *Last Asylums,* Taylor explains that she is connecting her personal story “to the history of the community care revolution” (xv), situating her lived experience within the larger, historical landscape of mental health transformation; in *Poppy Shakespeare*, Allan ties her narrative – her fictional characters and outrageous plot – to the *future* of community care, channelling the power of satire to offer a convincing and all-encompassing condemnation of current mental health services that inspires activism. Allan has elevated her argument through her narrative, created emotional moments through satire, carved out sympathetic characters whose mistreatment draws out both laughter and rage, and ultimately harnessed a fictional platform to fight for very real political change.

Anti-Recovery Mental Health Services

Throughout *Poppy Shakespeare*, Allan highlights the damaging effects of ill-conceived recovery initiatives that focus on policy, data and discharge to the detriment of actual patient-centred care. The novel shows a recovery agenda gone horribly awry – one that nearly kills the titular character – while underscoring the fundamental problems inherent to such a system, including the quantification of mental illness and the complexity of breaking an institutionalised mind that it has itself created. Farkas argues that “one of the most pressing problems facing the mental health field today is our lack of knowledge about the interventions and services that will help people recover from severe mental illnesses” (142), and while Allan doesn’t claim to solve this conundrum, purposely leaving her satirical narrative open-ended to encourage reflection and questioning, she is adding to the conversation by detailing what *doesn’t* work, what *not* to do, and above all else, what needs to change.

It becomes evident as soon as Poppy arrives that the current mental healthcare system is in shambles, focused more on containment and stabilisation than genuine recovery. Poppy is shocked to discover that doctors only see patients once a year for assessments: “But how do they know if you’re better? [. . .] If they never see you, how can they tell?” (91). Her question baffles the dribblers, who want nothing more than to stay at the Dorothy Fish, which offers them a bastardized form of maternal care– shelter in a decrepit, run-down building, food that borders on inedible, companionship via destructive inter-patient relationships, a modicum of attention from staff – that they accept as better than the alternative of no care at all. This echoes Phyllis Chesler’s criticism of mental institutions as “families bureaucratized,” an imbalance of power that results in “degradation and disenfranchisements of self, experienced by the biologically owned child (patient, woman), tak[ing] place in the anonymous and therefore guiltless embrace of strange fathers and mothers (95). The Dorothy Fish, sitting atop a hill akin to a pregnant belly, serves as a return to the womb, to a place of safety and contentment and need fulfilment, a holding zone that allows N to regress to a child-like state where she is taken care of and has no responsibilities: “The Dorothy Fish was the best of both worlds: you was getting the help but you done what the fuck you wanted” (7). The dribblers have been indoctrinated to accept tiny morsels of support and cling to them, welcoming the “embrace” of the system while remaining aloof to their own powerlessness. Poppy’s question of patient care highlights the disparity between her view of institutionalism as an outsider, her assumption that care and recovery are key, and that of the patients within it who couldn’t care less. It never occurred to the dribblers to *want* to get better, and Allan chides the mental health system for failing to inspire improvement in service users.

Allan further highlights the disjoint between recovery values and recovery practises through her portrayal of the doctors’ disregard of patient voice and choice. The Dorothy Fish has created and perpetuated a culture in which the patients dread discharge and manipulate their yearly assessments, exerting what little power they have to control their own lives. N explains,

> If you’d got better they kicked you out and if you’d got worse you got sent upstairs, so the thing was to prove you’d stayed the same; but not *exactly* the same, not *stuck,* they liked to believe they was making a difference, so what you done was each symptom got better, you

> found something else got the same amount worse, and that way you made sure at the end, when they sent you out and totalled the columns, you come out balanced. (92, emphasis in text)

The passive language N uses – "kicked out," "got sent" – shows her tacit acceptance of the power imbalance within the system, her knowledge that the decision of whether or not she is ready to leave will not be made *by* her but rather *for* her. Her input is irrelevant. The echoes Taylor's experience in the 1980s in which patients "could be drugged, transferred between institutions, detained in hospital – all without our consent or even our prior knowledge" (250). Allan shows that the NHS's own claim of "No decision about me without me" ("Equity and Excellence")[10] has still not come to fruition in twenty-first century recovery culture. By deciding for patients when they are to be released – when they have recovered – the staff at the Abaddon are denying patients the self-determination that is a hallmark of recovery. Leamy argues that recovery isn't "something the mental health system does to a person" (451), yet Allan shows that this mentality, this active healer-passive patient notion, is still very much prevalent within modern mental health services.

Anthony and Ashcraft protest that "often the effort that could be invested in promoting recovery becomes misdirected into complying with regulations that actually stall the recovery process" (469-70), and *Poppy Shakespeare* is a testament to this tendency of recovery initiatives to foster anything but. The doctors at the Dorothy Fish are not interested in science or "recovery-oriented principles and practice" (Anthony and Ashcraft 469), only in increasing discharge numbers to appease Veronica Salmon, the new Minister of Madness who demands that hospitals "improve their discharge figures or withdraw from the marketplace" (71). Evaluating illness and recovery is an expensive and protracted quandary that the hospital hopes to simplify – and expedite – by bringing

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[10] This phrase, coined in an NHS vision statement in 2010, heavily echoes the disability activism movement's own slogan of "nothing about us without us," first used in Krzysztof Kieślowski's 1972 Polish documentary *Workers '71: Nothing About Us Without Us* and incorporated into the disability movement in the 1990's ("Workers '71"). Without attribution or acknowledgement of this borrowed language, the NHS's usage of their now well-known phrase borders on appropriation and serves as another example of the exploitation of the disabled.

in Poppy as a control; her arrival, in conjunction with rapidly increasing assessments from once a year to once a week, is Dorothy's Fish's hastened, desperate attempt to shift patients out of the system as quickly as possible. Pollyanna's premature discharge at the start of the novel substantiates this notion of recovery tokenism. Her suicide poem makes it clear that she was ill-equipped for release, stating, "I feel completely unprepared / For life outside. I'm old and scared" (35). The hospital is her home, and Pollyana feels like "a fish thrown out the goldfish tank" (35); she cannot and does not survive outside it. Her release is an administrative necessity, not a medical success, the first step in the hospital's outpatient services overhaul that hinges on recovery figures as proof of methodological success. It is a situation that puts the cart before the horse; release is seen as proof of recovery in and of itself. Allan presents this logic as not just convoluted and profit-driven, but deadly. Anthony and Ashcraft are right to note that "mental health programs were built upon the assumption that people did not recover, and that assumption became a self-fulfilling prophecy" (469); yet *Poppy Shakespeare* shows that structuring a system around the assumption that patients can and should recover – and using this data as the measure of hospital success – is equally problematic.

The incentive behind this exploitation is clear, with Allan criticising the commodification of recovery and the link between increased discharge numbers and financial gain and prestige. Allan's Abaddon receives performance-related bonuses – fifty pounds for every 'cured' patient – that encourage them to prematurely release patients who can then be readmitted after three months and 'cured' again in an endless cycle of profitability. The Dorothy Fish has taken this to the extreme, discharging so many patients – an increase of 2450% – that it wins the coveted Beacon of Excellence award for being "one of the highest performing day hospitals in the country" (304). Yet the recidivism is rife: many of the released dribblers have returned to the Abaddon, some, like Rosetta, under sectionings that have found them even higher up in the hospital than they were before. Others, like Wesley, who hasn't been eating or sleeping since his discharge, are expected back at the Dorothy Fish soon. Allan makes it clear that recovery as it stands is a bureaucratic initiative, not a health-based one, a top-down, quota-driven enterprise that only perpetuates a cycle of institutionalism. The ‘recovered’ patients at the Dorothy Fish are indistinguishable from those still under the hospital’s care, with their release an arbitrary administrative move centred on numbers, not recovery.

The novel confronts head-on the problematic nature of quantifying mental illness and how this ties into recovery. As head doctor Derek Diabolus is overheard explaining to one of the attendants, “As a doctor, of course, one thinks only of one’s patients, but as a taxpayer I do recognise we can’t just keep pouring money in” (194) without results. “One needs evidence that the treatment is effective, quantifiable results, otherwise it’s very hard to justify extra funding” (194). Diabolus does, expectedly, understand the difficulty in producing results of this kind: “It’s hardly as though one can measure the tumour, or not in any obvious sense, I mean; where does one place the ruler, you see?” (195). Modern mental healthcare has certainly tried and relies on questionnaires like the Warwick-Edinburgh Mental Well-Being Scale, as well as self-reporting and observations, to gauge progress; yet, it is subjective work with no guarantees and no physical proof that a patient is either better or worse. Middle-Class Michael mentions several archaic physical methods of appraising mental illness, like measuring head shape and the length of humours, which fell out of fashion as science progressed, revealing that the struggle to arrive at an accurate system is centuries old. Robert Whitaker argues that “mad-doctors, of course, have always constructed ‘scientific’ explanations for why their treatments worked,” evidencing Benjamin Rush, Henry Cotton, Manfred Sakel and Egas Moniz’s bizarre treatments, which range from bloodletting to pulling teeth (196). Diabolus’s own ‘scientific’ proof of recovery is that discharged patients are in a better mental state than his control of Poppy, overlooking that in the wake of Poppy’s own mental health crisis, she is an increasingly low standard of psychological well-being.

The novel depicts a world that is very much segregated when it comes to mental health, a dangerous separation that Allan criticises as perpetuating mental health issues within the community. Cut off from her daughter and friends, without a job and the freedom to leave the hospital during the day, Poppy is bored and restless. “I can’t just sit on my arse” (109), she laments. “If I sit here I will fucking lose it” (111). Anthony validates Poppy’s complaint, explaining that engagement in non-mental health activities like clubs, sports, church or education is vital to recovery: “Recovery-oriented mental health systems must structure their settings so that recovery ‘triggers’ are present. Boring day treatment programs and inactive inpatient programs are characterised by a dearth of recovery stimulants. The mental health system must help sow and nurture the seeds of recovery through creative programming” (Anthony 534-5). The Dorothy Fish fails to offer this necessary support. There is no employment or educational assistance, no advocacy for self-management, and without meaningful ties to the community outside of the hospital, there is no impetus to join it. The Dorothy Fish fails to offer any level of social integration or hints of ‘normality,’ with patients sitting in the common room discussing diagnoses, assessments and medications, conversations that only further connect the patients to their illnesses rather than provided opportunities to move beyond them.

Allan portrays the hospital as not just prolonging mental illness, but intensifying it, chiding the Dorothy Fish for its medical collusion and complicity in Poppy’s mental health crisis. Poppy is made privy to a conversation between the doctors about her mental state, and it perpetuates her instability: “Of course I’m fucking stressed! [. . .] I wouldn’t *be* stressed if they let me out! [. . .] They’re worried I’m not coping. [. . .] They’re worried I’m cracking up, alright? The stress of being mentally ill is starting to make me mentally ill. I’m here ‘cause I’m mad and I’m mad ‘cause I’m here” (197, emphasis in text). The stigma of being mentally ill and Poppy’s inability to prove her sanity is the main propulsion for her mental decline;[11] once labelled mad, she cannot shake it, and her efforts to do so are only making her more unwell. It’s a Sisyphean task that is slowly breaking Poppy’s will, a vicious cycle that manifests in a downward spiral of Poppy’s mental health. The more she tries to

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[11] Research has shown that the stigma of mental illness is a stressor in and of itself, with the potential to exacerbate mental health issues and limit recovery (Pascoe and Smart Richman; Rüsch et al.; Yanos et al.).

protest her sanity without success, the looser her grasp on sanity gets. It is because she is in the system that she is starting to belong in the system.

The link between institutionalisation and the escalation of mental illness is nothing new. As Chesler explains, “Psychiatrically hospitalised women feared, correctly, that they might be driven mad by the brutality of the asylum itself, and by their lack of legal rights” (62) in the Victorian era. She quotes Adriana Brinckle whose 1857 unwarranted incarceration led her to lament, “An insane asylum. A place where insanity is made” (Chesler 62). Another mental health patient, Sophie Olsen, wrote in 1862, “O, I was so weary, weary; I longed for some Asylum from ‘Lunatic Asylums!’” (Chesler 62). Little had changed in 100 years, with Erving Goffman’s 1961 book on asylums chastising them as “betrayal funnel[s]” (131) that dehumanised patients and denied self-expression, therein producing the very behaviours that would get an individual admitted in the first place. Allan shows that despite modern governmental changes to the managing of madness under the guise of recovery, mental health services are still impotent and reductive, their faithfulness to their own survival, not their patients’.

In the wake of deinstitutionalism, community care’s focus on quick-turnaround mental health care has led to the elimination of “the relational, pastoral component” of services, leaving a “mechanistic, formulaic, depersonalised substitute for quality care” (Taylor 257) in its place, a shift that Allan portrays as garnering accolades and profits at the expense of patient health. As Taylor explains, the meaning and value of words like recovery, wellness and choice depend on who is saying them and the power of those employing them, and in *Poppy Shakespeare*, Allan makes it clear what happens when they are misused and abused. Despite entering the Dorothy Fish as a control, Poppy ends up with 33 diagnoses, and by the novel’s close, her role reversal with N is confirmed. At every turn, the Abaddon declines to fulfil the values intrinsic to the recovery agenda – person orientation, person involvement, self-determination, growth potential – leading to a mental health crisis that doesn’t just fail to drive recovery, but exacerbates stigma and turns small mental health issues into consuming ones. Poppy’s psychological derailment – at the hands of a broken system of segregation and dehumanisation – is Allan's most damning critique of the current state of mental health services in England. "Poppy never stood a chance" (48), grieves N.

N's Recovery Outside of Mental Health Services

Poppy's decline is precipitated by the seclusion, ignorance and stigma of the institution, while N's reclamation of independence and hope happen not within, but outside of the mental health system, calling into question the medicalisation and governmentalisation of recovery. N's improvement is due not to person-based care or community engagement or any other claim of the recovery movement, but rather to her growing relationship with Poppy and her experience with narrative writing, with Allan portraying N's recovery as tenuous and complex, sparked not by the hospital designed to support her but in spite of it.

N's improvement serves not just as a condemnation of mental health services, but as a commentary on the very nature of recovery. Ann Cvetkovich configures "depression as ordinary," rooted in small everyday situations that cause a gradual "shrinking into despair and hopelessness" (13) rather than grand moments of shock or anguish; she structures recovery as equally prosaic, discovering through her own experience with mental illness that simple activities like swimming, spending time with friends and going to the dentist help mitigate her feelings of despondency. Allan builds on this notion by portraying recovery as ordinary and banal, not a single 'a-ha!' moment but rather a process of protracted progress bolstered by small glimpses of hope and agency. While Cvetkovich specifically speaks about depression rather than mental illnesses at large, her notion of recovery as ordinary can nonetheless be applied to a broader spectrum of recovery, whose principles focus not on the specificities of various illness but rather the commonalities of disempowerment, disengagement and depersonalisation that need to be addressed and transmuted.[12] N's recovery sees her subvert the disabling nature of her mental illness through small

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[12] Woods et al. criticise the RN for being too individualistic, calling for narratives that are more collective and speak to these larger scale issues; this chapter shows how the novels of today manage to do both, to offer stories of "individual transformation" (225) that nonetheless have more widespread, collective reach. Many critics take issue with the recovery movement's propensity to ignore social relations and normalise

changes to her everyday life; Allan portrays it not as miraculous or expeditious or final, but as an ongoing – and perhaps unending – metamorphosis.

“People need other people,” notes Taylor, adding that “true independence – for everyone, well or ill – is rooted in social connection” (252), and it is through tethering herself to Poppy that N is unexpectedly freed, much like Sad Janet, who is bolstered by a newfound cohort of female supporters at the end of Britsch’s novel. After more than a decade at the Dorothy Fish surrounded by professionals who view her as a diagnosis and peers who feed her madness, after years of restricting her social circle to the dribbler-riddled Darkwoods estate at the foothills of the institution, N is finally ingratiated into the life of a sniff by her new friend. Poppy and N go to the cinema (“Best night of my life” (253)) and spend Christmas together, drinking wine and making dinner (“That’s the best Christmas Day I’ve had” (296)). N makes phone calls on Poppy’s behalf, advocates for her at the solicitor’s office. Davidson and Roe explain that their notion of “recovery in” is made up of “same innumerable small acts of living we all enjoy, [. . .] like walking a dog, playing with a child, sharing a meal with a friend, listening to music, or washing dishes” (466), simple activities that enhance everyday pleasure, reinforce competency and promote a life that is more than just illness; it is through these seemingly banal undertakings with Poppy that N’s mental health begins to improve and the idea of ‘recovery as ordinary’ is strengthened. Poppy’s friendship has lifted the weight of institutionalisation – of assessments and MAD money and dormancy – off N’s shoulders long enough for her to breathe and assess her *own* life and desires. Farkas finds that “people with psychiatric disabilities indicate that the most critical facilitator or barriers to their own recovery are how people interact with them” (153) and N is able to connect with Poppy as a friend – not a patient – in a personal way, as part of a partnership that inspires hopefulness. Farkas’s belief in the importance of interaction is corroborated by Taylor, who notes that “studies of recovery programme outcomes demonstrate very clearly that it is where people feel most strongly supported that the greatest

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individualism (Friedli, Harper and Speed, Rose) and this idea of recovery as ordinary configures recovery as a shared, communal, collective process while acknowledging the broader social context in which mental illness exists.

success is achievable" (253); while Allan validates this importance of care and connection in *Poppy Shakespeare*, the relationship that instigates N's recovery comes not from a therapist or a doctor or other hospital staff, but from Poppy.

Like Moshfegh, Allan stresses the link between productivity and recovery, echoing Anthony and Ashcraft's emphasis on the creation of "upward turning points" in the recovery process that "involve the provision of hope, understanding, choices, empowerment, and meaning and purpose" (470). Guiding Poppy, while a ridiculous and futile task, has given N reason, something to do besides sitting on the dirty couches of the common room revelling in her madness. Having lived her life as a dependant, N now has Poppy relying on her. For once, N has the power to evoke change, have her voice heard, and this shift away from incapacity has boosted N's confidence and improved her self-worth. This connection is validated by a 2002 study conducted by Steven J. Onken et al. on the treatment of mental illness, in which participants noted that "having a sense of hope, purpose and meaning in one's life supports recovery" (42). "Making a difference in others' lives gives meaning to one's own" (Onken et al. 44) and engenders the hope intrinsic to recovery. N is a successful guide for Poppy, in that she effectively educates her in the ways of Dorothy Fish and encourages her to assimilate, albeit a bit too well. N overhears Fat Cath commend her ability as natural: "You'd think she been guiding since before she was even born" (114). N prides herself on the fact that Poppy has "come along pretty remarkable good if you think of how normal she started," congratulating herself as "a good teacher" (276). While N's success as a guide imbues her daily activities with meaning, an example of her "boostrapp[ing] [herself] into hopefulness through achieving small gains (Onken et al. 45), it is a pyrrhic victory that, while aiding her own mental health, shatters Poppy's in the process.

N's mental health further improves as she begins writing Poppy's story, which will ultimately serve as the text of the novel itself, the words pouring out of her effortlessly. Writing is a cathartic release that shows N for the first time attempting to process her own trauma; relaying Poppy's downfall has forced N to confront her own illness, and she inadvertently writes her own recovery.

Several studies (Dale; Faccio et al.; Hanauer; Urken and LeCroy) corroborate this ability of self-writing to improve mental health by establishing a narrative in which the individual with mental illness has control. *Poppy Shakespeare* is *N's* story written in *her* distinctive voice; it is her point of view and her language, a story devoid of the marginalising medical terminology used by doctors. As mental health scholar Brendan Stone explains, "If madness is intimately bound up with the dissolution of the self, then to strengthen a sense of selfhood may also be to attenuate madness" (172). By putting her thoughts and experiences onto paper, by recording the everyday events of the Dorothy Fish, N is "actively reforming [her] fragile sense of selfhood," "soliloquizing" (B. Stone 171) to regain control over the inner voice that tells her that she has been born a dribbler and will die a dribbler. Taking ownership of her narrative through writing assuages the erosion of N's voice and power within the hospital. It is a testament to the childhood teacher who told N, "There's a poet in you" (38) and allows N to slowly chip away at the notion that she is mentally ill and nothing more.

Angela Woods, Akiko Hart and Hel Spandler's analysis of the Recovery Narrative helps conceptualise N's writing as therapeutic and emancipatory technology of recovery that fills a gap in representation. N's narrative is not what the trio would define as part of the RN genre, a "highly circumscribed kind of storytelling" (Woods et al. 221) that is "actively solicited, circulated and mobilised in ways intended to benefit service-users, professionals and services" (Woods et al. 226), though it is equally "emotionally charged," emanating from "a place of intense suffering" and, as mentioned above, "enveloped in discourses around empowerment" (Woods et al. 227). The restrictive nature of the RN – stories written and 'performed' by mental health patients that include guidelines surrounding length, purpose and derivation – have led Woods et al. to call for the "denaturalising" of the RN in order to draw attention to a wider range of stories and modes of self-representation that can better "articulat[e] a plurality of experiences" (Woods et al. 228). One of Woods et al.'s critiques of the RN is its propensity to highlight similarly rational experiences of insight while muting those – like N's – that are more chaotic. By writing N's narrative, Allan is giving voice to a sector of the mental illness community that has been continually disenfranchised; not only is N a low socio-economic status woman – an underrepresented minority in both the RN and memoir[13] – but her ending isn't the conclusive, happy, inspiring one commonly depicted in the genres. The RN is seen as evidence of recovery, as "an individual's experience of recovery as something which has already been achieved" (Woods et al. 231) and this is where fiction can intervene; by telling stories of those who are still going through recovery, of people, like N, who are struggling to cope with life outside the system and face recidivism, fiction like *Poppy Shakespeare* can normalise an experience of recovery as non-linear and unstable. Woods et al. argue the RN's goal of politicising mental illness experiences by reframing them as insightful and empowering can have a marginalising effect by "valuing certain kinds of reasoning and knowledge" (233); fiction offers a platform for the stories of psychiatric neglect, patient ambivalence and relapse that are omitted from the RN to be told. N's story is often rambling, disturbing and dark, punctuated by moments of exaggeration that beg belief, and Allan's anger is palpable throughout the novel; yet *Poppy's Shakespeare*'s value as a technology of recovery is undeniable. By defying narrative paradigms, highlighting the problems of recovery culture and giving voice to a quieted constituency, *Poppy Shakespeare* breaks with the RN to ultimately expand the repertoire of recovery.

Stone speaks of the difficulties inherent to narrating madness, notably the disjoint between the cohesion demanded of conventional narrative and the content of what is to be narrated: "Inhabiting the sufferer's mind is not the singular internal voice of thought – a voice that might be compared to a narrator's accent imposing coherence on the disparate fragments of `story'; on the contrary, consciousness is filled with wreckage, dispersion, obsessional repetition, or, inversely, characterized by stasis, aphony, catatonia. Such being-states do not fit well with narrative's drive to organize and arrange experience" (B. Stone 18). Allan attenuates this potential problem by writing N's story herself and narrating her madness second-hand; while it would be easy to argue that this detracts from the power of the narrative, to claim that something is lost between N's experience and

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[13] Woods et al cite the propensity of the Recovery Narrative to "whitewash" experiences of madness, focus on younger voices, photogenic faces and "white, often middle-class cis women and men" (233).

the experience as we read it, this certainly isn't the case. Allan doesn't tweak N's voice or her experience to fulfil narrative expectations, and N's meandering thoughts, perverse with slang and grammatical mistakes, are at times difficult to read; but rather than diminish the value of the story, this "wreckage" adds a level of authenticity that underscores N's mental instability, proof that Allan is narrating a story of mental illness that would otherwise be untold, or worse, silenced.

N's use of writing as therapy is paralleled by the author's experience, with Clare Allan having written *Poppy Shakespeare* on the heels of her own institutionalisation. The author was hospitalised for five months after completing the original draft, editing while on the ward. Allan felt "written out of her own narrative" (Robson), taking control back – like N – through writing. While the majority of the characters in *Poppy Shakespeare* are ambivalent about Middle-Class Michael's tirade against the privatisation of mental health services and the move toward community care, the novel itself serves as Allan's invitation to political engagement, her depiction of the inability of those within the system to affect change in their own care, a call to action for those outside the system – the readers. While *Poppy Shakespeare* is N's reclamation of her voice, it is ultimately Allan's combative response to the mental health services that she experienced as gravely inadequate.

While N is discharged, it is not a smooth transition, with Allan showing the difficulty N has in adjusting to life outside the Dorothy Fish after more than a decade within the system. "For three weeks after they kicked me out, all I done was lain in bed. Didn't eat, didn't smoke, didn't take my meds even, just lain on my side underneath the duvet and stared at the clock on the table beside my window" (316), N reveals. She feels hopeless in the wake of her loss of identity and daily routine. Poppy comes to check on her after 5pm, when the outpatient clinic closes, but N won't answer the door, the knocking on the door "like someone hammered on my coffin" (319). N views her rebirth into the real world as more of a death, with the comfort of the people and place she knows taken away from her overnight. She feels flattened, empty. "I weren't feeling nothing" (317). Discharge isn't cure, and recovery takes both work and time. Allan makes it clear that N's true recovery will begin *after* discharge, once she is free from the damaging and self-perpetuating cycle of the hospital's 'care,' and that her improvement has happened not because of the Dorothy Fish but despite it.

While N isn't cured – and Allan is overt in suggesting that this should not be the goal of mental health services – there is unequivocal evidence that N has grown, that she, unlike many of the dribblers, might just avoid readmission and learn to manage her mental illness outside of the hospital. As Taylor explains, "The person I am, I became through my madness: not by 'recovering' from it, which implies a return to a previously healthy state, but by entering into it and travelling to its roots" (Taylor xix), and this is what N has done, her writing helping connect past trauma to current mental illness in a way that allows it to be contained and surmounted. N, like Taylor, becomes a new version of herself, one that can live a meaningful life alongside her mental illness, and her discharge is a rebirth, predicated upon the replacement of hospital-as-womb by Poppy-as-mother, into a world that is both fresh and terrifying. N must find her footing – without Poppy and the hospital – and forge her own path "through" her madness. The novel ends, but N's story isn't over, with the reader left to consider what her future holds; though N isn't cured, her depression and other signs of mental illness still present, N has acknowledged that there is more for her out there than an institutionalised life. She has finally cut the cord between herself and hospital and moved on, away from her home of 13 years and toward, for once – hope.

Rabbits for Food: Private, but Still Inadequate

While *Rabbits for Food* is a more muted criticism of institutionalisation than *Poppy Shakespeare*, focusing on the role of the individual in his or her recovery rather than condemning widespread systemic failure, the two novels nonetheless intersect in a variety of ways. Both portray institutionalism as a de-personalising experience in which identity is broken down and reconstructed, and each intervenes in current debates on mental health issues ranging from recidivism to stigma to the quantification of subjective emotion. Together, they reveal that little has changed since Erving Goffman's famous 1961 rebuke of institutionalism and Chesler's criticism of the bureaucratised family that followed a decade later (Chesler 95), suggesting the need for a new, more patient-centred form of in-patient care that better fosters recovery and promotes social integration.

While *Rabbits for Food* is far from the anti-institutional polemic that *Poppy Shakespeare* is, Kirshenbaum's novel certainly does expose flaws in the mental healthcare system. The "freshly minted" (281) social worker who leads Cognitive Behaviour Therapy, Carolyn, is tremendously problematic, with Kirshenbaum using her character not only to highlight the ineptitude of hospital staff, but also to comment on how the internalisation of dominant recovery narratives can be detrimental to those living with mental illness. Carolyn placates Edward's fears of his impending discharge by saying, "It's going to be wonderful, I promise" (284). Chaz, a policeman-turned-patient, recognises the unethical nature of such a guarantee: "That's messed up. You don't go around making promises when who the fuck knows what's going to happen" (284). Carolyn's response to an anorexic girl announcing that she is looking forward to a colon cleanse when she gets home is equally disturbing: "That's good" (285). Carolyn turns to Bunny and inquires as to what she wants to do upon release, and when Bunny responds "read," Carolyn is dismayed: "No, no. I mean something really, really fun" (286), invalidating Bunny's response and making her even more unlikely to engage in future sessions. Carolyn's insistence that recovery must be marked by "fun" reinforces the misconception that someone is not in recovery unless they are smiling and laughing. Not only do scholars make it clear that recovery is living alongside symptoms, meaning someone in recovery may still have moments of tearfulness or social withdrawal, but enforcing a baseline of "fun" that one must meet in order to be recovered invalidates the very person-oriented and self-determination on which recovery was founded. This connects with Woods et al.'s criticism of the Recovery Narrative's "compulsory positivity" (222) which requires the presentation of recovery as an inspiring and uplifting experience; by casting Carolyn as inept and then depicting her advocation of this concept, Kirshenbaum joins Woods et al. in their criticism of recovery as requisitely positive.

Like Allan, Kirshenbaum explores the self-fulfilling, disempowering nature of institutionalisation and the futility in self-advocacy once one is deemed mentally ill; as Pilgrim notes, part of the holistic notion of recovery is recovery from invalidation, that is, relief from the "stigma and the personal impact of social exclusion" (Pilgrim 297), and this loss of agency within the institution impedes the mental health improvement that it sets out to aid. Bunny must remain in the hospital until her doctors agree she can be discharged: "Bunny can't sign herself out of the loony bin because, by virtue of her being here, she is not of sound mind" (272). This is the very circular logic that leads to Poppy's breakdown in *Poppy Shakespeare*; though Poppy is purposely misplaced in the Dorothy Fish for bureaucratic reasons, she cannot prove that she is mentally fit no matter how hard she rages. Kirshenbaum builds on the absurdity within this loss of agency by noting that, while Bunny cannot sign her own discharge papers, she can agree to ECT: "Despite that a person locked up in the psycho ward can't leave until discharged by the doctors, that same person, apparently, is sufficiently *compos mentis* to agree to electroconvulsive therapy, in writing" (332, emphasis in text). The patient's level of mental capacity shifts to suit the hospital's needs. The aides in Bunny's hospital invoke this notion of patient incompetence to manipulate situations in their favour. When Andrea threatens to report Patricia for making an inappropriate comment, Patricia barks, "Go ahead. Who are they going to believe? You or me?" (307). As Bunny explains, "It's one of the many disadvantages to being mentally ill. You are automatically in the wrong because you *are* wrong. Everyone knows that crazy people have no sense of proportion and often they are delusional and paranoid" (308, emphasis in text). With mental illness comes a disenfranchisement that is only magnified within an institution, and both novels call out this underlying assumption of incapacity as detrimental to mental health. As Goffman explains, "In the mental hospital, the setting and the house rules press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the outside, having failed in some over-all way, and that here he is of little social weight, being hardly capable of acting like a full-fledged person at all" (141). Mental health advocate Peter Campbell, who spent much of the 1970s and 80s institutionalised, corroborates this notion of dehumanisation, explaining, "At times it is hard work not to believe we [the institutionalised] are a separate branch of humanity" (qtd. in Taylor 248). Even decades after these criticisms, even in

Bunny's posh New York hospital, these pockets of powerlessness persist, and it is easy to see how the lack of agency implicit to the system serves as a reminder of public ostracism that only impedes recovery.

Bunny's responses to Dr Fitzgerald's questions about her mental state highlight the problems inherent with measuring mental illness, an issue that permeates *Poppy Shakespeare* as well. "On a scale of one to ten, how would you rate your depression?" (224), Bunny is asked, an ambiguous question requiring her to assign a number value to an indefinable experience. This echoes writer Eula Biss's condemnation of pain scales: "The pain scale measures only the intensity of pain, not the duration. This may be its greatest flaw. A measure of pain, I believe, requires at least two dimensions. The suffering of Hell is terrifying not because of any specific torture, but because it is eternal" (Biss 19). Bunny's depression may not be catastrophic – she isn't hysterically distraught or suicidal – but the duration of her sadness, and the fact that she sees no end to it, should surely be taken into account when describing it. Bunny cannot quantify her sadness: "These questions require Bunny to give a numerical distribution to darkness, defeat, panic, anxiety, and grief" (224), nebulous feelings of pain that cannot be pinpointed. Just as Biss laments that "pain presents a unique problem in terms of measurement, and a unique cruelty in terms of suffering—it is entirely subjective" (12), so too does depression. How sad, hopeless, overwhelmed must one be to reach a 10?

Both Kirshenbaum and Allan criticise the element of self-assessment essential to mental healthcare, yet they also acknowledge the lack of options. "Despair can't be monitored like blood pressure or measured in centimetres like a tumour" (261), writes Kirshenbaum, and any quantification of depression, anxiety, obsessive-compulsive disorder, must rely on input from the patient. As writer Nathan Filer explains, "In the mad, mad world of mental healthcare *language is everything"* and it is "the *words* people say – or do not say – as interpreted by professionals" (7, emphasis his) that matter most. Ultimately, it is a double-standard of care, in which patients are deemed too mentally unfit to sign themselves out or be taken seriously by medical staff and yet are expected to accurately articulate their own mental illness. It is only natural that patients' answers are laden with overthinking, manipulation and imprecision, and this has a knock-on effect when it comes to treatment. When Dr Grossman[14] explains the benefits and drawbacks of ECT, he notes, "The anecdotal evidence for recovery is very strong [. . .] however [. . .] there is no way to achieve a scientific standard of proof" (261). Without a tumour to measure or a blood count to check, the effectiveness of mental health treatments is reliant on patients' self-reporting, which is intrinsically unreliable and not impervious to non-pathological mood swings or 'bad days.' While neither Kirshenbaum nor Allan offer solutions to the conundrum of quantifying mental illness, both acknowledge it as a potential impediment to recovery and question the medical community's attempts to standardise care for immeasurable conditions of mental illness.

Kirshenbaum, like Allan, touches on the notion of recidivism within mental institutions, showing how the nature of mental illness results in a recovery that is anything but linear. While Allan frames her depiction of recidivism as a condemnation of a mental health services, chiding both premature discharge and the system's role in creating an unhealthy dependence, Kirshenbaum's portrayal is restricted to a single line. When Nina returns to the hospital, Andrea exclaims, "I knew she'd be back," explaining that the hospital is "a revolving door," a "minimum-security prison for repeat offenders of non-violent crimes" (267). It is a holding cell in which patients are rehabilitated to an acceptable extent, released back into the society that brought about their illnesses, and then in many cases face relapse. Mental illness is often a life-long condition, and a certain level of re-institutionalism is inevitable; there is no long-lasting, definitive cure, and for some, this means repeated visits to psych wards. Andrea's nonchalant comment about Nina's return – a response devoid of surprise, disappointment, pity – suggests that recidivism is a well-known and frequent phenomenon within institutions. While Allan allots significant narrative space to the recidivism of her characters, delving into both the causes and effects of repeated returns to institutionalism, Kirshenbaum's truncated depiction instead reveals a tacit resignation among those in the system.

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[14] It is worth noting that both *Sad Janet* and *Rabbits for Food* feature male doctors named Dr Grossman, obvious nods to the patriarchal practices within contemporary medicine.

Both *Rabbits for Food* and *Poppy Shakespeare* investigate the ways in which mental health impacts one's sense of self, with both depicting mental illness's ability to erode previous established sources of identity. In Allan's novel, the dribblers are so accustomed to their mental illnesses that they have become caricatures of their conditions, and this indelible connection between self and sickness drives their desire to stay within the system. While Kirshenbaum's characters don't exhibit this same reliance on the mentally ill identity, *Rabbits for Food* does show how the communal, de-personalising nature of institutionalism erases all signs of pre-hospital identity and overrides it with signals of illness. One's individuality is quite literally stripped away at the door, where personal belongings are mercilessly searched and "*Not Allowed*" (3, emphasis in text) items tossed aside. As Goffman explains, "At admission, loss of identity equipment can prevent the individual from presenting his usual image of himself to others" (21), requiring the patient to reformulate a new self predicated upon the rules of the institution. It is an immediate loss of control in which this new identity becomes inherently entangled with illness rather than individuality. "Although the mental ward is not unlike a prison, the inmates don't much discuss what they're in for. They don't have to ask. Depression, obsessive-compulsive disorder, anorexia – it's right there in plain sight" (243), explains Bunny. Like a prison, the psych word is a socially-levelling establishment in which all patients have been sent for rehabilitation, and Kirshenbaum once again draws this comparison to a prison in an attempt to criticise mental health services for its removal of patient agency. Bunny is shocked to find out after weeks at the hospital that Josh is a lawyer, having spent too much time in a social circle that defines its members by their station in life. "At a party, you could clock it: from the moment of introduction to the moment of having heard it all – that he is a lawyer, what kind of law he practices [. . .] would come in at under forty seconds" (324). But in the hospital, Josh's occupation is irrelevant. Any prior social hierarchy has been shattered; irrespective of someone's previous job– prestigious or unimpressive, blue-collar or white-collar – they have all ended up in the same place. Bunny suggests, "Could it be that *this,* only this, that they are here, is all anyone needs to know about any of them" (324, emphasis in text). Kirshenbaum suggests that severe mental illness looms large enough to overshadow any other part of one's identity and must be confronted and dealt with before reclaiming those parts of one's self. This differs from Allan's novel in which the characters have embraced their illnesses to the extent that there are no other aspects of themselves left to be retrieved. It is easy to picture Kirshenbaum's characters as earlier versions of those in *Poppy Shakespeare*, newly admitted in-patients who have not yet been inured to institutionalism in the way that N and Schizo Safid and Sue the Sticks have. When read in this way, Allan's satire serves as a cautionary tale of how remaining in the system too long slowly eats away at one's identity until there is nothing left but illness.

Structure and Affect

Unlike the more traditional single-perspective, chaptered layout of *Poppy Shakespeare*, the composition of *Rabbits for Food* is more complex. Kirshenbaum splits the novel into two complementary third-person narratives, one that details the events of a New Year's Eve gone awry and a second chronicling Bunny's subsequent institutionalisation in an upscale New York hospital, both of which are punctuated by short vignettes produced by Bunny in the hospital's Creative Writing class. This unconventional format serves as commentary on the nature of recovery, while the inclusion of Bunny's impassive anecdotes unsettles the emotionally-driven Recovery Narrative; by providing an alternative way of reading that hinges on moments rather than narrative cohesion, Kirshenbaum allows the reader to focus on the affective experience of mental illness – the chronic, disempowering loss of connection that is intrinsically entangled with Bunny's debilitating sadness.

By dividing the narrative into two sections – a 'before institutionalisation' and a 'during institutionalisation' – Kirshenbaum depicts entering a mental hospital as a colossal shift constituting a separation from previous life. It is a natural break in the narrative, a turning point not just in the story but in Bunny's existence. Like quitting a job, having children, the death of a spouse – institutionalisation is a major life event that changes a person in a way that makes reversion to the pre-event self impossible. This feeds into common notions of recovery as guided by forward momentum, not a desire to reclaim a pre-illness way of living. Though recovery isn’t linear, marked by periods of lagging or even backwards progress and others of rapid improvement, it isn’t circular either, with one reverting to a past, illness-free version of oneself. Davidson and Roe explain that recovery isn’t a return to “normal” (462) psychological state – which in Bunny’s case, arguably never existed – but rather changing one’s relationship with mental illness in a way that allows for new meaning and purpose. This echoes their notion of “recovery from” (Davidson and Roe 463) as marked by the – in many cases, unachievable – absence of symptoms, in contrast to “recovery in” (Davidson and Roe 464) in which those with mental illnesses learn to find happiness, success and productivity alongside them. One can imagine that if Kirshenbaum were to continue her story and show Bunny’s recovery, it would be a third section, a ‘Part 3’ that follows Bunny as she navigates this new relationship with her illness. Just as institutionalisation is a new chapter in Bunny’s life, so too is her pending recovery. Taylor mentions becoming the person she is now “through [her] madness” (Taylor xix), and the structure of Kirshenbaum’s narrative suggests that Bunny’s institutionalism is but one chapter in her life, a necessary part of the process that Bunny must traverse before writing her next section.

The short vignettes that Bunny writes in Creative Writing, generated from succinct prompts like “A Shoebox,” or “A Hat,” interrupt the narrative of the story in a way that mimics the experiences of both institutionalisation and recovery. By interposing the larger story arc of the novel with these intercalary elements, Kirshenbaum echoes the structure of the institutionalised day in which patients receive short bursts of support or interventions on a mandated schedule. Just as the reader groans when the story abruptly shifts away from a moment of action, so does the patient when she is forced to leave an activity – or in Bunny’s case, a lack of activity – to see a doctor or attend a group session. It is a minor but palpable loss of power that helps the reader relate to Bunny’s experience in the hospital. These vignettes can also be seen as a metaphor for the non-linear nature of recovery; while the larger plot of the novel progresses chronologically, it is thwarted by these excerpts chronicling seemingly unrelated previous experiences. Kirshenbaum’s story shifts between present day and past events, mirroring the propensity of recovery to progress and stall, improve and then backslide. The inclusion of these chapters is a clever literary tactic that manages to comment on recovery without even mentioning it, aiding the readers' understanding through the unexpected back alley of structure.

While Bunny's Creative Writing pieces are prompt-driven and limited to 300 words, a structural circumscription not unlike the Recovery Narrative, the similarities between the two end there, with Bunny relaying anecdotes about her past in a factual, dispassionate way that lacks the emotional self-reflection implicit in the RN. Bunny recounts her best friend Stella's death with surprising aloofness: "While Stella napped, the small bump on her forehead bled backward, into her brain, and she died" (246). For the prompt "A Pair," Bunny describes her beloved childhood hamster, My Darling, whose very name exudes cherished affection, and then impassively reveals the pet's disturbing death: "Two days after my birthday, My Darling eviscerated herself on a sharp edge of her hamster wheel" (276). Bunny reports both deaths pragmatically, belying the obvious tenderness she had for both Stella and her pet, and she rebuffs the chance to use her writing as a platform in which to interrogate the aftermath of this loss and share the impact of these tragedies in a public forum.

While this lack of introspection can be deciphered as an emotional block that contributes to Bunny's mental illness, such a reading fails to account for the power gained by distancing herself from these experiences and refusing to achieve – at least publicly – a healing catharsis. In their critique of the RN, Woods et al. voice concerns that the "imperative to narrate traumatic experience [is] another form of oppression," adding that there is "potential *dis*empowerment in 'telling your story' in order to meet the demands of mental health providers" (227, emphasis theirs). Bunny eschews the breakthrough that the Creative Writing teacher so clearly wants, getting tantalisingly close by relaying stories rife with trauma, yet stopping short by declining to find meaning in them; similarly defiant, nearly all of Bunny's writing samples far exceed the 300-word limit. But there is power in Bunny's refusal to adhere; she is writing her experiences on her own terms, reclaiming the authority that she has lost from her depression and institutionalisation and the stigma surrounding both. While the RN is composed with the expectation that it be performed for an audience who can embark on an emotional journey with the reader, the passivity with which Bunny writes distances her from such a voyeuristic possibility and instead puts the onus on the Creative Writing instructor, and in turn, the reader, to connect the dots between experience, emotion and significance. It is not necessarily that Bunny is unable to find meaning in these past traumas, but rather, perhaps, that she reproaches the expectation to share or perform them, rejecting – either knowingly or tacitly – the prescriptively positive, meaning-laden RN. Bunny is, after all, a professional writer, and any choices she makes in her narrative are undoubtedly purposeful; she is not failing to imbue her writing with reflection, emotion, positivity, closure, but actively choosing not to. Farkas argues that "coercion has the effect of diminishing, rather than strengthening the self" (146), and by writing her experiences as *she* sees fit, Bunny is able to regain a small amount of control of her life.

To this end, these anecdotes function as tools of counterdiagnosis, a desire, according to Margaret Price to "subvert the diagnostic urge to 'explain' a disabled mind" (17) and impute order and reason onto madness. This "appetite for diagnosis" (M. Price 27) is surprisingly strong: it is difficult to read Bunny's vignettes without connecting them to her depression. One can easily imagine these traumatic stories relayed on a psychiatrist's couch, interspersed with questions of, "How does that make you feel?" or "How do you think that has impacted you?" But Kirshenbaum denies the reader these diagnostic moments, disrupting the diagnosis-treatment-recovery paradigm and challenging "the readers' desire for neatness, for definition, and certainty, to find out what is really *wrong* with the autobiographical narrator in order that there might be a way to fix it" (Longhurst 40).[15] Bunny's stories are personal anecdotes rather than medical records, and thus they are free from professional interrogation and diagnosis, simply moments rather than the genesis or manifestation of psychological disorder. These stories aren't meant to pathologise but rather to empathise, elucidating the complexity of Bunny's life and in turn the complexity of her unhappiness;

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[15] I spoke with Kirshenbaum, and she revealed that she initially had these anecdotes as therapy sessions rather than creative writing pieces, but ultimately decided that it was "trite," and she would rather have Bunny explore these situations on her own terms.

Bunny's mental illness isn't borne from a single event that can be psychoanalysed, dealt with and then cured, nor can the term 'depression' fully articulate her affective experience. Katrina Longhurst explains, "Counterdiagnosis complicates and entangles [the diagnostic urge] in order to demonstrate the messiness and uncertainty of mental illness, and in doing so reminds the reader that the near-ubiquitous restitution or triumph narrative simplifies, and frequently censors, the intricate and muddled experiences of illness" (40). Bunny's writing excerpts are chaotic, confusing and, at times, absurd, and facilitate the reader's understanding of Bunny – and her mental illness – more than any writing within the pages of the *DSM-V*.

These intercalary chapters resist narrative cohesion, jumping back and forth across time, tense and points of view in a lack of progression that mirrors the inconclusiveness of Bunny's illness journey. Bunny's anecdotes do not coalesce to form a clear beginning, middle and end, nor does the overall novel drive toward a decisive conclusion; Bunny's mental illness equally resists movement through the stages of the diagnosis-treatment-recovery paradigm. Sara Wasson explains, "It is widespread contention in narratology that a narrative is informed by a sense of the ending to which it moves" (106); similarly, one could argue that in the medical community, an illness is informed by chances and modes of cure, and more specifically, mental illness is informed by a sense of recovery. *Rabbits for Food* destabilises each of these tenets, and in doing so diversifies our understanding of both narrative and illness. Bunny isn't hurtling toward recovery any more than the narrative is hurtling toward closure, and *Rabbits for Food* breaks with literary conventions in the same way that Bunny's depression provides a welcome deviation from mental illness conventions. Bunny's "ugly feelings" (Ngai 3) of inadequacy, defiance and indolence, as well as the fragmentation of the narrative itself, "resist the redemptive arc of suffering" (Ngai 6) expected within twenty-first-century neoliberal culture.

Much can be gleaned about Bunny's condition by reading her extracts in isolation, as fragments rather than as part of a larger story or illness arc. As Wasson explains, "I suggest that reading episodically is to read looking for a place to pause – to cease looking for the arc of the individual longitudinal journey and instead to consider how a particular scene constructs an emerging *present"* (108, emphasis hers). By removing the impulse to psychoanalyse Bunny's Creative Writing snippets and package them into a medical diagnosis, one can instead analyse them as individual "moments of suffering" (Wasson 109) that underscore the impediments hindering Bunny's wellbeing. Reading "A Movie," in which Bunny discusses staying home alone on Thanksgiving, reveals her disconnection with her family: "'Bunny, you won't believe it, but I swear to you,' Dawn said, 'the entire day, and no one, not one person, not even Natalie, asked where you were. It was like, Bunny who?'" (82). "Two People Having Lunch" ends on an equally upsetting note, with nine-year-old Bunny's sister asking her, "And you wonder why no one in the family likes you?" (169). By standing these anecdotes on their own and purposely separating them from the larger story arc, Kirshenbaum intensifies their impact, shocking, provoking and disturbing the reader like a sudden bolt of lightning. The structure of *Rabbits for Food* encourages this kind of affective "flash reading," what Wasson discusses as "a willingness to surrender – even if briefly – to the instant of the textual encounter, to the passage, the excerpt, the troubling episode, and to let that extract sit with you, remain with you, haunt you, without closing it off within a narrative arc" (111). Bunny's repeated encounters with loss and disconnection are devastating, and the reader hardly has time to recover from one gut-punch before Kirshenbaum delivers another. Freeing these anecdotes from the onus of larger narrative purpose allows them to simply evoke emotion, and thus the reader is able to reside with Bunny's pain and connect with her on a deeper, more meaningful level; *Rabbits or Food* exemplifies fiction's ability to move beyond the statistics, medicalised terminology and "compulsory positivity" (Woods et al. 222) of contemporary mental illness discourse to instead illuminate the often-occluded chaotic pathos of day-to-day living.

Bunny's experience is not one that can be neatly packaged into an inspiring tale of overcoming mental illness, and her writing need not acquiesce to this expectation in order to have value. By refusing to underpin Bunny's writing with messages of hope and encouragement, by making it clear that Bunny is writing for herself and no one else, Kirshenbaum sends a message of liberation that does paradoxically have wider reach. Bunny's illness *can* just be for her – not inspirational rhetoric or political kindling or pull-quote fodder – yet this signifies a provocative pushback to dominant recovery discourse that democratises what it means to be mentally ill. Bunny's writing validates and empowers readers whose relationship with mental illness is similarly subversive or those who simply wish to live life on their own terms, and thus, unexpectedly, Bunny's illness becomes not just for her but for all women.

The novel's abrupt ending is equally powerful, with Kirshenbaum's decision to leave Bunny in the throes of depression a purposeful break with narrative expectations. The author makes it clear that there is quite a lot of Binnie in Bunny;[16] Kirshenbaum connects Bunny's stubbornly lingering symptoms to her own ongoing experience with depression, having dealt with mental illness to various degrees throughout her life. "I didn't want [Bunny] to get better," explains Kirshenbaum. "I wanted to leave it open-ended." Discussing the mixed responses to this ambiguous ending, Kirshenbaum adds, "People wanted to know if she got better, but I just didn't want to do that. I would rather people ponder what happens next." Ending the novel with Bunny in a brighter place wouldn't send the right message about depression, she clarified: "With depression, there are periods of getting better, but it's not life-lasting that you are better. It may be controlled to some degree at certain points, but it doesn't just go away." It was essential to Kirshenbaum to depict Bunny's depression as continuing beyond the pages of the novel. *Rabbits for Food* purposely breaks with the diagnosis-treatment-recovery paradigm to instead convey an enduring, unpredictable mental illness experience, a subversive yet candid representation that is too often eclipsed by saccharine endings offering closure in the form of recovery. Bunny's gritty, abrasive attitude similarly disrupts mental health stereotypes, with Kirshenbaum challenging the conceptualisation of mental illness as a tragedy that befalls otherwise wonderful people. "[Bunny] isn't the nicest person in the world," declares Kirshenbaum. "I wanted to do that, to make her complicated in that way. If she were this really nice person, it would sentimentalise depression and I didn't want that." Instead,

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[16] As per a phone conversation on 29th July 2024

Kirshenbaum sought to foster a more grounded, less emotional empathy: "I wanted people to feel for her, even if they didn't like her."

Reforming Lost Connection

Despite the unsettling, nebulous conclusion of the novel, Bunny's burgeoning relationships within the hospital, her newfound sense of belonging, serve as a beacon of hope, exemplifying Solomon's belief that "depression will only intensify in the private cocoons we spin at our lowest" (453), and community and interaction are the necessary counteragents. Bunny is a self-described loner, and her admission to the hospital necessitates a level of social interaction that she initially resists: "To occupy your time here with hobbies and social engagement is not exactly mandatory but it is encouraged, *highly* encouraged, as if to play a game of charades or to sit around a table making paper swans from squares of cut-up newspaper with a bunch of other mental patients is a pathway to sanity" (213, emphasis in text). Bunny mocks the hospital's philosophy – though it is much more in tune to the recovery agenda than the Abaddon's – but by the end of the novel, she has modified her perspective on the power of community, admitting that "any good that is done here is the good they do for each other" (305).

Writing of his career at Fulbourn mental institution, David Clark explains, "It was several years before I even began to consider the possibility that patients could actually help each other – and that there might be patients who could help others better than doctors could" (225); while *Poppy Shakespeare* depicts a toxic camaraderie that exacerbates the patients' mental illnesses, Kirshenbaum sheds light on the ability of patients to support each other.[17] Bunny's mental health and overall temperament improve as she spends more time with her fellow patients – Josh, Andrea, Nina, Chaz – kindred spirits whose own mental illnesses imbue them with an incomparable level of understanding and compassion. They don't ask Bunny to explain her tears or inquire as to her why

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[17] Taylor explains that this is an aspect of recovery that has yet to be studied; given that both novels depict the power of inter-patient relationships (both for better and for worse), there is certainly basis to conduct this research in real life.

she's there. They don't have to ask the difficult questions because they are living the same experience. As sociologist Bill Hughes explains, "The non-disabled gaze is structured by pity and fear, and such negative emotional responses tend to have an 'elective affinity' with social responses that are characterised by [. . .] charitable paternalism and exclusion" (Hughes 62); Bunny's new friends offer a "gaze" from within, and their recognition begets a natural, unspoken empathy that helps shift Bunny's depression from a personal tragedy to one that can be shared. As the weeks progress, Bunny grows closer and closer to the motley crew of misfits, with Kirshenbaum explaining that she "connects with people who are slightly rebellious like her." Bunny talks fashion with Nina, helps plan a surprise party for Andrea, chats with Josh at every opportunity. She knows where her friends are at all times: "Josh it at his biweekly meeting with Dr Grossman, Teacher is at Origami, [. . .] Chaz went to Calisthenics, [. . .] Andrea is at Beauty" (304). Bunny cares about these people, and the feeling is mutual. When Bunny returns from her first ECT session, she finds that everyone has blown off their activities or walked out of group sessions early to be there when she returns. Bunny finally feels like she belongs, that she is accepted for who she is, and her icy disposition begins to melt.

Bunny's growing relationship with her fellow patients speaks to the notion that recovery is ordinary, found in the small joys of everyday tasks, of minor "upward turning points" (Anthony and Ashcraft 470) that signify hope. When Andrea returns from Beauty with her nails painted "like a bowl of jelly beans," Bunny refrains from responding with her trademark rudeness: "Bunny tells Andrea that her fingernails look fabulous, which is not what she really thinks" (306). For the first time, Bunny is able to hold her tongue and offer an un-truth purely for the sake of someone's feelings. It is a small but crucial step in the right direction, proof that there is hope for Bunny yet, and the very social interaction that she so adamantly avoided may end up being her saving grace. Anthony and Ashcraft's "upward turning points" are "moments of insights and choice when [patients] realise they can respond in new ways to familiar experiences. [. . .] a *split* second when they can either surrender to the symptom, reacting in habitual ways, or they can choose a new path" (470, emphasis theirs). For once, Bunny diverges from her trademark brusqueness to choose empathy. Similarly, Bunny breaks her longstanding avoidance of groups – one that goes as far back as Girl Scouts – to become one of the "ECT-ites," an exclusive "fraternity" of "cool kids" (248) who are undergoing electroconvulsive therapy. While Bunny's decision to undergo ECT may be partially rooted in a morally ambiguous bid to feel special rather than a desire to actually improve her mental health, it is nonetheless the first time Bunny makes a decision to actively belong to a group and the first indication that she is trying to change her pathway. As Davidson and Roe explain, "Recovery refers to the rights to access and join in those elements of community life the person chooses, and to be in control of his or her own life and destiny, *even and especially while remaining disabled*" (466, emphasis theirs) and Bunny's ability to find happiness while still unwell serves as a marker of her recovery.

Bunny's biggest roadblock to recovery isn't the depth of her illness or poor mental health services, but her fear of failure, which results in an inability to see her own progress. Kathleen Woodward writes of statistical panic – the fear resulting from figures surrounding risk – with statistical boredom at the other end of the spectrum, but what of 'statistical hope'? What of 'statistical shame' when recovery percentages suggest that one is in a good position to improve but one doesn't? This is Bunny's biggest fear: "Bunny can't say for sure if she wants to get well. To get well will take effort, so much effort, and she is weary. And what if she does try, tries her very best, and fails nonetheless? To try and to fail is all too familiar to her. All her life, she has tried and tried, and now she is tired, dog-tired, of trying" (263). Bunny has tried and failed at being a doting daughter, a loving wife, a supportive friend and a successful writer, and she cannot take any more disappointment. Depression is a known, and Bunny questions whether it is better to tolerate the sadness than to risk another embarrassing let-down. Bunny's situation mirrors that of Sad Janet in Chapter Two, another social outcast whose reluctance to try medication is rooted in her fear that it will not work, resulting in a humiliating sense of failure that will only further drive her sorrow. Woodward asks, "How could we possibly allow a single number to have such decisive and unambiguous power over us?" (Woodward 199); yet, these statistics are ubiquitous when it comes to mental health. Davidson and Roe cite longitudinal studies that report between 45% and 65% of sample patients experience partial to full recovery, claiming that “partial to full recovery is at least as common an outcome in serious mental illness, if not more so, than severe, persistent impairment” (462). This chapter has already discussed the complexities of quantifying both mental illness and recovery, yet figures and generalities are regularly attributed to them. When Bunny decides to undergo ECT, Dr Grossman comforts her: “My experience is that there is a dramatic improvement with the treatment” (330). With assurances like these – both statistical and anecdotal – undoubtedly comes a pressure. Woodward speaks of negative figures as causing worry and panic, but certainly hearing statistics that suggest an optimistic outlook can cause a different but equally distressing kind of unease, a fear of standing in the face of this hope and failing.

Davidson and Roe argue that not everyone can and will get better, that there are people for whom “recovery from” and “recovery in” “will remain distant possibilities for their foreseeable future, if not for the remainder of their lives” (467); ultimately, Bunny’s recovery is thwarted by this reluctance to dive in head first, for better or worse, with her persistent negativity showing an inability to engage with the work of recovery. Throughout the novel, any progress Bunny makes is largely unintentional – her writing, her friendships – and not something she proactively seeks. When she asks Albie to bring a present that she can give to Andrea on her birthday, Albie innocently questions if she is making friends. “I don’t have friends here. [. . .] I don’t have friends anywhere” (290), Bunny retorts. Despite all evidence to the contrary, Bunny believes she is alone. “A person’s recovery is something that he or she needs to pursue actively, and there are individuals who have yet to take up this challenge” (467), argue Davidson and Roe. They continue to explain that an individual whose recovering is stalling often “has yet to take on the work of either recovering or ‘getting into’ recovery, has yet to begin to differentiate the illness and its effects from the remainder of his or her life, and has yet to begin to figure out how to live a meaningful life in the face of enduring disability” (Davidson and Roe 467). This speaks directly to Bunny’s situation; while she is marginally better at the end of the novel, Bunny is relying on ECT to jumpstart her recovery rather than embracing, or even acknowledging, the role of community in supporting her mental health.

While *Poppy Shakespeare* ends with N on the path to recovery, having been bolstered by her friendship with Poppy and the writing of her friend's – and her own – story, Kirshenbaum's novel concludes with Bunny in a much darker place. Bunny has to choose recovery, and she has yet to do so. While it would be easy to read this as a negative depiction of mental illness and recovery, to do so would render getting better normative. Kirshenbaum fights against this with her portrayal of Bunny's struggle with recovery, ultimately adding to the "plurality of experiences" that Woods et al. call for. Their critique of the Recovery Narrative as a "genre of inspiration" that must be "emotionally uplifting, palpably reassuring, and inspiring change of some kind" (Woods et al. 231) implies the need for narratives that counteract this, that show recovery as messy, as difficult, as uncertain, and *Rabbits for Food* fills this gap in representation but offering a narrative that ends without the mitigation of the main character's mental illness, with a question mark rather than a full stop.

Concluding Thoughts

Simi Linton argues that "disabled people are rarely depicted on television, in films, or in fiction as being in control of their own lives – in charge or actively seeking out and obtaining what they want and need" (Linton 25); this chapter shows that a change is underway. There is a message within both novels about the power and necessity of self-advocacy; in a medicalised landscape where decisions are too often made *for* those with mental illness, there is power in speaking up for oneself, for telling one's story or refusing to do so, for confronting the absurdity of the system, for admitting that recovery is hard and giving up would be easier. N and Bunny might be what Susan Wendell terms "unhealthy disabled,"[18] yet they are strong, empathetic, intelligent, and, at times, motivated

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[18] Whereas "healthy disabled" people are "people whose physical conditions and functional limitations are relatively stable and predictable for the foreseeable future," the "unhealthy disabled" are those whose conditions are unpredictable and who face more "blame and responsibility for [their] disabilities" (Wendell).

and determined. They argue with doctors, laugh with their friends, tell stories and play games. They live. They have broken free from the attics, the institutional shackles, the yellow wallpapered drawing rooms of their canonical predecessors to live the best lives that they can – illness or not. N, Poppy and Bunny are more than madness, and their voices in the text reflect a spectrum of emotion beyond those in the *DSM-V*. Both Allan and Kirshenbaum portray their protagonists building relationships with other patients (N with Poppy and Bunny with Josh, in particular) that are rooted not in illness but respect and understanding; it is these relationships, not the doctor-patient ones, that truly matter. *Poppy Shakespeare* and *Rabbits for Food* depict recovery as amplified by these small victories – pockets of empowerment and unexpected friendships, for example – configuring recovery not as predicated upon a dearth of symptoms but upon a preponderance of ordinary.

It would be easy to look at *Poppy Shakespeare* and come to the conclusion that the main impediment to recovery is a lack of person-oriented care within a mental health system too focused on regulations and prestige; however, *Rabbits for Food* presents a far less reproachful version of metal health services, and yet Bunny and her peers still struggle to improve their mental health. Together, the two novels paint a more holistic and complex picture of recovery as contingent on both internal and external factors; doctors, nurses, therapists, aids – they must spark a desire to recover just as much as they must buoy the recovery itself, and emphasis on patient perseverance and individual circumstance are equally essential within the medical community. Similarly, more widespread acceptance of recovery as a process rather than an outcome, as subjective rather than objective, is needed in order to best support those with mental illness, as is a more extensive acknowledgement of the possibility of recovery to transpire outside of mental health services. The biggest barrier to recovery may not be the interpretation of the term or the details of care but simply the blinding fixation on medicalised recovery as endgame.

Poppy Shakespeare and *Rabbits for Food* reframe recovery as a journey without definitive end, breaking down the healthy/ill divide to configure recovery as ongoing, non-linear growth marked by chaos, reluctance and fear; these qualities, too often obscured by compulsively happy narratives predicated upon a happy ending, are celebrated by Allan and Kirshenbaum and form a welcome addition to the tapestry of mental illness representation. By breaking with the expectation of inspirational meaning-making, by featuring characters who struggle to improve their mental health and whose stories end with ambiguity rather than finality, these novels are paradoxically inspirational in their own right. They give voice to stories that have been quieted or ignored, power to those who feel hopeless, relief to those who see themselves in N or Poppy or Bunny. *Poppy Shakespeare* and *Rabbits for Food* fulfil Fiona Ng et al.'s request for "less articulate and polished narratives or ones where the narrative is not fully resolved" rather than solely "narratives of individuals who are fully recovered" (279), highlighting the importance of elevating the experiences of those who are 'in it' rather than 'over it.' Not everyone wants to get better, not everyone can get better and not everyone will get better, and these stories of hardship, failure and resignation reflect a diversity of experience whose literary inclusion can only be commended.

As such, the novels intervene in current recovery discourse by highlighting the shortcomings of the modern-day recovery agenda within mental health services while depicting alternative routes toward mental health improvement that help diversify the understanding of what recovery looks like. While these are laudable contributions that educate readers and challenge dominant recovery paradigms, fiction could further empower the mentally ill by including stories that normalise recovery and subvert the prevailing narrative in which recovery is relevant only as a problem. Furthermore, novels that depict a version of mental health services that is actually effective in promoting recovery would be welcome additions to the literary canon as would those that explore recovery entirely outside of the medicalised diagnosis-treatment-recovery paradigm. Both novels are clear that recovery is rooted in empowerment, demonstrating how mentally ill women are doubly disenfranchised by connected – not competing – forms of discrimination, and novels that further consider ways in which this can be overcome would undoubtedly contribute to the aims of the disability movement.

While Allan satirises governmental regulations and bureaucratic red tape to politicise her readers and drive home the inefficiency of the public healthcare system in the UK, a similar criticism of the American private healthcare system is absent from *Rabbits for Food*. That said, Kirshenbaum isn't necessarily disserving the mental health community by suggesting issues like insurance, access and quality of care aren't relevant within mental health – they absolutely are, and no author who has done their due diligence in researching would conclude otherwise; rather, Kirshenbaum is illustrating that even in a world devoid of these issues, in a near-utopian healthcare landscape where cost and insurance are never mentioned, Bunny still struggles to recover. Kirshenbaum's omission is a purposeful one employed to show that money – while it can buy top-notch insurance and access to state-of-the-art care – can't buy happiness. Or recovery. While this is certainly a message worth sending, narratives that do address the problematic nature of American healthcare in regards to mental health would be well received, as would comparative stories that bridge the socioeconomic healthcare gap highlighted by the two novels.

When read within the social, cultural, medical and political context of the early twenty-first century, these narratives can be seen as reflecting and then challenging the dominant discourse surrounding mental health and institutionalisation, ultimately diversifying what it means both to be mentally ill and to recover. While many canonical novels echo the mental health trends of their times, contemporary narratives like Allan's and Kirshenbaum's do so with a breadth and purpose more extensive than that of their literary predecessors. Where Wilkie Collins's 1859 novel *The Woman in White*, which focuses on the very real Victorian fears of mistaken identity and false institutionalisation, serves to fear-monger and alarm, *Poppy Shakespeare* and *Rabbits for Food* aim to empower and politicise; Ken Kesey structures *One Flew Over the Cuckoo's Nest* (1962) as a Foucauldian condemnation of the institution as barbaric and authoritative, while Allan and Kirshenbaum offer a more nuanced critique of institutionalisation that hinges on enablement, isolation and bureaucracy as impediments to recovery. *Poppy Shakespeare* and *Rabbits for Food* break new ground by striking a balance between condemnation and hope, allowing for the conveyance of a multitude of recovery-oriented issues which can equip the reader with knowledge, empathy and the desire to better the world around them. The institution is not merely a setting in which a plot unfolds – it *is* the plot. These novels move beyond canonical depictions of institutionalisation to show its relevance not simply as a prison for the mentally ill or an instrument of socio-emotional destruction but as a microcosm of the mismanagement of recovery. Consequently, neither Allan nor Kirshenbaum gives the reader a happy ending, instead aligning the ambiguity and uncertainty of their final scenes with the nebulous nature of mental illness and recovery. To this end, *Poppy Shakespeare* and *Rabbits for Food* break with previous depictions of institutionalism that portray in-patient treatment as protracted, but ultimately constructive, as in *The Bell Jar* (1963), *I Never Promised You a Rose Garden* (1964) and *She's Come Undone* (1992). *Poppy Shakespeare* and *Rabbits for Food* are complex novels that aim to spark conversations rather than quell them with definitive answers, seek to resist rather than reinforce stereotypes, and serve to broaden the scope and audience of representations, marking, ultimately, the emergence of a new, more inclusive, uncapitalised, de-naturalised twenty-first century recovery narrative.

Chapter Four: Power, Identity and Race: An Intersectional Look into Jacqueline Roy's *The Fat Lady Sings*, Helen Oyeyemi's *The Icarus Girl* and Mira T. Lee's *Everything Here is Beautiful*

> The actuality of our layered experience is *multiplicative*.
> Multiply each of my parts together, one x one x one x one x one, and you have *one* indivisible being.
> If you divide one of these parts from one you still have *one*.
>
> Critical race feminist Adrien Wing[1]

This chapter explores intersectionality in contemporary fiction, focusing on the ways in which existing marginalities, such as race, ethnicity, sexuality, class and age, interact with mental illness – and each other – to influence power relations, generate social inequality and complicate identity processes. As Patricia Hill Collins and Sirma Bilge explain, "Intersectionality is a way of understanding and analysing the complexity in the world, in people, and in human experience" (25); recent novels have opened up the critical space by depicting increasingly multifaceted characters whose varied backgrounds help democratise our understanding of disability. Mental illness – and disability at large – does not occur within a vacuum of white, middle-class heterosexuality, and I aim with this chapter to engage with the growing field of intersectionality scholarship that recognises this plurality and challenges the separation between and hierarchies within multiple marginalities.

As Mary Romero argues, "It is impossible to understand the effects of gender, age and class as the sum of '-isms'" (12), and intersectionality serves to dismantle this additive approach to oppression. The investigation into the mutual constitutive nature of gender, race, class, sexuality and disability helps erode the historical compartmentalising of minority that scholars condemn as exclusionary and limiting: in 2002, psychologist Rhoda Olkin queried when those aboard the diversity

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[1] Adrien K. Wing's "Brief Reflections toward a Multiplicative Theory and Praxis of Being," page 194, emphasis hers.

train would “hold the door” for those with disabilities (Olkin), citing a predominance of ableness within minority studies, four years before Christopher M. Bell similarly questioned the absence of non-white scholarship in disability studies (Bell, “Introducing White Disability Studies”). As the twenty-first century progresses, academics are responding to this call for a broader spectrum of intersectionality with journal articles, anthologies and research, alongside authors like Jacqueline Roy, Helen Oyeyemi and Mira T. Lee whose narratives about women at the intersection of multiple avenues of oppression are reaching the general public and beginning to receive the critical attention that they deserve.

I pause here to briefly unpack the term ‘intersectionality’ and rationalise my choice to use it as a key concept in this chapter. Romero is careful to distinguish between “diversity” and “intersectionality,” explaining that diversity is not invested in power relations but rather “celebrating difference for the sake of inclusion,” which does not “dismantle the everyday practices of privilege or oppression” (38); intersectionality is not simply exposure to differences but rather exposure to the inequity and imbalance of power brought on by a combination of differences. Diversity is including a picture of a black girl in a wheelchair on a primary school poster; intersectionality is showing the way that her gender, race and disability interact to impede her access to curriculum, resources, friends and play, or the manner in which her school experience differs from that of an able-bodied white boy. While it is important to praise the inclusion of diverse women in the contemporary fiction of mental illness, this is not enough, and this chapter sets out to explore the ways in which these women’s overlapping differences are embedded in a complex oppression that they seek – both consciously and subconsciously – to resist. Through an analysis of three contrasting depictions of intersectional identity, I contend that contemporary literature configures the lived experience of multiple marginalities as a recursive, unending process of reconciliation that is both empowering and overwhelming, isolating and also uniting, yet ultimately “transformative” (Collins and Bilge 134): I argue that fiction of today contributes to timely debates on identity politics, power structures and social inequity in a recuperative way that emboldens readers to self-reflect and converse, to challenge and engage, and to actively champion the social justice that lies at the heart of intersectional theory.

History of Intersectionality

As Collins and Bilge explain, “Intersectionality’s history cannot be neatly organised in time periods or geographic locations” (63), with its “core ideas of social inequality, power, relationality, social context, complexity, and social justice formed within the context of social movements that faced the crises of their times, primarily, the challenges of colonialism, racism, sexism, militarism, and capitalist exploitations” (Collins and Bilge 64). Though many scholars link the birth of intersectionality to Kimberlé Crenshaw’s coining of the term in the late 1980s, the idea of intersecting oppressions had been percolating for decades at that point, as decentralised but concomitant movements and collectives fuelled by women of colour.

In the 1960s, women’s growing disenchantment with the Black Power and Chicano Liberation movements within the United States – de facto patriarchies that failed to address the feminist agenda – led African American women to self-politicise as ‘black feminists’ and Mexican American women to form an autonomous Chicana feminist movement. The decade following saw a proliferation of political pamphlets, essays and creative writing[2] that confronted the social injustice specific to African American women that “could not be solved by race-only, or class-only or gender-only or sexuality-only frameworks” (Collins and Bilge 65). This culminated in 1977 with the Combahee River Collective’s (CRC) “A Black Feminist Statement” that focused on “how systematic oppressions of racism, patriarchy and capitalism interlock” (Collins and Bilge 67), as well as heterosexism and homophobia. As part of this collective of black feminists, Barbara Smith explained: “I didn’t have to leave my feminism outside the door to be accepted as I would in a conservative Black political context” (Collins and Bilge 68), and the CRC not only created a welcoming space for

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[2] *The Black Woman* (1970) by Toni Cade Bambara, Frances Beal’s essay “Double Jeopardy: To Be Black and Female (1969); Maya Angelou’s poem “Still I Rise” (1978); the formation of “Where We At” Black Women Artists Inc (1971), a collective of Black women artists; *The Bluest Eye* (1970) by Toni Morrison; Alice Walker’s *Meridian* (1976) and many others

those like Smith, it birthed many of intersectionality's key terms – 'interlocking,' 'manifold,' 'simultaneous' and 'synthesis.' Though black women like Sojourner Truth, Maria Stewart and Anna Julia Cooper[3] had written and spoken about their experiences of multiple marginalities a century earlier, their stories and messages failed to reach the masses, and it took the widespread civil rights movements of the 1950s and 60s to generate a large-scale, receptive audience that could instigate the kind of political activism achieved by the CRC.

The Chicana feminist movement gained traction within a similar timeframe, with several key works carving out political space for Chicana empowerment.[4] *This Bridge Called My Back: Writings by Radical Women of Color* (1981), a pioneering collection of writings from black, Chicana, Latina, Native American and Asian American women edited by Cherrié Moraga and Gloria Anzaldúa,[5] laid the foundation for collaborations between women from different racial and cultural backgrounds. Asian American feminism emerged within universities such as UC-Berkeley and San Francisco State University, where the efforts of female Asian American students led to the publication of the journal *Asian Women* in 1971. Anthologies *Making Waves* (1989) and *The Forbidden Stitch* (1989) shared creative writing and artwork from women of a multitude of Asian backgrounds. Indigenous/Native and Latina feminism began to take foot in the United States toward the end of the twentieth century as well.

In Britain, 'black' feminism merged the experiences of African, South Asian and Caribbean women to mobilise a large contingency of women originating from elsewhere in the Empire. The Organisation of Women of Asian and African Descent (OWAAD) was active between 1978 and 1983 and condemned the role of colonialism in their ongoing subjugation: "When we use the term 'Black,'

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[3] Truth's 1851 address "Ain't I a Woman?" to the (mostly white) Women's Rights Convention; Stewart's 1831 essay "Religion and the Pure Principles of Morality, the Sure Foundation on Which We Must Build" and subsequent speeches on black women's oppression; Cooper's 1892 *A Voice from the South: By a Black Woman of the South*

[4] Writings such as Dorinda Morena's anthology *La Mujer – En Pie de Lucha* (1973) and Marta Cotera's 1976 and 1977 monographs

[5] Anzaldua's *Borderlands/La Frontera: The New Mestiza* (1987) furthered the Chicana feminist agenda and remains a core text on race, class, gender and sexuality today.

we use it as a political term. It doesn't describe the skin colour, it defines our situation here in Britain. We're here as a result of British imperialism, and our continued oppression in Britain is the result of British racism" (Collins and Bilge 75).

As Collins and Bilge explain, "By late 1970s and into the 1980s, the core ideas in social movement settings began to develop a shared vocabulary, or signifiers of intersectionality" that avoided the "pitfalls of additive approaches" (76), and by the 1990s, social institutions responded by openly recruiting previously excluded people. Universities around the world began to add race, class and gender studies courses to their curriculum, but this intersectionality still "found itself fighting for space and legitimacy within prevailing academic politics" (Collins and Bilge 79), balancing an adherence to academic norms with its heavily politicised, outspoken pedigree. It is within this landscape of tenuous inclusion that the desire for an umbrella term became popular, with the hope that it "might enable coalition building among the exponentially growing study area of race, class, and gender" and "help legitimate the kind of scholarship produced within these areas by making it more compatible with academic norms of discovery, authorship and ownership" (Collins and Bilge 80). In a 1989 article published in University of Chicago Legal Forum,[6] Kimberlé Crenshaw coined the term 'intersectionality,' identifying areas of intersectionality and suggesting how to use it as an analytic tool in a subsequent 1991 article. By the early 2000s, Collins and Bilge argue that "intersectionality's presence within academia is everywhere" (98), in journals, anthologies, special editions of journals and books, entrenching its social value and legitimising it as an avenue of inquiry and praxis.

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[6] "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" (Crenshaw) remains a key text in intersectionality today, the first to argue that the "convergence of discrimination and disadvantage" resulted in experiences that could not be "adequately addressed or remedied by legal and social systems that evaluate racial and sexual discrimination separately" (Samie).

Disability and Intersectionality Today

As intersectionality continues to develop in the twenty-first century, it has branched out from its largely race, class and gender centred roots[7] to include similarly complex areas of marginalisation like disability, religion and sexuality, all the while holding fast to its tenets of power relations, in/equality and identity. Contemporary studies involving intersectionality focus largely on overlapping marginalities as a source of stress or inequality, for example, Do et al.'s 2019 study surrounding the psychological impact of racial segregation and poverty on black Americans (Do et al.), or Bastos et al.'s 2018 investigation into the link between health care barriers and racial discrimination, sexuality, gender and class (Bastos et al.). This supports Collins and Bilge's argument that "when it comes to the organisation of power, different people find themselves encountering different treatments regarding which rules apply to them and how those rules will be implemented (9), ultimately showing how the mutually constitutive nature of race and gender influence "who is advantaged or disadvantaged within social interactions" (7). I will show in this chapter how recent fiction engages with this notion of power relations and how the confluence of race, ethnicity, gender, sexuality and mental illness not only disenfranchises modern women but empowers them as well. While academic studies serve as black-and-white evidence that overlapping marginalities often create stigma and generate problems, fiction allows for an exploration into the shades of grey that lie beyond statistics and case-studies. Novels like Roy's *The Fat Lady Sings* and Lee's *Everything Here is Beautiful* offer insight into the lives of the women whose mental illness sits alongside other areas of marginality, their ups (Gloria's rebellious singing at gaining her freedom) as well as their downs (Lucia's mental illness negatively influencing her work opportunities), situating their resistance to these stigmas and inequities as both politically and personally transformative.

Collins and Bilge go on to argue that "using intersectionality as an analytic tool means contextualising one's arguments, primarily by being aware that particular historical, intellectual, and

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[7] Romero explains that "race, class and gender" were referred to as the "holy trinity" in the 80s (1).

political contexts shape what we think and do" (28), and novels offer a platform in which to explore these perspectives. *Everything Here is Beautiful* examines the cultural stigma toward disability within American immigrant communities, exploring how Lucia's first and second husbands, Russian and Ecuadorian immigrants, respectively, configure her mental illness as shameful and life-limiting, seeking to attenuate it through familial support outside of the medical realm. Lucia's sister Miranda must navigate Chinese American cultural expectations when caring for her, revealing how transnational identity shapes access to treatment and understanding of mental illness. In contrast, *The Icarus Girl* situates its exploration of psychological distress within the legacy of British imperialism: Jessamy's dual heritage as Nigerian and British is represented not simply as a personal conflict but as an embodiment of postcolonial tensions, where Yoruba spiritual traditions clash with Western psychiatric frameworks. Meanwhile, Jacqueline Roy's *The Fat Lady Sings* foregrounds the racialised and gendered exclusions of 1990s Britain, where Black women's experiences of mental illness are compounded by institutional neglect, the erasure of their sexual identities and the conflict between Afro-Caribbean and British expectations, resulting in an intensely isolating marginalisation. Taken together, these novels highlight how women's encounters with mental illness are never purely individual, but are profoundly shaped by cultural context – whether through migration and diasporic ties, colonial histories or the intersection of race and sexuality in late-twentieth-century Britain. These women's lives are complicated not just by the juxtaposition of multiple marginalities, but by the times and places in which they exist.

While intersectionality as an avenue of analysis is nothing new, disability as a facet of identity and component of intersectionality is still an emerging idea, with scholarship involving the relationship between mental illness and other marginalities particularly sparse. The integration of disability into feminist, critical race and LGBTQ theory is certainly underway, with Rosemarie Garland-Thomson advocating for a feminist disability studies in 2002, arguing that "disability is still not an icon on many critical desktops" ("Feminist" 2) despite interacting with registers of race, sexuality, gender and ethnicity in a way that "support[s] an imaginary norm [,] structure[s] the relations that grant power, privilege, and status to that norm" ("Feminist" 4) and invites critical attention. Christopher M. Bell and Therí Alyce Pickens have pushed the link between disability and race, with Bell's Swiftian essay, "Introducing White Disability Studies: A Modest Proposal" calling out disability studies for its white-centred approach (Bell) and Pickens' *Black Madness :: Mad Blackness* (2019) reconceptualising the interaction between blackness and disability.

Scholars have begun to examine the link between disability, race, ethnicity and gender in literature, an endeavour I aim to further in this chapter with my discussions of female mental illness in contemporary fiction. In *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*, Garland-Thomson investigates the disabled black women of Ann Petry, Toni Morrison and Audre Lorde, suggesting that they signify an emancipatory difference that precludes assimilation and challenges cultural norms. A special 2006 edition of *MELUS* titled Race, Ethnicity, Disability and Ethnicity sets out to fill a similar research gap, with editors Jennifer C. James and Cynthia Wu noting that "there is very little work that addresses the ways in which the categories of race/ethnicity and disability are used to constitute one another or the ways that those social, political, and cultural practices have kept seemingly different groups of people in strikingly similar marginalized positions (James and Wu 4). The journal covers a spectrum of topics ranging from trauma in *The Farming of Bones* to language and body in *The Woman Warrior*, with Anna Mollow's analysis of race, gender and mental illness in Meri Nana-Ama Danquah's memoir *Willow Weep for Me* and Éva Tettenborn's investigation of non-pathologised sadness in contemporary African American literature serving as forays into non-physical disabilities. Mollow configures Danquah's depression as both "personal misfortune" and "social problem," concluding that "if despair is both a cause and a symptom of depression, then perhaps part of its solution is a hope that is both personal and political" (88), citing the autopathography's subtitle – *Black Woman's Journey Through Depression* – as evidence of this faith. Tettenborn notes how "African American writers employ and critique melancholia to comment on the relationship between the black self and its losses" (116), praising contemporary fiction for achieving the "seemingly impossible by portraying resistant subjects created out of losses" (107).

Bell's 2011 anthology *Blackness and Disability: Critical Examinations and Cultural Interventions*[8] and Alice Hall's edited volume *The Routledge Companion to Literature and Disability* evidence additional ventures into intersectionality within literature.[9]

While scholarship connecting disability to issues of race, ethnicity, gender and sexuality is beginning to find its footing within intersectionality theory, there is substantial room for additional research. If, as Simi Linton argues, disability "is a prism through which one can gain a broader understanding of society and human experience" (117) and, as Collins and Bilge explain, "Intersectionality is a way of understanding and analysing the complexity in the world, in people, and in human experience" (25) it seems only natural that the two become more fully integrated. Important work is being done to join up disability studies and other areas of marginalisation, but there is a clear gap in intersectionality research involving female mental illness and twenty-first century fiction, one that I endeavour to reduce with my research.

Arguably the most controversial and divisive aspect of intersectionality is its relationship to identity, with some critics warning that configuring identity as the defining feature of intersectionality is both limiting and destructive,[10] with others, like Collins and Bilge, disagreeing, claiming that critics don't believe there is too much identity in intersectionality but rather that there is "too much *identity politics* in intersectionality" (126, emphasis theirs). Collins and Bilge applaud intersectionality's ability to aid self-understanding and self-acceptance, noting that "focus on the social construction of identities has been a space of individual and collective empowerment" (114). Additionally, intersectional approaches challenge the essentialist view of identity, the belief that

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[8] Bell's volume includes Michelle Jarman's analysis of race and mental illness in Bebe Moore Campbell's *72-Hour Hold*, Stella Bolaki's investigation of illness in Audre Lorde's work, and Ned Mitchell's examination of 'borderlands' in Piri Thomas's *Down These Mean Streets* and Susana Aiken and Carlos Aparicio's *The Transformation.*

[9] Hall's volume includes Siobhan Senier's investigation into disability in indigenous literature, Sami Schalk's look at disability in black speculative fiction, and Chris Foss's exploration of disability in graphic novels and comics.

[10] Jennifer Nash criticising the overemphasis on the black woman's experience (Nash); Darren Lenard Hutchinson condemning intersectionality's focus on women of colour (rather than men and white women) as exclusionary and patriarchal rather than universalising (D. Hutchinson).

identity is a fixed entity carried from one situation to the next, instead supporting a more subjective perspective that Romero likens to a Rubik's cube with a "rotating mix of identities and shifting systems of domination which result in certain social identities being more salient than others at a given time and place" (11). Collins and Bilge agree that social context plays a vital role "in how people use identity to create space for personal freedom" (125). The main criticisms against intersectionality identity politics hinge on its propensity to foster separatism, linking with Nancy Ehrenreich's notion of an "infinite regress problem" (263) in which multiple divisions create increasingly smaller groups (middle-age, upper-class black lesbians, for example);[11] the objection is that such an emphasis decentres class analysis in favour of individualised forms of struggle that fail to bring systemic change. By prioritising cultural recognition over economic redistribution, some critics argue that identity politics is not political enough; while a valid criticism, one could argue that social acknowledgement begets "individual and collective empowerment" (Collins and Bilge 114) and influence, which can then engender economic change, and therefore cultural recognition and economic redistribution need not be seen as quite so adversarial. Finally, critics like political scientist Wendy Brown express concerns that, because it relies on "a compulsive repetition of traumatic events" (Collins and Bilge 129), identity politics may inadvertently trigger a victim mentality seeped in passive, disempowering oppression, a self-conception that is anathema to the change identity politics seeks to evoke.

While I do touch on fiction's wider contribution to contemporary intersectional theory, such as its recognition and destruction of damaging stereotypes and its depiction of power imbalances and social inequities, I primarily seek to interject in this conversation on identity, focusing on how *The Fat Lady Sings*, *The Icarus Girl* and *Everything Here is Beautiful* present three contrasting views on identity that coalesce to configure identity as transformative and coalitional: Roy's, in which

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[11] Similarly, Judith Butler mocks the 'etc.' that often follows lengthy lists of social divisions mentioned by feminists, viewing it as a "sign of exhaustion as well as of the illimitable process of signification itself" (J. Butler 182); however, this criticism loses relevance within an intersectional approach that admonishes a hierarchal system and replaces it with one of mutual constitution.

Gloria and Merle find a joyous freedom through accepting their identities as mentally ill (and in the former's case, homosexual) black women, Oyeyemi's Jess, whose hybridity births an abject turmoil that requires the forging of a new diasporic identity to gain this self-acceptance, and Lee's, whose protagonist resists identification altogether, instead vying to be a citizen of a global world. These novels intervene in ongoing debates by both debunking the criticisms of identity politics within intersectionality – for example, Gloria and Merle joining forces to find happiness, despite their differences in age, degree of illness, cultural background and sexuality, thus defying the fear that intersectional identity fosters a separatism that cannot be overcome – and also validating them, as with Lucia's desire to override her confusing multitude of individual identities with a universalising identity as a human being.

Together, Roy, Oyeyemi and Lee's novels offer an inside-out look at identity that establishes it as a versatile and complex entity comprised not just of the race, ethnicity, disability and sexuality presented to the public, but of the hope, fear and love experienced silently within as well. This inner dialogue positions fiction as a unique location to examine the lived experiences that intersectionality seeks to better, to investigate the challenges of these women in a way that exposes the raw emotion of day-to-day living and offers insight into the effusive reach of both overlapping marginalities and mental illness. This thesis aims to fulfil Collins and Bilge's call for intersectional approaches that investigate "how understandings of the politics of identity can constitute *a starting point for intersectional inquiry and praxis and not an end in itself*" (132, emphasis theirs) by suggesting ways that fiction can prompt conversations, can educate and elucidate, can spur on the "praxis" of self-reflection and self-advocacy that can in turn politicise readers to fight for personal or collective betterment and the social justice that underpins intersectionality.

Surmounting "spirit murder" in Jacqueline Roy's *The Fat Lady Sings*

In her 1993 book *Sisters of the Yam*, author and activist bell hooks explores black women's emotional health within social systems of domination, notably sexism and racism, and the ability of community to foster healing: “It is important that black people talk to one another, that we talk with friends and allies, for the telling of our stories enables us to name our pain, our suffering, and to seek healing” (8); Samara Linton and Rianna Walcott answer hooks’ call for community in their 2018 anthology *The Colour of Madness: Exploring BAME Mental Health in the UK*, dedicating their book to “those past and present who were not able to tell their stories. For those who told their stories but were not heard. For those who are steeling themselves, waiting for their moment to speak” (Dedication). It is clear from this dedication that nearly 30 years after hooks’ work, the voice of black women – and certainly the mentally ill black women – continues to be supressed, though the merit in sharing it remains invaluable. The pain and suffering to which hooks refers, as well as the silencing indicated by Linton and Walcott, coalesce to epitomise American legal scholar Patricia William’s idea of “spirit murder” (127), a form of non-physical racial violence that destroys the spirit and humanity of non-white individuals by denying them inclusion, safety and acceptance. While Williams speaks primarily about racism, I expand her idea in this chapter to include the power inequity and marginalisation experienced by those who live at the juncture of racism, sexism, homophobia and ableism, using Jacqueline Roy’s *The Fat Lady Sings* to exemplify the systematic “spirit murder” within mental health systems and the ability of community and self-acceptance to counteract it.

I will also engage with Therí Alyce Pickens’s *Black Madness :: Mad Blackness*, in which Pickens argues that “critical discourses about madness and Blackness tend to implicate but not include each other” (3), with the two too often examined analogously or as extensions of one another in an overly simplistic manner that inevitably leads to the priority of one over the other. Pickens’ methodology focuses on the conjunction of blackness and madness, not the competition between, spaces where “Blackness and madness become usefully entangled” with a goal “not to unravel them but rather to pinpoint the facets of their intertwining so that we might rest with the knots history and culture have created” (Pickens, *Black Madness* 11). Pickens sets out to break down the borders that have been drawn between blackness and madness. She turns her analysis to Black speculative fiction, organising her book not into chapters but into conversations that she suggests "intertwine, agree, and, perhaps, rebuke each other" (Pickens *Black Madness* 20), offering a new conceptualisation of black mental illness that "challenge[s] the paradigms of subjectivity that white supremacy and ableism enforce" (Back cover copy) in a way that prompts dialogue, not resolution. Using Pickens' argument as a springboard, I set out here to show how black madness and mad blackness diverge and collide in *The Fat Lady Sings*, interacting with other facets of marginalisation like lesbian sexuality and cultural displacement to both subjugate and embolden Roy's characters, to simultaneously obscure and clarify their understanding of themselves; through her lyrically beautiful depiction of the two black women's intertwining experiences, Roy gives a nuanced presentation of mental illness as coloured through non-hierarchical lenses of race, class and sexuality in a way that helps broaden the notion of what it means to be part of Black Britain. Merle and Gloria's joint quest for healing not only elucidates hooks' notion of communal empowerment but ultimately reveals a resistance to repeated attacks on their personhood, an affront to Williams's notion of "spiritual genocide" (155).

The Fat Lady Sings is itself a metaphor for the silencing of black, mentally ill women; originally published in 2000, the novel quickly and quietly disappeared from bookshelves after failing to attract critical and commercial success, a testament to the racially rooted "historical bias in British publishing" that boasts a canon of "prevailing white orthodoxies" (Evaristo vii). In an effort to challenge this literary hegemony, author Bernardine Evaristo re-released *The Fat Lady Sings* in 2021 under *Black Britain: Writing Black*, a series curated with Penguin UK to "resurrect texts that will help reconfigure black British literary history" (vii) by propelling the voices of these marginalised authors and characters back into circulation. Roy's novel, set in 1990s London, explores the lives of 50-something Gloria and 20-something Merle as they are disenfranchised and disillusioned by a mental healthcare system grounded in white cultural values. Roy's use of Gloria and Merle as dual protagonists is equally empowering; their alternating narratives create a polyphonic space that resists hierarchical silencing and counterbalances the loneliness of exclusion that both feel.

When visiting the Maritime Museum in Greenwich, Merle notes a distinct absence of slave ships, an overt erasure of black culture from British history that mirrors the lack of black mentally ill women in canonical fiction. Historically, literary criticism and academia have focused their inquiry into women's mental health on a multitude of white characters and authors – Plath's Esther Greenwood, Woolf's Clarissa Dalloway, Chopin's Edna Pontellier, Brontë's Lucy Snowe, Fitzgerald's Nicole Diver, Perkins Gillman's narrator in "The Yellow Wallpaper," to name but a few, offering largely sympathetic and empowering readings of white mental illness;[12] conversely, the most prominent representation of black madness – Brontë's Bertha – is a dehumanised villain whose mental illness is caricatured to such an extent that it necessitated the release of an unofficial prequel a century later to contextualise and validate the character's mental state. Evaristo's *Black Britain* seeks to intervene in this disparity by re-inserting BAME characters into the literary repertoire in a way that destabilises stereotypes of black madness and normalises mental illness within the black community. Though Bertha's madness was reclaimed in *The Wide Sargasso Sea* in 1966 with Jean Rhys linking her poor mental health to Victorian patriarchy and the social-political climate of the West Indies, Roy's novel is similarly empathetic in its first iteration, showing a progressive move within the fiction of black female mental health. Gloria, Merle and their mental health are front and centre in *The Fat Lady Sings*; they aren't relegated to the wings of the plot (or to an attic), nor are they demonised. They are not setting fires or terrorising past lovers with animalistic wrath like Bertha, but simply doing their best to live their lives alongside mental illness.

More than 150 years after the publication of *Jane Eyre*, the 'angry, black woman' (ABW) stereotype continues to pervade both television and cinema screens, with her aggressive, illogical, bitter and domineering behaviour frequently referred to as 'crazy' or 'insane'[13] in what mental health columnist Savala Nolan argues is a continued attempt to "control and undermine Black

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[12] One must only read my literature review to see this evidenced in full

[13] *Amos 'n' Andy* (1951-1953), *Sanford & Sons* (1972-1978), *Good Times* (1974-1979), *The Jeffersons* (1975-1985), *Martin* (1992-1997) *The Jerry Springer Show* (1991-2018), *The Maury Povich Show* (1991-2022), *Big Momma's House* and sequels (2000, 2006, 2011), *Barbershop* and sequels (2002, 2004, 2016), *Diary of a Mad Black Woman* (2005), *Why Did I Get Married* (2007), *Everybody Hates Chris* (2005-2009)

women" and "protect a status quo" (Nolan) in which Black women are irrational rather than rightly aggrieved by real-world issues. Nolan goes on to explain that not only is black woman's anger often conflated with madness, the ABW stereotype can also feed mental illnesses like anxiety: "There are quantifiable consequences to living in a culture that plasters a demonising stereotype to people who express normal human emotions. Instead of showing your anger, you stifle it — and it burrows inward and hurts." Nolan ends her column by suggesting we craft a new world that challenges the ABW trope, "a world in which we care how Black women are doing, and in which we want to hear them speak" (Nolan); it is a world that hooks, Linton and Walcott wholeheartedly support and one that Roy endeavours to create with *The Fat Lady Sings*.

Not only does Roy's novel deviate from the damaging and all-too-common ABW characterisation, it also breaks from Michele Wallace's well-cited myth of the Black Superwoman, a woman of "inordinate strength, with an ability for tolerating an unusual amount of misery" (Wallace 107) who can easily overcome any obstacle, including, one can assume, mental illness. Many scholars denounce this stereotype of the strong black woman, with hooks condemning society for "socializ[ing] everyone to believe that black women were put here on this earth to be little worker bees who never stop" (hooks 41) and critical race feminist Guilaine Kinouani adding, "In a world that orders you to keep strong and, to take the bricks of oppression thrown at you with a smile, our tears are political. Our tears are victories" (i). Merle and Gloria are not invincible; they are not impervious to their traumatic pasts, with Roy linking Merle's miscarriage and troubled upbringing to the voices in her head, and Gloria's grief over the death of her long-time partner Josie to the loneliness that drives her perceived mental illness. Kinouani adds, "Being vulnerable is revolutionary. It is deeply humanising. And saying we are hurting is also often giving ourselves permission to start to centre our psychological needs" (i). Gloria and Merle are neither monster nor superhero, neither destroyed by nor unperturbed by their mental illnesses. Their struggle with their illnesses and the mental healthcare system smacks of reality, not myth, not caricature. *The Fat Lady Sings* is an empowering novel that promotes social acceptance and subverts dominant discourse by presenting black, mentally ill females as strong yet vulnerable, troubled yet optimistic, but above all, human.

The Fat Lady Sings is a kaleidoscope of representation, giving voice not only to the black female experience of mental illness, but also breaking with the "heteronormative convention of black British writing" (Evaristo x). In her introduction to the novel, Evaristo notes a dearth of black lesbian fiction, citing Juanita Bynum's *The Threshing Floor* (1986) and Jackie Kay's *Trumpet* (1998) as the only examples she can recall, and applauds Roy's inclusion of the homosexual Gloria as candid and progressive. Gloria's sexuality is not without issue, with Roy highlighting the lack of acceptance of her 33-year relationship with Josie as detrimental to Gloria's mental health. A pastor calls their love "wickedness," Josie's sister Emilie refers to her as "the devil in disguise" (87), and after Josie's unexpected death, Gloria is left out of the funeral arrangements by Josie's family, forced to sit in a pew at the back by herself. When Gloria shouts, "You can't shut me out" (162) during the service, she notes that the rest of the congregation pretends not to hear, "Like true Britons" (162); the underlying cultural difference between the Caribbean-born Gloria and Josie's black British family interacts with Gloria's sexuality to create a unique othering that serves as a turning point for Gloria. It is after this scene at the funeral, after this invalidation and invisibility, that Gloria decides she has had enough: "They can't hold me back. They can't say I don't exist and I am not important. Every day, I make sure everybody knows that I am here" (191). It is an 'I' that resists "spirit murder," that breaks with the cultural, racial and sexual hegemony of 1990s Britain, an 'I' for which Gloria takes a stand and is pushed down again and again. Gloria starts singing – loudly, proudly, persistently – and begins living her life for herself, without shame, only to find out that this kind of cathartic living, like her sexuality, is simply unacceptable.

Roy configures Gloria's outlandish, chaotic behaviour and incessantly jubilant singing as anathema to white culture's construction of 'normal' as "polite, quiet and not too loud" (Jibril). As Roy explains in an interview with *Bad Form* magazine's Halima Jibril, these characteristics "might be a measure of normality for White groups, but Black groups just don't fit with that, and yet that is what we are measured against" (Jibril). Gloria sings to occupy her mind, to ease her loneliness, so the "sorrow can't catch up with [me]" (Roy 6), but is taken to the mental hospital by police when a neighbour reports her for disturbing the peace. Gloria argues that the noise wouldn't have been an issue if she were white, but "if anybody black makes a noise, everyone gets scared there's going to be a riot" (9). Even within the walls of the institution, she finds that her expressive way of living is objectionable. "When you went for the walk the other day, you were very loud and jumping around a lot," chides one of the white doctors during ward rounds. Dr Daley continues, "And then on Saturday, at the Founder's celebration, you were so excitable and agitated that you had to be sedated," targeting Gloria's fervour as problematic rather than his staff's tacit use of medicine as behaviour management. Gloria agrees that these events happened, "But there is different ways of seeing it. [. . .] What is excitement to some people is normal behaviour to others, isn't it?" Dr Daley retorts: "This is the crux of the matter, Gloria. Your view of what is normal conflicts with that of most other people" (139). Roy makes it clear that "most other people" is white British culture, and Gloria's response speaks volumes: "So how come you're so sure that you are right and I am wrong?" (140). The doctor says only that Gloria's judgment is impaired, and with this unsatisfactory answer, Roy leaves the question purposely lingering for the reader to consider. As Roy explains, "There's a huge denial of Gloria in this novel, and it's happening on multiple different levels from race, class and sexual orientation. [. . .] She is consistently turned off through medicalisation and told she's not allowed to sing when singing is just Gloria wanting to express her emotions" (Jibril). As Alice Hall argues, applying a postcolonial perspective to disability can "highlight the ways in which an individual's impairments may be seen radically differently, indeed perhaps not as a disability at all, depending on the community in which they live" (Hall, *Literature* 50). Neither Gloria's sexuality nor her exuberant living fit within the thresholds of British acceptance, and Roy, through Gloria, challenges these unspoken rules and their adherence to homogenous cultural expectations predicated upon a white, middle-class, heterosexual norm.

Hooks cites late twentieth-century novels *Sassafrass, Cypress and Indigo* (Ntozake Shange, 1982); *The Bluest Eye* (Toni Morrison, 1970); *The Color Purple* (Alice Walker, 1982); *Praisesong for the Widow* (Paule Marshall, 1983); *Maru* (Bessie Head, 1971) and *The Salt Eaters* (Toni Cade Bambara, 1980) as stories that ”address the deep, often unnamed psychic wounding that takes place in the daily lives of black folks in this society” (4), exposing the estrangement, loneliness and distress felt by those at the intersection of female blackness. In *The Fat Lady Sings*, Roy reveals how the late-capitalist twenty-first century, in which aberrations from the norm have been pathologised, labelled and medicated, has repackaged hooks' "unnamed psychic wounding" as mental illness, transforming aggrieved black women into 'mad, black women' whose healing involves a team of doctors rather than a collective of female allies. As Linton explains, "For some of us, our colours are deemed too vivid. The intensity causes heads to turn and draws attention, and we find ourselves labelled as patients, service users, and case studies" (Linton v), and this is certainly the case for Gloria, who dares to be herself – while black and female – and is in turn rewarded with medical incarceration.

As Nirmala Erevelles and Andrea Minear explain, intersectionality allows us to see "how individuals located perilously at the interstices of race, class, gender, *and* disability are constituted as non-citizens and (no)bodies by the very social institutions (legal, educational, and rehabilitational) that are designed to protest, nurture, and empower them" (129, emphasis theirs), and *The Fat Lady Sings* serves as an exploration of power politics involving mental illness, gender and race. While Evaristo claims that "the novel is not about race or racism" and "there certainly isn't an overt message that [Gloria and Merle] are treated differently on account of their identity" (Evaristo ix), the book is rife with microaggressions that do suggest underlying racial, gender and illness prejudices that result in disenfranchisement. Merle, in the midst of a mental breakdown, attacks white nurse Don at intake, with Gloria calling him "Buckra"[14] and explaining, "He views it as a black thing, a savage thing. [. . .] All the time they just keep provoking us. Then when we strike back, it proves all the prejudice they carry in their hearts" (3). Gloria's comment recalls Dr Samuel Cartwright's 1851

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[14] the slave term for white master

‘discovery’ of *Drapetomia,* a mental disorder causing slaves to run away, for which the “therapeutic early intervention” was whipping (V. Jackson 14); for centuries, the natural reaction to imprisonment – whether within the walls of a plantation or a mental institution – has been pathologised and racialized. Later in the novel, when Merle is told that she must move back in with her husband upon discharge, even though she believes that he is exacerbating her illness, it is difficult to unpick the degree to which Merle’s illness, gender and race each contribute to the doctor’s decision; one finds it hard to imagine a white man being told he must return to his emotionally abusive wife. Too often “decisions are made for people who look like me by people who do not” (vii), laments Linton. When Merle is nearly raped by a male patient, Gloria has to jump in and protect her. White nurse Don gives the perpetrator merely a slap on the wrist: “Come on Jim, get back in your own bloody bed” (199), his indifference rooted in a blurred amalgamation of misogyny, racism and ableism. Other racially-motivated microagressions permeate the novel, ranging from Louise chiding Gloria for not getting out of bed (“She believes it is laziness. It’s not just a race thing” (149)) to Merle’s tardiness to school as a child being tied to her diasporic background (“Sister Mary will call it West Indian time. She will say that she doesn’t want West Indian time in her classroom, only Greenwich Mean Time” (102)).

While the novel is free from racial slurs and glaring racism, this doesn’t necessarily mean, as Evaristo claims, that the novel isn’t “about race” (ix) or that it doesn’t send a message about racial identity. As Pickens explains, “We have not moved beyond identity because we have not moved beyond whiteness as a standard, invisibilized though it may be” (*Black Madness* 7), and until whiteness is de-centred as the norm, both within disability studies and on a larger cultural scale, the interweaving of race and mental illness will continue to tease out larger issues of power, prejudice and politics. That said, there is a level of truth to Evaristo’s statement: the novel cannot simply be “about race” because the characters’ race cannot be separated from the other elements of their identity, including their mental illnesses, genders, cultures, sexuality and age, and the novel is not so much “about race” as it is about the intersection between race and a bevy of interlocking and inter-changing systems of oppression. When Gloria is referred to as lazy for staying in bed, it is not just a knee-jerk reaction to her race, but a perception of her as a mentally ill, unfit, older black woman that garners the nurse's disdain. While the novel concludes on an uplifting note, it is not the end of the characters' journeys – both literally and in regard to their mental health – mirroring Pickens's belief that black madness and mad blackness "exceed the boundaries of a text" (*Black Madness* 112) and reject finality. Roy has tasked the reader with envisaging what lies ahead for Gloria and Merle, pondering the longevity of their confidence, contentment and freedom, and how these women's lives will continue to unfold at the intersection of sexism, racism, homophobia and ableism.

Roy's novel breaks free from the confines of previously existing paradigms in which mental illness and blackness are depicted as analogous or as competing forms of stigma to instead focus on the spaces where they become "usefully entangled" (Pickens *Black Madness* 11). Disabilities studies scholar Michelle Jarman notes that ability and race are "two dynamic discursive processes that inform one another" (91), and *The Fat Lady Sings* exemplifies this overlap by depicting blackness through the lens of madness (Merle's response at intake being viewed as savage rather than a normal reaction to being incarcerated against one's will, for example) and madness through the lens of blackness (such as Gloria's singing as a sign of mental illness in white culture). Roy's novel validates the illness experience of a social sector too often left out of the public sphere of representation in a way that neither sentimentalises black female madness nor vilifies it, with Roy explaining,

> As Black people, we are constantly dealing with that silencing process and trying to find ways of making our voices heard in a way that still enables us to keep something of ourselves. The people who licence us to be heard so often are white people, and they will do that on their terms. We constantly have to adapt to what they want from us to have a voice, and that's doubly so if you're caught up in the mental health system. (Jibril)

The Fat Lady Sings is a testament to this silencing – by doctors and nurses, by white culture, by the mother country itself – and the strength and bravery required to reclaim one's voice from a position of ostracism. As hooks argued three decades ago, "Living as we do in a white-supremacist capitalist patriarchal context that can best exploit us when we lack a firm grounding in self and identity (knowledge of who we are and where we have come from), choosing 'wellness' is an act of political resistance" (7), and it continues to be one today. Though Merle and Gloria differ in their levels of self-understanding and self-acceptance, they resist "spirit murder," instead empowered by their friendship to ignore doctors' orders and seek wellness as they themselves define it. Merle and Gloria are not the passive victims that critics of intersectional identity politics decry; they don't settle for subjugation or alter their behaviour to fit a mould. They choose themselves as they are. At the novel's close, Merle takes a taxi to the train station alone with no intentions of returning to husband Clyde, and Gloria, despite promising herself that she would act her age, "never skip" and "act ladylike" (283), decides to live her life on her own terms. Roy's concluding words serve as an invitation to live one's best life, with or without mental illness, and send a buoyant message that overlapping marginalities needn't be life-limiting or burdensome, that healing is possible through shared experience: "And then I can't help myself; I open up my mouth and I just sing and sing" (283).

Negotiating Diasporic Identity in Helen Oyeyemi's *The Icarus Girl*

Helen Oyeyemi's 2005 novel *The Icarus Girl* offers a similarly subversive configuration of race and mental health that challenges the cultural hegemony of which Pickens and Roy are justifiably critical. In Oyeyemi's novel, eight-year-old protagonist Jessamy Harrison struggles with "diasporic turmoil" (E. Stone 270), rooted in her mixed Black Nigerian-White British heritage, that leaves her feeling like she belongs nowhere. Upon visiting Nigeria with her parents, Jess befriends the mysterious Titiola, whose nickname TillyTilly mirrors both Jess's inability to embrace her own Yoruban moniker and the duality that Jess feels as a product of two seemingly antithetical cultures. Over the course of the novel, the reader begins to question the corporeal existence of TillyTilly, increasingly faced with evidence that only Jess can see her; yet, Tilly's magic is undeniable – she reveals previously unknown information about Jess's stillborn twin, speaks the Yoruban language that Jess does not, renders the girls invisible as they spy on others in plain sight. Tilly's mystical adventures evolve into more sinister games as the novel progresses, eventually resulting in a psychic break that finds Jess grappling for self-articulation and spiritual closure in the mythical Yoruban bush, a neutral, liminal space that transcends the ineluctable black/white, Nigerian/British dichotomies that underpin Jess's identity struggle.[15]

Oyememi's novel explores the entanglement between black diasporic identity and madness and sits within a larger framework of the African Bildungsroman novel alongside other recent works like *Purple Hibiscus* (Chimamanda Ngozi Adichie, 2003), *Everything Good Will Come* (Sefi Atta, 2005), 26a (Diana Evans, 2005) and *The Book of Not* (Tsitsi Dangarembga, 2006). While traditional Western Bildungsroman novels follow a protagonist's moral and/or psychological journey from childhood to adulthood, with canonical works *Great Expectations* (Charles Dickens, 1861), *Jane Eyre* (Charlotte Brontë, 1847), *Catcher in the Rye* (J.D. Salinger, 1951) and *To Kill a Mockingbird* (Harper Lee, 1960) exemplifying this, *The Icarus Girl*'s setting within a postcolonial African context complicates this maturation process, breaking with the established loss-journey-conflict-growth paradigm and other pillars of the Western genre such as plot resolution and passage of time. As philologist José Santiago Fernández Vázquez explains, postcolonial writers adopt Bildungsroman principles only to subvert them, "incorporatin[ing] the master codes of imperialism into the text, in order to sabotage them more effectively," co-opting the genre as a "strategy of resistance" (86) that re-centres the Western Bildungsroman from an African perspective. Jess's loss isn't the typical death of a loved one or fractured relationship but the loss of her sense of self, the imbalance and confusion caused by her Nigerian-British hybridity, and her path toward understanding and acceptance isn't traversed alone or with the guidance of a supportive adult but alongside the nefariously reckless TillyTilly. The novel

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[15] See Ezekiel Adesawe's "Exploring Wilderness in Yorùbá Culture: A Journey of Understanding" for more information about the role of Yoruban wilderness in their culture.

ends not with a neatly packaged conclusion but with uncertainty; unconscious after a car crash, Jess finds herself in the Yoruban bush fighting TillyTilly, and the novel's final words ("Jessamy Harrison woke up and up and up and up" (322)) can indicate either self-acceptance, further retreat into madness, or death, depending on the reading. This lack of finality substantiates the postcolonial Bildungsroman protagonist's fate "never to stop searching, to never stop wondering who they are and where they belong" (218), as Ericka A. Hoagland writes in "The Postcolonial Bildungsroman." *The Icarus Girl* adheres to traditional Bildungsroman structure just enough to leave the reader seeking the narrative closure that underpins the genre, but it never comes, with Oyememi showing instead how Jess's hybridity and madness interweave to preclude any sense of lasting peace.

While the novel itself is a hybrid of the Western Bildungsroman and postcolonial writing, a confluence of literary traditions, the title serves as a melding of cultures, with Oyeyemi linking the Greek myth of Icarus to Jess's struggle with her British-Nigerian heritage. Just as Icarus's wings – fashioned by his father to help him escape the Minotaur's labyrinth – melt when he flies too close to the sun, so too do Jess's parents fail to adequately support her in her effort to surmount her diasporic turmoil and navigate her mental health. Their conflicting views of treatment reflect their differing cultural perspectives and drive a further wedge between Jess's Nigerian and British identities rather than offering cohesion, with father Daniel trusting in Western psychology practises and psychiatrist Colin McKenzie to treat Jess, while mother Sarah leans on Yoruban animistic beliefs and the construction of an *ibeji* to release the tormented soul of Jess's deceased twin. Neither is depicted as a cure-all, with Jess's mental state linked to her duality in a way that configures acceptance, not cure, as the ameliorative tonic. Jess's relationship to her hybridity, the realisation that it is an ongoing process of reconciliation and spirituality that cannot be compartmentalised or simply surmounted, links to the notions of mental illness recovery mentioned in Chapter Three. Jess doesn't expel her Otherness or learn to deny it, in the same vein that Poppy and Bunny don't 'cure' their mental illnesses; Icarus's wings won't – can't – bring Jess closure because her hybridity is not a situation from which she can escape but rather one that she must traverse and accept.

The Icarus Girl has been the subject of much critical scholarship surrounding Jess's diasporic identity as a "half-and-half child" (236). Jordan Stouck connects Kristeva's notion of abjection with the conflict arising from Jess's hybridity and to the structure of the novel itself, with its "assertion and rejection of real and fantastic genres" and "alternation between English and Nigerian cultural references" (98). Diana Adesola Mafe analyses Oyeyemi's work as a postcolonial Gothic text that breaks from historically male-focused Yoruban bush stories; she reads TillyTilly as an otherworldly doppelganger who helps Jess navigate her hybridity by allowing her to "articulate a cultural identity between identities" (24). Focusing more on the role of Nigerian spirituality in the novel, Jane Bryce examines the *ibeji*, a statue used to placate the soul of a deceased twin, as a mitigating force that calms the *abiku*[16] that haunts Jess; Bryce applauds Oyeyemi for "revisioning the tragic fate of the 'abiku country' through the feminization of the realist novel" (Bryce 60) by suggesting an alternative, more hopeful vision for the future of the diaspora that includes the possibility of spiritual regeneration. Madeline Hron has a similarly redemptive interpretation of *The Icarus Girl* that reads the liminality of childhood as representative of "the sociocultural and psychological alienation of the immigrant" and Jess's acceptance of her Yoruban name in the closing scene as a sign of "reconciliation with Yoruba culture" (36) and newfound self-acceptance.

Despite an abundance of critical attention, very little has been paid to Jess's increasingly unstable mental state and the link between Jess's possible mental illness and her hybridity. The complexity of the novel and the multitude of possible readings renders such an analysis a difficult task, particularly as Oyeyemi resists pathologising Jess, leaving the reader to make sense of Jess's tantrums, social isolation and relationship with TillyTilly. It would be easy to view Tilly as the result of a schizophrenic break, a purely imaginative being who exists only in Jess's head; however, if this is the case, and the increasingly mischievous Tilly is the product of mental illness, then the novel sends a problematic message that mental illness is a quandary that needs eradicating. After TillyTilly starts 'getting' people and destroying property, Jess refers to Tilly as "not good" and "scary" (273) and her

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[16] a Yoruban term for the spirit of a child that dies before puberty (Nla)

friend Siobhan worries that Tilly is going to "punish [Jess] in a bad way" (272), possibly even kill her, resulting in the characterisation of mental illness as a menacing and destructive obstacle. That said, reading Tilly as symptomatic of mental illness is an oversimplified interpretation that necessitates a disregard for Yoruban culture and Jess's hybridity, which Oyeyemi makes it clear are the driving forces of the novel, and an analysis that incorporates these elements allows for a deeper, more meaningful investigation into the confluence of race, ethnicity and madness within the novel.

A more sophisticated interpretation of TillyTilly is as a mystical being – not uncommon in animistic Yoruban spirituality – whose presence causes Jess to confront her dual heritage and forge a new 'in-between' identity. This reading, adopted by scholars such as Brenda Cooper and Pilar Cuder-Dominguez, decodes Jess's madness, her screaming fits and increasingly frantic and unhinged behaviour, as an unavoidable result of racial and identity tension. As Cooper writes, "the performance of multiple identities is hazardous and may result in the loss of sanity altogether" (55), noting Jess's belief that if she could simply choose one cultural identity "she would be able to get rid of TillyTilly" and wouldn't feel so "stretched" (Oyeyemi 257). Likewise, Cuder-Dominguez views TillyTilly as a "racial shadow," a "truly Nigerian child that compensates for a diasporan subject's feelings of inadequacy and lack of ethnicity" (Cuder-Dominguez). Cuder-Dominguez engages with Sau-ling Cynthia Wong's notion of a double as "symptomatic of a crisis in self-acceptance and self-knowledge: part of the self, denied recognition by the conscious ego, emerges as an external figure exerting a hold over the protagonist" (Cuder-Dominguez), a duality that must be reconciled. While these more nuanced readings take into account Jess's hybridity and her inability to resolve this dichotomy, suggesting madness as an ineluctable outcome of dual heritage vilifies both hybridity and madness rather than the geo-political context in which they are constituted or the contemporary society that continues to stigmatise them. Establishing madness as an inevitability echoes twentieth century novels like *The Bell Jar* and *The Golden Notebook* that configure female madness as the only viable response to a harshly patriarchal society, readings that supported the emerging feminist agenda by politicising women to challenge the status quo; that said, positioning

Jess's madness as predicated upon her fixed Black Nigerian-white British heritage and individual identity limits the capacity to confront and change the social circumstances that render Jess's reconciliation of these multiple identities impossible, and such analyses begin to unravel the connection between race and madness, but unsatisfactorily so.

E. Kim Stone argues that Jess's hybridity and madness are even more entangled than the above analyses suggest, with Oyeyemi using TillyTilly as a tangible reminder of past Nigerian traumas conducted at the hands of the British, particularly the Transatlantic slave trade, thus connecting Jess's identity crisis to historical power structures. Stone contends that, in a further break from the traditional Western Bildungsroman, the adults in *The Icarus Girl* fail to proffer sensible guidance to the young protagonist, instead, offering only "amnesiac neo-colonial national identities to Jess, forms of postcolonial subjectivity that don't fit her biracial sense of self" (268) and contribute to her madness. These conflicting national identities, which begin at the start of the novel with innocent arguments between Jess's parents as to whether she should play outside like Nigerian children or read inside like British ones, become undergirded with more neo-colonial connotations once the family travels to Nigeria. On the plane, Jess has a tantrum over taking anti-malaria medication, with Oyeyemi invoking memories of the medical colonialism that allowed throngs of British to move to West Africa at the start of the twentieth century, a cultural legacy that Jess renounces in her refusal to take the pills.[17] Once they arrive at Sarah's family's complex, more neo-colonial signifiers appear, including her grandfather Gbenda's use of cologne and camphor, both European products, his crisp linen shirt and Baptist Bible group that "not only mark him as a beneficiary of British colonialism but also mark his national allegory as complicitous with indigenous African slave traders" (E. Stone 276). Building on Stone's ideas, one can see how these colonial atrocities (and any lingering benefits)

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[17] In "Colonialism, malaria, and the decolonization of global health," Jesse B. Bump and Ifeyinwa Aniebo recount how "malaria became a colonial problem, how malaria control rose to prominence as a colonial activity, and how interest in malaria was harnessed to create the first schools of tropical medicine and the academic specialization now known as global health," going on to explain how "historical experiences shape malaria policy around the world today and how the inequalities are perpetuated in the structure of global health" (Bump and Aniebo); with malaria medication historically linked to colonisation, Jess's refusal to take the medication can be seen as a rejection of the colonial attitudes of her ancestors.

remain actively disremembered, with Gbenda demonising England as the country that "curse[d]" his daughter, causing her to abandon medicine for English literature, and referring to Daniel as an "*omugo oyinbo* man who knows nothing" (27). Like Jess's habit of amending books that "hurt her" by crossing out the painful events and replacing them with "happier things" (59), Gbenda's cultural amnesia allows him to reframe his disdain for the British as a personal, not historical, issue that ultimately fails to enrich Jess's negotiation of her diasporic identity.

The forgotten trauma of British-Nigerian relations has, Stone argues, manifested in the appearance of Titiola, who first appears to Jess dressed as a slave child – barefoot, dirty, neglected – in the Boys' Quarters and calls Jess "Jessy," "a halfway thing" (41) that mirrors her dual heritage. Tilly's games centre on 'getting' those who have wronged Jess, serving as a "precarious postmemory" (E. Stone 283) that demands remembrance of and retribution for past cultural atrocities. As Holocaust scholar Marianne Hirsch explains, postmemory is a way of describing the "relationship that the 'generation after' bears to the personal, collective, and cultural trauma of those who came before – to experiences they 'remember' only by means of the stories, images and behaviors among which they grew up" (Hirsch). The truth of Nigerian-British relations has been withheld from Jess, and Tilly serves as a reclamation of the past. When Jess articulates a (naïve and childish, to Tilly) desire to belong, Tilly boils over in rage, encouraging Jess instead to "hate everyone [. . .] the whole word," reiterating the trauma of British colonialism and slavery: "Land chopped in little pieces. [. . .] It's all been lost. Ashes. Nothing, now, there is no one. [. . .] There is no homeland. [. . .] Stop looking to belong, half-and-half child. Stop. There is nothing, there is only me, and I have caught you" (249-250). While Tilly is finally able to articulate the "forgotten suffering" (E. Stone 283) of the Yoruban people, she threatens and scares Jess rather than offering a path to acceptance, and as a result Jess becomes more and more unwell.

It is only in the mythical Yoruban bush – not Nigeria, not England – but a "wilderness for the mind" (318) that Jess inhabits after she is rendered unconscious in a car crash, that Jess can begin to form a new diasporic identity. Collins and Bilge argue that "social context matters in how people use identity to create space for personal freedom" (125), but for Jess, the social contexts of both England and Nigeria offer not space, not freedom, but alienation and loneliness. Here in this in-between place of the Yoruban bush, connected to the past, Jess is free from the stigma of being too black for England, too white for Nigeria, and can begin to see the "coalitional possibilities" (133) of accepting her Yoruban roots and being part of a "collective we" (135). In a dream-state, Jess responds to her Yoruban name, Wuraola, her "true name," and plays a back-and-forth chasing game with Tilly in which she "jump[s] into Tilly's unyielding flesh [. . .] back into herself" (Oyeyemi 322). While responding to her Yoruban name might indicate a move toward self-acceptance, the final scene of "get[ting" TillyTilly, who has throughout the novel voiced postcolonial rage, in a way that "hurt them both burningly" (322), could also indicate ongoing identity confusion, further descent into madness, or even Jess's death. And this ambiguity, I argue, is the point.

The unclear ending, as well as the Yoruban poem[18] that follows, in which a leopard is referred to as a "gentle hunter" whose "tail plays on the ground / while he crushes the skull" (323), suggests that the dichotomy percolating within Jess is not simply eradicated but enmeshed in the very nature of who she is, and the process of forming this new diasporic identity is ongoing and evolving. As Stone explains, "Connecting to the past, no matter how painful that past has been, is necessary to moving beyond the helpless madness so many young female protagonists of third-generation African novels remain mired in" (285); by ending *The Icarus Girl* at the climax and denying the reader any kind of satisfying denouement, Oyememi resists the finality of the Western Bildungsroman, instead leaving the reader to decide whether or not Jess remains "mired in" her madness. Tilly has forced Jess to confront the truth of the past, to understand the historical context that complicates her hybridity, but the degree to which this has changed her remains purposely unclear, with Oyememi generating an unease and insecurity familiar to those who, like Jess, live at the intersection of multiple marginalities.

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[18] "Praise of the Leopard (Yoruba)"

While the notion of an essential identity has been deconstructed by intersectionality scholars (Brodwin, Eisenberg, Hekman, D. Kondo), *The Icarus Girl* shows how the intracategorical theory of mutual construction – which focuses on the ways that multiple categories of difference and oppression interact – can engender unique identity crises when these areas of marginality are at odds with one another. In the case of Oyememi's novel, Jess's identity as half Nigerian and half British is complicated by the historical context of British colonialism within Africa. Jess's breakdown is predicated not just on the realisation that she is too black for her white British school and too white for her black Nigerian relatives (though this inability to fit in anywhere certainly plays a part), but rather that these two categories of identity sit on opposing sides of postcolonialism, embodying both historical power and oppression, and are therefore difficult to reconcile, even in the present day. Erevelles and Minear acknowledge the difficulty in theorising overlapping fronts of oppression as mutually constitutive, questioning what happens if "some differences coalesce to create a more abject form of oppression (e.g. being poor, black, and disabled)" or at the other end, "if some differences support both privilege/invisibility within the same oppressed community (e.g. being black, wealthy, and gay)" (129); while these questions are rhetorical, meant to engage the reader and underpin the complexity of intersectional identity studies, Oyememi shows that embodying oppositional identity markers can further complicate identity processes by adding an additional layer of marginalisation – poor mental health. The cultural dichotomy present within Jess's life – her parents' differing views on play and mental health, the contrast between her British home and her grandfather's Nigerian complex – pulls Jess in opposite directions until she shatters, and she must find a way to forge a new, cohesive British-Nigerian identity. Tilly's function as a "postmemory" serves to educate Jess about the past and explain her struggle with her hybridity in a way that allows Jess not only to recognise the need for self-articulation and spiritual cohesion but to open up neutral ground – the Yoruban bush – in which she can fight for it.

In both *The Fat Lady Sings* and *The Icarus Girl*, blackness and madness need not "vie for narrative space" (Pickens, *Black Madness* 28), nor do their mad, black female characters exist simply to “shore up the values of others” (Pickens, *Black Madness* 29). The novels bring the black female mental illness experience to the forefront, presenting a spectrum of mental illness ranging from childhood to post-menopausal and underscoring issues of isolation, invisibility and identity and their relation to Black madness. The novels situate race and mental illness as an entanglement predicated upon dominant social discourse and historical precedent – not as competing levels of Otherness augmented by stigma – that proffer new conceptualisations of self- and social-acceptance. Both Roy and Oyeyemi make constructive and provocative contributions to the new canon of Black British writing by adding visibility to a diversity of experiences and shattering stereotypes of black madness, showing a growing trend in twenty-first century fiction toward de-centring white sanity as a literary – and cultural – norm.

“Too many faces” in Mira T. Lee’s *Everything Here is Beautiful*

Mira T. Lee’s *Everything Here is Beautiful* portrays contemporary mental illness as part of a larger multicultural tapestry, deftly interweaving disparate notions of disability, acculturation and identity to highlight the complex relationship between race, ethnicity and mental illness. Lee’s story spans continents and includes a diverse cast of characters ranging from Yonah (a Russian-Israeli Jew) and Stefan (a Swiss doctor) to Ecuadorian Manny and Chinese American sisters Lucia and Miranda. Lee alternates the narration between these characters, chronicling the ways in which each of their lives is derailed by Lucia’s mental illness. This narrative fluidity allows for a layered intricacy that serves both to sanctify the aims of contemporary intersectionality while interrogating some of its most recognised theories. In this section, I show how Lee’s empathetic depiction of Lucia’s schizoaffective disorder exposes and then dismantles the link between mental illness and cultural expectations, breaking Asian stereotypes – both narrative and cultural – while underpinning the inequity experienced by those at the crossroads of marginalities. Lee simultaneously confronts the notion of mutual construction by presenting a subversive view on identity performance that configures “strategic essentialism” – the shifting prioritisation of various identities (“Criticism, Feminism and the Institution") – as emotionally exhausting and socially distancing. *Everything Here is Beautiful* explores current issues of intersectionality in a way that spreads awareness and breeds empathy, with Lee explaining in an interview at the close of the novel, "To me, great fiction happens when we find the humanity in each of our characters, no matter who they are or what their situations may be. Even when we're unfamiliar with a particular experience, we can relate at an emotional level" (Lee, "A Penguin Readers Guide" 9); ultimately, Lee constitutes this empathy and understanding as a unifying force with the power to transcend social and physical differences and mitigate the oppression of racism, sexism and ableism.

By shifting the action between America, Switzerland and Ecuador and incorporating characters from a range of ethnic backgrounds, Lee examines how perceptions of mental illness – and disability – are coloured by cultural attitudes. Russian-born Yonah, who moved to Israel as a teenager, attributes Lucia's odd behaviour to their cramped living quarters and the hustle-and-bustle of capitalist New York City rather than mental illness. He rages when Lucia is admitted to a psychiatric hospital, explaining that he, as her husband, will take care of her at home: "They lock her up, like animal," he argues. "This is jail" (25), he roars. Yonah's non-Western, anti-medical view of mental illness is unsurprising given his Russian heritage[19] and directly contrasts with Miranda's opinion of her sister's treatment. Having immigrated to the United States from China with her mother at seven-years-old, Miranda's views more closely align to American ideas of mental illness rather than those of her birth country. While many studies conducted in China (Xu et al., Yin et al., Yu et al.) find a reluctance toward psychiatric referral and the stigmatisation of mental illness, Miranda fights for her sister to stay in hospital, takes copious notes regarding her medication and symptoms, and persistently pushes Lucia to take her pills. Lucia's second husband, Manny, and his Ecuadorian extended family offer the least compassionate response to Lucia's illness. Manny is "too ashamed" (84) to explain to his mother that Lucia is in the hospital being treated for mental illness,

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[19] Mental illness in Russia is viewed as a capitalist issue and largely stigmatised, with the mentally ill institutionalised in hospitals where they are prone to cruel and inhumane treatment (Jenkins et al.; Nersessova et al.; Sparks; Yuki).

and he unabashedly sleeps with other women when Lucia disappears during psychotic episodes. When Manny, Lucia and their infant daughter, Essy, move to Ecuador, Manny's aunts on the campo constantly whisper about Lucia, expressing pity for Manny's mother, Mami: "'You don't know what it's like for a mother, to see her own son this way. A man who cannot control his own wife. Ay, que verguenza.' Disgrace" (281). This failure to accept Lucia's mental illness as an issue beyond her control is mirrored by the treatment of Manny's younger brother, Fredy, who was born with Down's Syndrome. Mami embraces Manny and Lucia's relationship largely because if they marry, Manny can get a green card and bring Fredy to America, where he can receive more advanced medical treatment amid a more accepting society: "Mami said, 'In America, his kind are special. They treat them well,'" with Manny adding, "And no one accuse[s] a woman of carrying the spawn of the devil" (52). Shortly after Fredy is born, a medicine man refers to him as "a deadweight" and "a curse" (56), revealing a lingering cultural aversion toward those with disabilities that is corroborated by recent studies ("Ecuador"; Huiracocha et al.; Rattray; "Stigma").

Lee investigates the connection between Lucia's heritage as a racially Chinese, American-born woman and her mental health, with Ma and Miranda each perceiving Lucia's effortless acculturation as embroiled in her mental illness in different ways. The cultural gap between Lucia and Ma sows tension between mother and daughter, with Ma's expectations of Lucia predicated upon Chinese traditions to which older sister Miranda more successfully adheres. Ma is chagrined by Lucia's decision to study English rather than maths and science, dismayed by her abandonment of the violin for the electric bass. Miranda works a desk job in the city while Lucia travels to Vietnam, Brazil, Bolivia and Latin America to engage in various types of freelance work. Lucia values adventure over stability, freedom over security, American ideals over Chinese conventions. When Lucia first exhibits symptoms of mental illness, Miranda chalks it up to this acculturation: "For years I tried to defend my sister's free spirit as a tenacious form of American idealism, which I both respected and admired" (33), not realising that her sister has been hearing voices. Ma is more confused about Lucia's motivations, wondering, "*Why does Chinese girl born in America want to visit poor countries* *all the time?"* (33, italics in text); she ultimately chides her daughter for being "too much American" (186) and blames Lucia's worryingly erratic behaviour on American individualism and the desire to have it all. While Miranda mistakes Lucia's mental illness for extreme acculturation, Ma condemns this Americanism for fuelling it. While at first glance, Lee seems to be warning of the dangers of American assimilation on mental health, she ultimately refuses to validate Ma's indictment, ending the novel with Miranda admiring now-adult Essy and her similarities to Lucia: "Your mother was a good person, too. A dreamer, always a dreamer, wanting to have it all. This is very American, you know" (354); Lee breaks this link between American values and mental illness by framing Lucia's idealism in a positive light at the novel's close.

Lee makes it clear that Lucia's relationship with Chinese ideals – which shifts depending on the situation – is no more tied to her mental illness than her Americanism. At times, Lucia attempts to utilise Asian stereotypes in her favour, as a shield of acquiescence that she hopes will deflect pathologisation, but she fails: "That first hospital stay, I was a compliant patient, a Sweet Asian Doll, and for this I was branded with a Severe Lifelong Mental Illness" (171). Lucia is mentally ill regardless of whether she presents a passive demeanour that substantiates Asian stereotypes or whether she challenges them. This superficial attitudinal change cannot attenuate the voices she hears or the scope of her illness. The mask of conformity fails to deceive the spies that she believes are following her, with Lucia explaining that they "knew who I was, in spite of my disguise as a Sweet Asian Doll" (157). This is a change from the late nineteenth and early twentieth centuries when women who subverted female expectations of second-class domestic servitude were often pathologised and institutionalised, and then deemed 'cured' of their mental illnesses only if they complied. While patriarchal Victorian society valued subservient women, using illness to control those who would otherwise not be, Lee shows that this connection between expected behaviour and illness has been broken in modern society, not just regarding gender roles, but also ethnic stereotypes. Lucia's cultural aberration doesn't cause or exacerbate her mental illness, nor does her veil of a "Sweet Asian Doll" cure her of it. By distancing Lucia's mental illness from her adherence to cultural expectations – whether American or Asian – Lee fulfils her aspiration to show that "mental illnesses do not discriminate" (Lee, "A Penguin Readers Guide" 7) and reach all corners of society, regardless of gender, race, ethnicity or behaviour.

Lucia's tendency to disrupt Asian cultural norms is intentional and purposeful, with Lee expressing a desire to create a story that challenges these stereotypes: "[It's] important to see stories starring people of color that don't necessarily fit into the expected frameworks – for example, of an 'Asian American story'" (Lee, "A Penguin Readers Guide" 7-8) Lee explains. Though Lee doesn't elaborate on what she considers to be an "Asian American story," critical race scholar Lisa Lowe, writing in 1991, cites novels *The Joy Luck Club* and *The Woman Warrior* as canonising generational conflict as the cornerstone of Asian American fiction, noting that "the question of the loss or transmission of the 'original' culture is frequently represented in a family narrative" (26). Lowe applauds these works for feminising and heterogenising this strife through their depiction of mother-daughter relationships that vary in levels of intergenerational discord. While Lowe sees *The Joy Luck Club* and *The Woman Warrior* as progressive within the context of the late-twentieth century, Lee's narrative can be seen as ushering in a new era of Asian American fiction that moves beyond generational tension to depict more modern problems with extrafamilial, intrapersonal and social roots, allowing for a more holistic investigation into the effects of intersectionality. That said, one could argue that to engage with issues beyond the clash of first- and second-generation immigrants, which Lee does depict toward the beginning of the novel with the tension between Lucia and her mother, she has to kill off Ma, removing the possibility for future conflict altogether, thereby passively acknowledging the power of this relationship. While *Everything Here is Beautiful* expands the Asian American canon to include wider issues of culture and illness, it doesn't regard the contributions of its predecessors as now-irrelevant, and Lee stops short of completely discounting the impact of intergenerational conflict in her investigation of twenty-first century Asian American women.

In line with Lee's expressed desire to expand the repertoire of Asian American fiction, *Everything Here is Beautiful* is a multicultural story rather than strictly an "Asian American story" and Lucia's boisterous, outspoken personality deviates from the dominant American perception of Asian Americans as "smart, competent and hard-working," "quiet" and "too focused on academics, one-dimensional and lacking personal skills" (Hassan). Lucia's mental illness – which prevents her from holding down a steady job, adequately mothering her child and positively contributing to capitalist society – dispels the notion of Asian Americans as the "model minority," a term first coined by sociologist William Peterson in 1966 in response to the success of Japanese Americans, a notion that continues to feed contemporary ethnic stereotypes (Wang). It is an interesting point of intersection in which Lucia's mental illness unquestioningly impacts her life in a negative way, yet serves to squash damaging stereotypes of Asian Americans. Somewhat ironically, this self-sacrifice (albeit unintentional) for the behest of the collective is a hallmark of the traditional Chinese values that Lucia deviates from in every other way. By being both Asian American and mentally ill, Lucia becomes simultaneously more Asian American and less Asian American. It is through this lens of Asian American mental illness that Lee exposes the complexity of modern-day intersectionality, elucidating Collins and Bilge's argument that the "major axes of social divisions in a given society at a given time, for example, race, class, gender, sexuality, dis/ability, and age operate not as discrete and mutually exclusive entities, but build on each other and work together" (4).

Lucia's fluctuation between being a "Sweet Asian Doll" and "too much American" is part of Lee's larger interrogation into the shifting components of identity – ethnicity, cultural identification, mental health, immigration status, motherhood, marital status – and how these intertwine and coalesce to shape one's sense of self. The novel's engagement with identity politics challenges the idea of essentialism, the belief that we each have a fixed, 'essential' identity that we carry from place to place, from situation to situation. Lucia regularly speaks about the mutability of her identity, becoming one thing when it suits her and something else when needed, whether it be parading her Sweet Asian Doll veneer or utilising her "silly American disguise" (171) when reporting in Vietnam.

Even her name – Lucia to those outside her family, and “Mei-mei” to Ma and Miranda – changes depending on the situation. While Collins and Bilge explain that “much intersectionality scholarship supports this perspective on human subjectivity,” noting that “social context matters in how people use identity to create space for personal freedom” (125), Lucia configures this multiplicity as problematic, not emancipating. She remarks during a moment of reflection in front of Picasso’s *Girl Before a Mirror*:

> Well, the girl was me, of course. With one face for myself, one for everyone else, the People of the World. [. . .] Maybe I needed more faces, one for each person I knew, or maybe infinite, for each new person I was still to meet! And then it hit me. Oh, Great Master, revealing to me the ways of human nature, the ideal of the soul mate, why true love was so hard to find. Zing! The faces. We each had too many faces!” (169)

Lucia sees herself as fractured into pieces – Chinese, American, Chinese American, Lucia, Mei-mei, schizophrenic, mother, immigrant, writer – different faces that she wears at different times, and she struggles to work out how these interact and who she truly is. She recognises each as one facet of her identity (“Writing is part of who I am“ (228)) but not the entirety of it (“Schizophrenia does not define who I am” (178)). She envies El Pollo Loco, the strange man who dresses in a chicken costume every day and walks down Main Street, while others mock and abuse him: “There’s something reassuring about this fixed identity, instantly recognisable to everyone in the world, including himself” (164). El Pollo Loco knows exactly who he is at all times; it is an identity that trumps all others. It’s a luxury that Lucia – with her multiple and sometimes conflicting identities – doesn’t have. While contemporary intersectionality scholarship dismantles the idea of essentialism, *Everything Here is Beautiful* shows how for someone like Lucia, who struggles to navigate the many moving pieces of her identity, the idea of a single, constant identity might be desirable.

Though Lucia is unable to coalesce the facets of her identity, Lee makes it clear that any sort of identity separation or hierarchy is problematic. Lucia’s attempt at employing Gayatri Spivak’s

1996 notion of “strategic essentialism” (“Criticism, Feminism and the Institution”), a political strategy in which one aspect of identity is prioritised as a way to mobilise disenfranchised groups and evoke change, backfires, further alienating Lucia. In her new mother’s group, Lucia fails to bond with the other parents, whose primary worries are soiled clothes and sleep deprivation, whereas Lucia’s problems – like voices telling her that her baby will die if she touches it more than twelve times – are quite literally life-threatening. Lucia cannot simply leave her mental illness at the door and focus on being a mother, and rather than empowering Lucia, the group leaves her feeling like an even worse mother. Within the hospital, Lucia’s mental illness fosters a connection and understanding with other patients, but, as a mother desperate to see her child, she doesn’t quite fit in with the others, who are only concerned with themselves and content to stay on the ward. By showing Lucia as an outsider in these groups, Lee highlights the problems inherent to early-stage feminist and racial movements that “elevated one category of analysis and action above others” (Collins and Bilge 3), in which divisions prevented true cohesion. Black women felt left out of the mostly white feminist movement, and women felt left out of the male-dominated Black Power movement. Just as the development of intersectionality in the late twentieth century addressed these race-gender problems, Lee shows the need for increased advocacy for the mentally ill within other marginalized groups today. It is clear that mental illness – and disability at large – is still evolving as an element of intersectionality. In 1991, Lowe writes that “essentializing Asian American identity and suppressing our differences – of national origin, generation, gender, party, class [. . .] supports racist discourse that constructs Asians as a homogeneous group” (30); though Lowe’s sentiment can be applauded, it is striking that she leaves out dis/ability as a further category of difference. Lee’s novel, as well as growing scholarship within disability studies, is helping to highlight the importance of mental health as a component of intersectionality and the need for it to be legitimised and incorporated into other areas of marginalisation rather than viewed in isolation.

Ultimately, Lucia expresses a desire for one unifying identity rather than these fissures, to be seen as a singular person rather than an amalgamation of various pieces. While the dribblers in

Poppy Shakespeare embrace their mentally ill identity to a detrimental degree and Bunny in *Rabbits for Food* distances herself from it, Lucia advocates for the abandonment of the notion altogether, preferring instead to be seen as a person rather than a product of her illness, ethnicity or race. When asked by an interviewer why, as a Chinese American, she has spent so much time in South America, she ponders: “But what would it be, I wonder, to conduct one’s life as a Chinese life instead of just a life? I speak Chinese, I cook Chinese food, practice tai-chi on occasion and drink oolong tea, but to flaunt one’s ethnicity seems terribly gauche. I’m human first, aren’t I? Aren’t we all?” (166). Likewise, when a police officer asks her if she lives nearby, she replies, “I live in the People’s World” (91). Where Jess in *The Icarus Girl* is able, with great difficulty, to embrace her hybridity and come to terms with what it means to embody historically conflicting nationalities, Lucia’s goal isn’t to make sense of these various pieces of identity but rather to supersede them by identifying first and foremost as a human being. Lucia’s life is simply a life, not a Chinese life or a mentally ill life or an American life, nor is it a Chinese American, mentally ill life. Lee has not only succeeded in her ambition to convey to readers “that these illnesses are only one component of a person’s life” (Lee, “A Penguin Readers Guide” 9), but arguably that a life need not be perceived as a Rubik’s cube of shifting parts at all but rather a unified, cohesive whole.

Lucia’s frustration with her self- and social image helps contextualise the ongoing conversations happening within disability studies regarding the mentally ill identity and identity itself as a concept, particularly Lennard J. Davis’s notion of a new “dismodern era” (311) in which difference is universalising. By investigating the plurality of Lucia’s identity through the intersection of her illness, race and social roles and conveying Lucia’s frustration at being pigeon-holed into leaning into one aspect of it or another, Lee advocates for a less categorical view of identity. Lennard explains, “What dismodernism signals is a new kind of universalism and cosmopolitanism that is reacting to the localisation of identity. It reflects a global view of the world” (311), one that Lucia certainly seems to embrace by responding “I live on Earth” (Lee 21) when asked how she likes living in a new city. Within a dismodernist framework, Lennard argues that “all humans are seen as wounded" (313) as part of a society where "impairment is the rule, and normalcy is the fantasy" (314); he argues that we are all incomplete subjects who require technological and social dependency to appropriately function. *Everything Here is Beautiful*, with its shifting perspective between uniquely suffering characters, exemplifies this notion of collective deficiency. Yonah, with one arm, is quite literally incomplete, Lucia requires medication to treat her mental illness, Manny lacks a green card, and Miranda feels helpless without her stack of books, pamphlets and notes. As dissimilar as the characters are, they are connected by both their own "wound[s]" and the stress of loving those who have their own. In so much as we are all different – and differently incomplete – we are the same, and it is this shared 'disability' that fosters the solidarity and unification that Lucia craves. Following this line of thought, the critics who decry intersectional scholarship for creating a problem of infinite regress can be challenged on the notion that these differences generate not an influx of separate groups with disparate agendas but rather a single, human group unified by difference.

Lee explains, "Even though this is not a book about race, the main characters are Chinese; the story is about who these women happen to be" (Bader), and this comment suggests a desire to look beyond these identity components and focus on the characters as people. While Roy made a similar comment about *The Fat Lady Sings*, and rightfully so to the extent that the novel is devoid of overt racism and deals with race not on its own but as an overlap with other marginalities, her novel did show the microaggressions levied toward Merle and Gloria and their endeavour to accept themselves and surmount attempts of "spirit murder." Lee's comment sits differently, and she advocates not for a critical lens that frames these characters and their experiences as shaped through a variety of interlocking identity components – which is a cornerstone of contemporary intersectional scholarship – but rather for a top-down framework that identifies individuals as human first. Lucia's struggles throughout the novel highlight the difficulty in achieving this and the degree to which cultural and illness stereotypes further complicate the identity process. The social construction of identity is problematic when there is a disconnect between social perceptions and personal attitudes. It is hard for Lucia to project herself as simply human when she is continually reduced to a single facet of who she is, called “Chinita” (73) or “*loca*” (84, italics in text) time and time again, or, as she is posthumously (and callously) referred to at the close of the novel, “a Chinese girl from some hot-weather foreign country” (333).

Lee’s aim is to counteract this division of identity by showing the interior lives of her characters in a way that fosters understanding and emphasises commonality. Cultural studies scholar Paul Gilroy writes, “The reoccurrence of pain, disease, humiliation, grief, and care for those one loves can all contribute to an abstract sense of human similarity powerful enough to make solidarities based on cultural particularity appear suddenly trivial” (17). Lee corroborates this in the dedication to her novel, identifying emotion as a link that transcends cultural, ethnic and personality differences: “Empathy: because the commonality among human beings is emotion, and the only way we can bridge our vast discrepancies in experience is through what we feel. Let us be humbled in the knowledge that one many never fully understand the interior lives of others – but let us continue to care” (Dedication). Lee isn’t downplaying the complexity or adversity of marginality but rather linking our increasingly heterogeneous society to a precarious expansion of identity that can be grounded by empathy.

Throughout the novel, Lucia refers to the Spanish term *querencia*, explaining that “it’s the place we’re most comfortable, where we know who we are – where we feel our most authentic selves” (170), and it is the quest for this that drives Lucia’s restlessness and incessant relocation. She feels it each time she moves, enraptured by the newness of her surroundings and fresh acquaintances, frequently commenting that “everything here is beautiful” (217); but this sensation never lasts long, and Lucia always reverts to feeling uneasy with herself, questioning who she is and her purpose in life. She realises, perhaps too late, that the antidote to this unrest is her first husband, Yonah, who always saw Lucia not as Chinese, American, a mother, a sister, a daughter or mentally ill, but for exactly who she was – just Lucia – even if Lucia didn’t quite know who this was.

Concluding Thoughts

The Fat Lady Sings, *The Icarus Girl* and *Everything Here is Beautiful* are well-crafted stories of female mental illness that, when read together, exemplify the complexity of intersectional identity, presenting it as, respectively, emancipatory, evolving and vexing, challenging the "reductive notion that identity studies are intellectual ghettoes limited to a narrow constituency demanding special pleading" (2) that Garland-Thomson explains is a persistent impediment to intersectional studies. While these novels are about more than just identity, the question of "Who am I?" permeates each text, and although messages on oppression, stereotypes and inequality can most certainly be teased out, it is this notion of identity that both connects and distinguishes the novels. Tobin Siebers explains that "identity is out of fashion as a category in critical and cultural theory" due to its conceptualisation "as a crutch for the person who needs extra help, who is in pain, who cannot think independently" (Siebers, "Disability and the Theory" 319). Just as Siebers sets out to challenge this belief that identity is disabling, so too does contemporary fiction. Identity is not "out of fashion" in these novels, but at the very core of them, depicted not as a crutch but a vehicle for self-acceptance and self-discovery that serves to destabilise cultural and social norms in a way that is not disabling, but empowering.

Given the varied construction of identity in these three novels alone, I argue that there is no danger in configuring identity as a cornerstone of intersectionality, as contemporary fiction reveals a plurality of identity experiences that tie into larger issues of family relationships, geopolitics and stereotypes and elude a singular, defining characterisation. There cannot be "too much identity" in intersectionality inasmuch as there cannot be too much sand on a beach; it is the existence of a multitude of identities that allows for intersectionality to function as a field of inquiry and praxis. Without these individual experiences and expressions of various marginalities there can be no discussions of oppression or inequality, and in these novels, identity functions as a location where these conversations can begin and return to, where the personal impact of historical and political landscapes can be contextualised and where ultimately, these unique lived experiences of intersectionality can be better understood.

In the introduction to their monograph on intersectionality, Collins and Bilge explain, “Our goal in this book is to democratise the rich and growing literature of intersectionality” (30), to expand the audience beyond those at the centre of it. They close their book with the suggestion that “intersectionality is a tool that we can all use in moving toward a more just future” (Collins and Bilge 204), but this necessitates a more diverse and interactive group of interested parties – white people must be interested in black history, straight people must see the value in LGBTQ studies, the able-bodied must engage with disability studies. Contemporary authors are doing this work by penning narratives with provocative characters at the nexus of multiple marginalities, whose stories serve as a springboard for readers to contemplate the issues of intersectionality not within the pages of an academic journal or the halls of a university, but within their own homes and among their own friends and family. As Lee says in an interview with Eleanor Bader, “I also hope the book reaches people who might not read a memoir, news story, or blog post about mental illness and break through the shame, stigma, and silence that persist in many cultures when someone suffers from a psychological disorder” (Bader), but she is selling herself short. Her story, and the others in this chapter, not only shed light on mental illness, but the entanglement between mental illness and race, gender, sexuality, class and religion. As Romero explains, from a sociological perspective, intersectionality has “the power to connect private troubles with public issues” (Romero 11), and contemporary novels are accelerating this process by offering fictional microcosms of real-world problems that expose readers to power structures, inequalities and identity processes experienced by those whose race or sexuality or immigration status may differ from their own. Within disability studies, intersectionality’s power lies not just in its ability to challenge the white canon – though it certainly does this – but in its nuanced exploration of these interlocking systems of oppression that can at any time, for anyone, suddenly include disability, a worthy investigation that can instigate a widespread reclamation of power within the disabled community, and beyond.

Chapter Five: "Loving you saved me":[1] Reinforcing Stereotypes and Romanticising Mental Illness in Young Adult Literature

Previous chapters in this thesis have applauded contemporary fiction for expanding representations of female mental illness, for breaking with the "compulsory positivity" (Woods et al. 222) of the Recovery Narrative and the linear trajectory of the diagnosis-treatment-recovery paradigm to include experiences that are chaotic, complex and unresolved. I have shown throughout this thesis how elevating these subversive experiences gives voice to a wider spectrum of illness that in turn helps nurture empathy, foster empowerment and mitigate stigma. While this is a welcome trend in contemporary fiction, Young Adult Literature (YAL) has yet to catch up, instead perpetuating worrying tropes and archaic stereotypes that undo much of this progressive work.[2] When it comes to mental illness, YAL of today parallels the "problem novels" (Cart 25) and "bleak books" (Cart 50) that dominated the 1970s and 1990s, respectively, works that only scratched the surface of weighty issues like addiction and violence and instead hinged on tidy resolutions and messages of hope; recent novels are equally guilty of this triviality, and they too often conclude with characters completely free from mental illness symptoms in an erroneous configuration of recovery as absolute cure. Misrepresentations such as these are dangerous missteps that fail to convey the seriousness of mental illness, burying the truth beneath a veneer of romanticisation that, at best, renders mental illness minor and solvable, and, at worst, trendy and desirable. At the other end of the spectrum, many contemporary YA novels dramatise mental illness, painting it as demonic and dangerous, eschewing its value as a lived experience by limiting it to a one-dimensional plot device that delivers tension and conflict. This chapter elucidates the potential consequences that these pervasive messages have on young people, ranging from ethical and moral considerations to safeguarding concerns to the egregious proliferation of stigma buoyed by this miseducation.

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[1] *My Heart and Other Black Holes,* page 298

[2] The phrase 'Young Adult Literature' is capitalised throughout this thesis to distinguish it as a recognised genre

While YAL is undoubtedly a popular genre, I argue that its role extends – or, should extend – beyond merely its entertainment value. YAL expert Michael Cart addresses the multifaceted benefits of YAL, writing about the value of such literature as part of YALSA's[3] guidelines. He sees the potential advantages as threefold:

> 1. YAL allows adolescents to see themselves represented in literature and "receive the reassurance that one is not alone after all, not other, not alien but, instead, a viable part of a larger community of beings who share a common humanity."
> 2. YAL has the "capacity for fostering understanding, empathy, and compassion by offering vividly realized portraits of the lives – exterior and interior – of individuals who are *un*like the reader" thereby inviting its readers "to embrace the humanity it shares with those who – if not for the encounter in reading – might forever remain strangers or – worse — irredeemably 'other'."
> 3. YAL offers the opportunity to tell the truth, "however disagreeable that may sometimes be, for in this way it equips readers for dealing with the realities of impending adulthood and for assuming the rights and responsibilities of citizenship" (Cart, "The Value").

While the treatment of mental illness within some YAL is commendable (*The Hunger Games* trilogy's portrayal of PTSD, for example[4]), too many "sick-lit"[5] novels continue to fall well short of Cart's lofty ideals. Rather than use their platform to foster community, empathy and truth, many YA authors rely on stigma-laden stereotypes to perpetuate out-dated ideas about mental health – it is dangerous, shameful, no one will listen if you ask for help – or conversely, they romanticise issues like self-harm and suicidal ideation by portraying them as fashionable and attractive. YA novels *Willow* and *My Heart and Other Black Holes,* discussed later in this chapter, depict teenagers

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[3] Young Adult Library Services Association

[4] I have conducted extensive research and read dozens of YAL novels in preparation for this chapter, and this is the only novel/series that I have come across that I feel I can praise for its portrayal of mental illness in young people; that said, I do not want to suggest that it is the only one, and there may be others that I simply have not encountered. The criticisms levied in this chapter are in line with the themes and trends of current YAL and not necessarily indicative of every single book within the genre.

[5] a term coined to describe narratives that deal with themes of death or illness (Biernat)

overcoming mental illness easily and decisively with the magic of 'true love;' novels like these send a damaging message that individuals continuing to struggle are weak or unloved, presenting prolonged difficulties as abnormal and ultimately alienating the very individuals that they intend to draw in. Novels like *I Was Here* and *13 Reasons Why* fail to foster compassion, instead depicting suicide as an outlet for personal growth or a successful revenge strategy. Rather than promoting truth and social progress, many novels rely on backwards representations of mental illness as dangerous and violent. *Finding Alice* portrays schizophrenia as demonic through the titular character's religious awakening and attempted exorcism, while *The Summoning* features a rag-tag group of mentally ill teens, each uniquely aggressive and disturbed. This chapter analyses how the dangerous messages within these texts negatively skew young adults' impressions of mental illness in a way that can lead to further stereotyping and stigma as well as additional self-harm and loss of life, echoing the shortcomings of the problem novels and bleak books that beleaguered previous generations.

These portrayals are particularly disturbing when one considers mental health trends within the demographic. The statistics among children and young adults are harrowing,[6] with teenage girls at particular risk of developing a mood disorder, self-harming and attempting suicide; yet, despite these disturbing statistics, less than one-third of young people seek help for their mental health. Raising awareness of mental illnesses and normalising discussions on mental health are paramount in reducing the stigma that prevents so many young people from getting the support they need.

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[6] A 2020 study conducted by NHS England reports that the incidence of mental health issues rose among children aged 5 to 16, increasing from 1 in 9 in 2017 to 1 in 6 in 2020 and now affects an average of five children in a typical school classroom. Before puberty, the prevalence of mental illness is roughly the same for boys and girls, but by adolescence, girls are twice as likely to have a condition like depression or anxiety. In fact, nearly a quarter of teenage girls exhibit depressive symptoms according to the NHS, and 71% of antidepressants administered to 13-17 years olds are prescribed to females. Self-harm among teenage girls is equally concerning, with the number of hospital admissions for issues like cutting quadrupling between 2007 and 2017 (Vizard et al.). The Millennium Cohort Study conducted by UCL in 2020 corroborated these "stark inequalities," finding that 22% of 17-year-old females experienced high psychological stress compared to only 10% of males; 10% of females attempted suicide, more than double the 4% of males that did so (University College London). Globally, the World Health Organization cites depression, anxiety and behavioural disorders as the leading causes of illness and disability among adolescents, and suicide as the third leading cause of death among 15- to 29-year-olds ("Mental Health of Adolescents").

Young adults are a particularly impressionable and vulnerable group, whose notion of ‘truth’ is based largely on social media, friends, books and television, and it is through these conduits that larger social change involving mental health can begin;[7] therefore, platforms like YAL are increasingly important, with their depictions of mental illnesses reaching wide and diverse audiences in an ever-growing capacity to mould the views of young people. Adolescents are in the infancy of constructing their opinions and understanding of mental illness, and any exposures to mental health conditions – fictional or otherwise – will undoubtedly contribute to their emerging belief system. Representations of teenage girls with mental issues are particularly key given the disproportion of mental illness among this real-life cohort. As Otto Wahl writes in *Media Madness: Public Images of Mental Illness*, “The images of psychiatric disorder that are presented to public audiences shape their attitudes and influence their behaviour” (ix), and these portrayals can either placate stigma by engendering empathy and knowledge, or they can enhance discrimination by representing mental illness in harmful or stereotypical ways. Sadly, much of contemporary YAL does the latter.

Adding to the frustration surrounding these out-dated, dangerous representations of mental illness is the misguided shoehorning of Author’s Notes laden with warnings that belie the messages within the texts. In Gayle Forman’s *I Was Here*, for example, Meg hides her depression in shame at the behest of her mother, and her suicide is ultimately romanticised; yet Forman’s Author’s Note encourages readers to “tell someone” if they are having suicidal thoughts, ensuring young people that “there are people out there to help you find the light” (274). Similarly, main character Aysel swiftly overcomes her once-debilitating depression by falling in love with Roman in Jasmine Warga’s *My Heart and Other Black Holes,* asserting on the final page, “I’m done with the shadows” (302); however, on the next page, Warga’s Author’s Note states, “The road to recovery is long and ongoing. In many cases, the battle with depression is a lifelong one” (303-304). These Author’s Notes read like

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[7] As a parent to 8- and 10-year-old boys and a primary/secondary school teacher for nearly 20 years, I have seen firsthand how impressionable children are and, worryingly, how little they question information from these platforms.

legal disclaimers rather than heartfelt advice, and the platitudes within them ring hollow when read on the heels of novels that perpetuate stigma and glamorise mental illness.

There is clearly much work to be done within the realm of contemporary YAL, yet the criticisms levied by this chapter are not unique to modern-day literature but rather a progression of those imparted by previous generations; as this next section reveals, the depiction of serious, distressing topics in YAL has been the subject of controversy for decades.

A Brief History of Young Adult Literature[8]

Michael Cart explains that the term 'Young Adult Literature' "like gelatin, is inherently slippery and amorphous" (3), with its critical reception as a genre shifting over time along with the trends and themes of the literature. Despite the nebulous nature of YAL, most critics pinpoint Maureen Daly's 1942 novel *Seventeenth Summer* as the inaugural YA novel, the first written specifically for teenagers; a slew of similarly named and equally trite imitators[9] followed in the wake of Daly's success. During these early years of YAL, Cart notes that the genre was viewed as "a rung on a ladder [. . .] between children's and adult literature" (18) rather than valuable in its own right, and these initial books pandered to their target audience by offering young women frivolous stories about dating, relationships and fitting in. An equally blithe sub-genre for boys was emerging as well – the hot rod novel[10] – which provided levity and escapism in the years after World War II.

More of the same dominated the 1960s, and critics began vocalising concerns over the triviality of the genre. In 1966, George Woods wrote: "A critic in touch with the world and aware of the needs of the young expects to see more handling of neglected subjects: narcotics, addiction, illegitimacy, alcoholism. [. . .] There are few, if any, definitive works in these areas" (qtd. in Cart 20). This was echoed by author Maia Wojciechowska, who in 1968 criticised the onslaught of "tepid little

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[8] While YAL began as an American genre in the 1940s, it has in the 21st century expanded to become a global phenomenon with novels written in many languages; that said, this chapter focuses on novels originally written in English in line with works analysed in the rest of this thesis.

[9] notably Betty Cavanna's *Going on Sixteen* (1946) and Rosamond Du Jardin's *Practically Seventeen* (1949).

[10] Henry Gregor Felsen's near-monopoly on this trend elicited an outpouring of car novels, including *Hot Rod* (1953), *Street Rod* (1953) and *Crash Club* (1958),

stories of high school proms" and instead called for "the gulf between the real child of today and his fictional counterpart" (13) to be bridged. S. E. Hinton answered this call with her wildly successful novel *The Outsiders* (1967), which depicted "real" (Cart 21) teenagers grappling with violence and death; while this was a welcome deviation from the wholesome books of the early half of the decade, the novel was criticised for romanticising violence.[11] Robert Lipsyte's similarly dark book *The Contender* was published that same year, leading Cart to comment that "in the late 1960s, Young Adult Literature was in a hectic period of transition from being a literature that had traditionally offered head-in-the-sand approach to one that offered a more clear-eyed and unflinching look at the often unpleasant realities of American adolescent life" (23).

This shift from idealism to realism gave way to a new trend that dominated 1970s YAL: the problem novel. Robert Cormier's *The Chocolate War* (1974) is credited with instigating this fad, with the novel's violence and despair daring "to disturb the comfortable universe of both adolescents and the adults who continued to protect their sensibilities;" Cart suggests that Cormier "took his young adults into the very heart of darkness for the first time, turned the lights on, and showed them what the landscape there looked like" (22). Many "grandmasters of the field" (Cart 23) emerged during this time, including Judy Blume, Richard Peck, Walter Dean Myers and Lois Lowry – authors whose works were still flying off bookshelves when I was a child in the late 1980s – yet the problem-driven nature of their popular works was the frequent target of criticism. Canadian critic Sheila Egoff reflected in 1980 that novels were "very strongly subject-oriented with the interest primarily residing in the topic rather than the telling," going on to say that the problem novel "is to young adult literature what soap opera is to legitimate drama" (qtd. in Cart 25). Cart argues that these novels, which "have only problems whose source is rarely explained and denouements that have no extending ripples" (Cart 25), offer little to young readers.

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[11] This criticism of romanticising precarious situations is one that I argue YAL continues to do today with literature surrounding mental health.

This chapter argues that more than 40 years after the heyday of the problem novel, contemporary YAL involving mental illness echoes the characteristics of this much-maligned trend. Driven by plots that either romanticise or demonise mental illness, YAL of today focuses on mental illness as a dramatic element rather than a precarious real-life issue. Critic Roger Sutton argued that in these 1970s problem novels, "instead of a character being the focus of the novel, a condition became the subject of examination" (33); contemporary YA novels replicate this controversial trend, and too often the emotions and actions of characters are of interest only as far as they intersect with the realm of mental illness. Sutton equally criticised the "unduly hopeful outlook on problems and their consequences" (33) that problem novels offered, a criticism that is equally valid today. The trite, predictably happy endings of contemporary YAL, often predicated upon the eradication of mental illness, certainly offer no "extending ripples" that elicit introspection or interrogation. Sutton unpacks the reasoning behind the ubiquitous "last-ditch happy ending" (33): "These novels provide titillation, vicarious excitement, and escape. [. . .] And light, escapist reading usually demands a happy ending. A book with a happy ending somehow seems more *finished* at the end, often not requiring a single thoughtful backward glance. Not by readers, not by critics." (33, emphasis his). I argue, as did Sutton in the early 1980s, that YAL should provoke questions, should leave the reader reflecting on her own life and the impact of the messages within the novel. "Neatly comfortable endings should be taken as a signal: This book is a dead end" (Sutton 34). While YAL certainly evolved beyond the problem novel of the 1970s, this chapter shows that it has come full circle with literature of mental illness, focusing too often on mental illness as a solvable problem that affects teenagers rather than the complicated lives of teenagers who happen to have mental illness.

The turmoil of the late 1970s – the Vietnam War and Cold War, political upheaval – led to a renewed desire for escapism, and YAL returned to the frivolity of post-World War II literature, this time in the form of romance and horror fiction. The emergence of genre fiction coincided with the burgeoning materiality of the 1980s, and the surge of shopping malls – and thus, bookstores – saw teens purchasing their own books at an unexpected rate.[12] The books of horror icons R. L. Stine and Christopher Pike saw flashy, gory covers that appealed to young adults, just as the pretty, blonde, white girls on the covers of various romance series – *Wildfire*, *Sweet Dreams*, *Sweet Valley High* – beckoned more specifically to teenage girls. While the latter undoubtedly perpetuated stereotypes, including distrust among girls, competition for boys and antiquated sex roles, Cart admits that "stereotypes sell" (31), a criticism I echo in this chapter, and these books flew off shelves nonetheless.

The decadence and triviality of the 1980s gave way to the dark, gritty 90s, and the lives of teenagers were increasingly impacted by homelessness, violence, drug use and suicide, hard-hitting issues that dominated the media. It comes as no surprise that the literature followed suit, and the light-hearted genre fiction of the previous decade was replaced by "bleak books" (Cart 50) that embraced authenticity. While young people obsessed over Irvine Welsh's *Trainspotting* and Jeffrey Eugenides' *The Virgin Suicides*, parents and critics expressed concerns about the novels' graphic nature (Reilly; Simmons; Spitz), worrying that teens were growing old before their time and "shouldering burdens far beyond their years" (Cart 51). But not everyone found this problematic. Author Chris Lynch argued in 1994 that no topic should be off-limits: "If they're thinking about it, we should be writing about it. And there's nothing to be afraid of" (38). This sentiment was echoed by Richard Jackson in 1998, who wrote that "when reviewers today worry about bleak stories, they are worrying, on behalf of the audience, about the readiness of young readers to face life's darkest corners. But in America there are kids *living* in those dark corners, and they need our attention as much as the feisty, pert, athletic, and popular youth so reassuring to adults. Even children in the sun will enter the darkness" (R. Jackson 1985). I argue the same regarding mental illness; it is a genuine issue affecting real teenagers, and thus there is merit to seeing the impact of it depicted in literature. That said, these bleak books of the 90s faced the same criticism that I now levy against contemporary fiction: they are too consumed by happy endings and hopefulness rather than

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[12] Rather than marketing toward schools and libraries, publishing houses began targeting teens directly.

authentic conclusions that may see unresolved situations and fraught characters. As Sutton argued in 1998, bleak books were “books about Working Things Out: the teen-age drunk finds AA, the runaway leaves her career in child prostitution and comes home,” forcing “unreasonably hopeful conclusions to unduly dismal situations” (qtd. in Mosle 35), and this chapter will show that contemporary fiction of mental illness has fallen in the same predictable trap, with worrying consequences. Situating these bleak book criticisms within the evolution of YAL makes it clear that the YA novels of the 90s were merely a repackaged, modernised iteration of the 1970s problem novel, and this chapter argues that contemporary sick-lit novels are the most recent version of this worrying fad.

While the bleak books of the 90s faced extensive criticism, the decade is responsible for a massive shift in the reputation and recognition of YAL. The 1994 Miami Beach YALSA conference, which saw authors, librarians and critics join together to discuss how teenagers could be better served by libraries, is viewed as a turning point. YAL was beginning to be considered worthwhile in its own right rather than as merely a stepping stone between children’s literature and adult novels, and this newfound respect for YAL lead to the creation of several prestigious literary awards.[13] Cart argued in 1996 that there was no “critical apparatus” for analysing YAL, nor was there “any perceived need” (71), but this evolved as the industry began to acknowledge YAL as a valuable genre. This shift was buoyed by the unprecedented success of J. K. Rowling’s *Harry Potter* series, and by the end of the 1990s, YAL had solidified itself as reputable literature. Sales figures from the 2000s prove the drawing power and continued growth of YAL.[14] Most publishing houses now have a YAL department, as do nearly all bookstores and libraries, and young adult series like *Gossip Girl*, *Percy*

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[13] Including the National Book Award for Young People’s Literature in 1996 and the Michael L. Printz Award in 1999

[14] In 2001, the Los Angeles Times cited YAL as a $1.5 billion dollar industry, with USA Today reporting that 14- to 17-year-olds bought 35.6 million books that year. Sales in 2012 topped $3.3 billion, more than twice the 2001 figure. Cart notes that between 250 and 500 YAL books were published each year in the 1980s; in 2021, more than 10,000 such novels were released (Cart 86).

Jackson, *Divergent* and *Harry Potter* have been adapted to the screen to reach even wider audiences.

While its financial success is unquestionable, YAL as a genre continues to be let down by novels that deliver tempered looks at gritty topics and protagonists who navigate them with far too much ease. The prevalence of these destructive, clichéd portrayals, marketed to and devoured by a cohort increasingly at-risk of developing real-life mental health issues, poses a variety of complex ethical questions that build on those raised in previous decades, when the dark, controversial subject matter of the problem novel and bleak book spawned concerns among both critics and parents. This chapter advances the moral interrogations of previous generations by addressing the complicated nature of twenty-first century adolescence and the potential consequences bred by the gulf between lived and fictional mental illness.

The most pressing question is one that addresses the very purpose of YAL: When it comes to depicting mental illness, does YAL have a duty to authenticity or to themes of hope, and are the two incompatible? As Sutton argued in 1982, "If a reader finds himself asking the three questions of a protagonist [. . .]: what *does* she do, what *should* she do, what would *I* do, he is being made to think, to integrate the book and himself. But a significant book is marked by the provocation of a fourth question, which is really more of a challenge: What do I, the reader, do now?" (35, emphasis his). Sutton acknowledges that "undoubtedly, confrontation of this kind can upset and disturb adolescent readers," yet he continues, "At least, I hope it can, and I wish it could happen more often" (35). Forty years on, how is this call for YAL to unsettle and disrupt complicated by the prevalence of mental illness among young people today, and, following on from Sutton's argument, is an unvarnished depiction of mental health the most valuable one for young readers?

Ethical questions surrounding the representation of recovery require similar contemplation: Does YAL's proliferation of happy endings predicated upon cure normalise getting better to the detriment of those who struggle to improve their symptoms? Should YAL focus not on cure but on finding acceptance and living a full life *despite* mental illness? And, given the propensity of characters to eschew adult support – at times with fatal results – is there a moral obligation to show teenagers seeking and receiving help from trusted adults – clinicians, parents, teachers or otherwise? While these are complex, overarching questions that cannot be wholly answered within the scope of a single chapter, I pose and attend to them nonetheless in an effort to embed my analysis within a larger ethical, historical and cultural framework of YAL, mental illness and stigma. As a starting point, this chapter analyses the shortcomings of recent sick-lit and the potentially damaging messages within such novels, implications that will, if left unchecked and unchallenged, continue to enforce stereotypes and misinformation; I conclude with suggestions for improving portrayals of mental illness in YAL,[15] ultimately opening up the topic for further investigation into the ethical, social, medical and cultural impact of current depictions.

Love Saves the Day

One of the most prevalent and damaging tropes in YAL is the depiction of teenage love as the sole impetus for mental illness recovery. In these stories, love cures all – and quickly – with protagonists shifting from suicidal contemplation, cutting and depression to doe-eyed delight in a matter of weeks; it is a colossal abridging of recovery that belittles adult support and presents mental illness as fleeting and avoidable. Two such novels, *My Heart and Other Black Holes* and *Willow*, not only feature plots that hinge on this destructive cliché, but also perpetuate stereotypes, depict cure as necessity and sensationalise depression in a harmful mismanagement of mental illness.

Jasmine Warga's 2015 novel *My Heart and Other Black Holes* romanticises suicide through its portrayal of ideation as a quirky, attractive personality trait and simplifies recovery by depicting mental illness as a temporary inconvenience that can be easily assuaged by falling in love. Warga, quoting Marcel Proust on the first page, writes, "The real voyage of discovery consists not in seeking new landscapes, but in having new eyes" (Epigraph), succinctly summarising her disturbing presentation of mental illness as an insignificant problem that simply requires a shift in perspective,

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[15] particularly those of teenage girls

not the serious condition that demands meaningful – often professional and often life-long – work that it truly is.

The novel relies on stereotypes, trite metaphors and light-hearted humour, which coalesce to form a problematic representation of not just depression, but disability as a whole. Sixteen-year-old protagonist Aysel describes her depression as a “black slug inside of me” (91), an inescapable sadness that drives her to regularly peruse the pro-suicide website Smooth Passages. Despite the gravity of suicide, Aysel oscillates between wistful daydreams (“I spend a lot of time wondering what dying feels like. What dying sounds like. If I’ll burst like those notes, let out my last cries of pain, and then go silent forever” (1)) and tasteless jokes (“And if I wasn’t already fantasizing about dying, working at the phone bank [. . .] would definitely do the trick” (2)), neither of which do justice to the permanence and raw emotion involved with such a heavy decision. It’s a failed attempt at relating to the target audience that trivialises suicide by simultaneously presenting it as both poetic and droll.

Warga’s portrayals of inherited madness and physical disability as undesirable are not just troubling, but harmful and irresponsible. Aysel’s father is currently institutionalised for murdering a local teen who was causing problems in his store, and Aysel would rather kill herself than end up like him, confident that “certain things are coded into us from the very beginning” (132), and a life with severe mental illness isn’t worth living. Aysel’s biggest fear isn’t the actual act of suicide, but rather a failed attempt: “The last thing I want is to end up in a wheelchair, eating pulverized food and being watched around the clock by some sassy nurse” (8). Warga paints physical disability in the same vein as madness: death is preferable to both.

The novel perpetuates dangerous stereotypes about depression that belittle those suffering from the illness and disserve mental illnesses at large. Surprised that so many people from California are on Smooth Passages, Aysel quips, “Isn’t living by the ocean supposed to make you happy? (9), ignorantly suggesting that depression in anyone on the West Coast isn’t justified. When she first meets her suicide partner, Roman, he is chatting with friends, leading her to wonder, “If [he] has so many friends, why does he want to off himself?” (39). Apparently only the lonely – those with textbook depression – are allowed to be suicidal. Aysel's generalisations about depression continue when she sees Roman smile: "Maybe he's not as depressed as he thinks he is" (36). Roman clearly takes pride in his physical appearance, which leads Aysel to remark, "He doesn't look like someone who would want to kill himself" (39). Aysel's snap judgements about Roman's mental health are erroneously linked to his physical appearance and external temperament, an ill-informed and fallacious assumption that depression must *look* a certain way to be authentic. These off-the-cuff remarks are meant to exemplify Aysel's dark humour, but instead she comes across as a self-appointed gatekeeper of depression who callously devalues the lived experiences of those whose mental illness doesn't fit her mould; ultimately, Aysel's basic and formulaic understanding of depression reveals that she is grossly uneducated on the very condition she has. It is a misstep by Warga, who, while attempting to write Aysel as an eccentric, relatable character, further harms the mental health community by suggesting that all depressed people are sad, dishevelled loners and ignores the possibility that sometimes those most in need of help are those most well-versed in hiding it.

More problematic than Warga's light-hearted approach to suicide and reiteration of precarious stereotypes is her faithfulness to a hackneyed 'love conquers all' trope that delegitimises psychiatric routes to recovery and presents mental illness as a matter of will.[16] Despite Aysel's broody confidence in the permanence of depression ("Depression is a part of you. [. . .] It's impossible to escape" (14)), her entire demeanour shifts within a few weeks of meeting Roman. The two become suicide partners, forming a pact to jump of a cliff together in 26 days, but, mesmerised by Roman's "deep-set eyes" and "full lips" (153), Aysel – rather predictably – falls in love with him and decides she would rather live. Aysel's previously steadfast depression wanes after only a few hours with Roman. "I find myself smiling. My cheek muscles feel different – they're like a room that

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[16] While I have certainly challenged medicalised recovery in this thesis, Aysel's denigration of professional help isn't built on an understanding of disability studies or recovery paradigms but rather a smug adolescent 'I know best' mentality. Her lack of maturity – both in knowledge surrounding her mental illness and general life experience – indicates that some professional intervention would likely help her navigate her depression.

hasn’t seen light in years that suddenly had all the blinds pulled open and the sun is beaming in at full volume” (225). Aysel’s abrupt attitude change perpetuates the dangerous cliché that love fixes everything – including mental illness – and, even more worryingly, seems to suggest that a pro-suicide message forum is an effective on-line dating platform for teenagers. A kiss is all it takes for Aysel to abandon her once concrete suicide plans altogether: “He’s no longer the person I want to die with; he’s the person I want to be alive with” (231). It’s an eye-rolling moment that undermines the enormity of suicide.

Though Aysel has decided to live, Roman hasn’t yet, and his solo suicide attempt imbues her with a desire to “fix” (228) him as he has her, with Warga painting depression as an easily solvable conundrum that must be eradicated to live a full life. Aysel explains, “Knowing you has helped me see things differently. See myself differently. And all I want is for you to see yourself the way I do” (293). “Loving you saved me” (298), she insists. This declaration of love is enough for Roman to decide that he, too, will give life a try, even though he just tried to kill himself the day before. His change of heart is like the flick of a switch and sends a dangerous message about the speed and ease of recovery and its predication upon romantic connection; by applauding Aysel and Roman’s decision to live, Warga suggests that those who *do* kill themselves simply haven’t met the right person or tried hard enough to change their perspective on life.

In *My Heart and Other Black Holes,* love conquers all, even suicide, in a dangerous oversimplification of recovery that advocates kisses and handholding over psychiatric help. While professional intervention is by no means a panacea, as this thesis has made clear, there is certainly merit in young people – whose brains and bodies are still growing, whose hormones are very much in flux, whose life experiences are limited – in reaching out to educated and mature adults for support. As Sarah Katherine Thaller explains in *Crazy Stories and Unhinged Tropes: Portrayals of Mental Illness in Young Adult Literature*, in novels that depict characters who get better “without any medical or psychological intervention, the message is that people should have the ability to cure or heal themselves, thus creating shame in readers who require professional treatment” (146), a criticism heavily echoing that levied against the saccharine endings of problem novels and bleak books. The notion that "adolescents should, apparently, have the ability to overcome anything, including debilitating mental conditions" (Thaller 146) on their own or by finding love, is not only preposterous but destructive. Both Aysel and Roman proudly eschew therapy, agreeing to talk about their feelings to each other instead, a precarious arrangement in which they substitute infatuation for the professional help that their doctors believe they need.

While Thaller and I are critical of this idealistic depiction of mental illness and recovery, there are certainly those in favour of promoting hope over realism. In 1997, educators Suzanne Reid and Sharon Stringer wrote about the value of optimism in YAL:

> We support anything that encourages hopefulness and courage. [. . .] For us, this window of light is a prerequisite for literature that we would recommend, because we feel that adolescents, without the buffer of long-term varied experiences, do run a greater risk of despair than adults. We like to reassure students that most situations are safe and most people today are well-intentioned, because, in our experiences, we have found this positive view of our world to be so. (Reid and Stringer)

While this desire to provide comfort is kind-hearted, it is an arguably naïve, outdated viewpoint that is complicated by the contemporary issue of mental illness, which – far from being "safe" and "positive" – may result in stigma, isolation and despair regardless of the effort put into navigating it. Despite Aysel's insistence that she is "done with the shadows" (302), mental illness is often a life-long, recurring issue, and neither she nor Roman is equipped with the skills to cope with depression. Roman will continue to grieve for his sister's death, in which he played a part, and Aysel's father's madness will always loom over her; neither has fully processed these traumas, only masking their pain beneath a veneer of love. The novel's conclusion is meant to evidence the kind of strength and hope that Reid and Stringer support, but the seemingly happy ending is, in reality, anything but, leaving a vital and unanswered question lurking behind: What will happen to Aysel and Roman when their relationship, like nearly all teenage romances, ends, and they have no other support system on which to lean?

Willow, Julia Hoban's 2009 YA novel featuring a girl who self-harms following her parents' deaths, follows a similarly trite plot structure in which mental illness is miraculously cured by love and cutting is glamorised as erotic and alluring. Willow's desire to cut diminishes in the wake of her growing affection for Guy, yet she – like Aysel – refuses to speak to an adult about her distress, instead co-opting her new boyfriend as medicine and shifting her coping mechanism from one dangerous medium – cutting – to an equally perilous one – teenage love.

The cover art – a photo of a teenage girl with gashes across it – and the slash marks above the chapter numbers further sensationalise cutting by using it as a marketing ploy to draw the reader in. The number of slashes at the start of each chapter decreases as the book goes on in an effort to show that Willow's desire to cut is dwindling, but it comes across as a tasteless gimmick that both trivialises the physical and emotional pain of cutting while also suggesting that there is only one option when cutting – to get better.

While Hoban's nuanced and emotional handling of Willow's motivation behind her self-harm is commendable, her depiction of cutting is nonetheless problematic in that she uses it to mark Willow as temptingly 'different' at the expense of other teenage girls with more menial – and thus less attractive – concerns. Seven months earlier, Willow's parents drank too much at dinner and asked Willow, who didn't have her driver's license yet, to drive home in a storm. Willow crashes the car, killing both of her parents, and subsequently moves in with her much older brother and his family. Willow is riddled with guilt and haunted by memories of her parents' deaths, the pain of the accident "too difficult to process" (59). Not only does Willow feel solely responsible for the crash, she feels like "a refugee" (24) at her brother David's house, engulfed by the belief that she "smashed her brother's picture-perfect life as surely as she smashed her parents' car" (29). Upon returning to her parents' house after a week in the hospital, Willow faces the truth of what has happened. Overcome by an "overwhelming, extreme sensation" that she fears will destroy her (222), Willow subconsciously begins stabbing herself with a screwdriver while dismantling a bookcase. "The physical pain that I was causing was better than the best drug the hospital had. It was just forcing everything else out. [. . .] I couldn't feel anything but the pain, and I knew that I had found a way to save myself" (222). Willow has taught herself to "transmute emotional pain into the physical realm" (96) and pre-empts confrontation with the trauma of the accident by slashing her skin; several studies corroborate the ability of self-harm to mitigate mental distress ((Barton-Breck and Heyman; Klonsky) and cite this as a popular reason behind self-harm,[17] and to this end, Hoban's depiction is laudable.

While Willow's use of cutting as a numbing agent is both authentic and moving, her self-harm is romanticised in its demarcation of her as deep, unique and worthy of Guy's affection. Willow is adamant that she isn't an ordinary teen, lamenting that she "thinks about the razor the way other girls might think about ice cream" (59). Juxtaposed against her classmates who shop and gossip about boys, Willow's cutting is intended to portray her as mature and reflective; it is a damaging depiction that shows self-harm as beautiful and affirmative above all else. Throughout the novel, Guy comments on how Willow is complicated and "so different from anyone else" (139). Rather than depicting cutting as having "a profoundly isolating effect" (Barton-Breck and Heyman 457), it lures Guy in. Willow is the damsel in distress, and Guy is the white knight that must save her from herself; he, not Willow, is the hero of the story. While Willow's cutting does inarguably set her apart from the crowd, it is relegated to fodder for Guy's attraction to her, an eye-catching accessory without which their romance does not exist. Without Willow's cutting she is just another girl; it is her faithfulness to the razor that makes her intriguing, in a troubling advocacy for self-harm as a means to stand out from the crowd.

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[17] Andy Barton-Breck and Bob Heyman's 2012 study found that cutting "allowed intense mental distress to be concealed, so that the person who was self-hurting could present a front of calm normality" (453); E. D. Klonsky's 2007 study had similar findings, in which 65% of self-harming adolescents surveyed reported the reason for their actions was "to stop bad feelings" (231).

Willow is a textbook example of David Mitchell and Sharon Snyder's notion of "narrative prosthesis" (274), a term the two coined in 2001 to describe situations in which disability is used to drive narrative. Willow's cutting, an outward sign of her poor mental health, is merely an idiosyncrasy, a "stock feature of characterization" (Mitchell and Snyder 274) that makes for a more interesting story, for the "anonymity of normalcy is no story at all" (280). Her self-harm marks Willow as damaged and fragile, begetting the vulnerability necessary for Guy to save the day; it is a plot device rather than a commentary on teenage mental health, a throwback to the problem novels and bleak books of the previous century rather than a modernised exploration of mental health. The novel "rehabilitates or compensates for its 'lesser' subject by demonstrating that the outward flaw 'attracts' the storyteller's – and by extension, the reader's – interest" (Mitchell and Snyder 279); in Willow's case, it also attracts Guy's attention. Literature too often relies on disability for narrative purposes but fails to identify those with it as a "disenfranchised cultural constituency" (Mitchell and Snyder 280), a criticism applicable to *Willow*, which configures its protagonist's cutting not as disempowering or alienating, but constructive and attractive.

Not only is Willow's cutting painted as beneficial, her depression and trauma are employed as opportunities to belittle the more commonplace complaints of her classmates and further delineate Willow as 'not like other girls.' When Kristen prattles on about an SAT course, Willow chides, "Nothing could seem less important" (43). She derides Vicki for getting tearful after breaking science equipment: "Doesn't this girl know that a couple of broken beakers and a failed physics experiment are nothing to cry over?" (52). When a classmate refers to a hair-colouring mishap as a catastrophe, Willow scolds, "That's her idea of a catastrophe?" (58) and suggests that she show her pictures of her parents' accident. This mentality that things could always be worse sets a dangerous precedent for the treatment of mental health by suggesting that a threshold of trauma must be met in order for sadness to be valid. Yes, Willow has suffered unbearable loss, but that doesn't nullify other less harrowing causes of emotional pain.

Hoban's troubling portrayal of self-harm continues with her pervasive sexualisation of cutting, which ultimately serves to downplay the seriousness of self-harm by depicting it as romantic and seductive. There is an erotic connotation to self-harm early in the novel, with Willow noting that "her blood spouts as voluptuously as David's tears" (37). When Willow is forced to open a cut on her foot when she can't escape to get her "fix," she comments that she "feels like a woman playing footsie with her lover at a fancy dinner party" (50). These bizarre similes supplant the gravity of Willow's cutting with images of innocent arousal. Later in the novel, when Guy insists that Willow call him the next time she cuts, Willow notes that "the sound of their breathing in tandem is shockingly intimate" and grasps the phone "as if it were her lover" (183). Even Guy's medical assistance is described like an erotic, forbidden tryst: "His hands, his big and beautiful hands that have bandaged her arm and felt her scars, only remind her that he knows her deepest secret" (214). By accentuating a link between cutting and desire, Hoban suggests that Willow is substituting her romantic connection with Guy for the release of cutting and hasn't processed the trauma of the accident.

Willow's most damaging feature is, like *My Heart and Other Black Holes*, its representation of love as an expeditious cure-all for mental illness, one that renders the protagonists passive cogs in their recoveries. After meeting Guy, Willow's outlook on life rapidly shifts, as she acknowledges that "when he's with her she's able to forget the lure of the razor for more than five minutes at a time" (138), echoing Aysel's immediate infatuation with Roman. Guy's power over Willow is evident early in their relationship, with Willow resisting the urge to cut simply because Guy asks her to; it is an immediate change of character that depicts love as a poetic saving grace, suggesting that if only she had met Guy earlier, perhaps she would not have started cutting at all. After a few kisses, Willow falls in love with Guy, crediting him with her improved mental health: "It is his love that enabled her to endure the grief that issued forth" (304). Guy's love is a quick remedy that effaces the hard work and introspection more realistically associated with recovery. Guy's control over Willow's recovery is furthered by his insistence that she stop cutting once they sleep together. "I'm your lover now. [. . .]

That box of blades can't be your lover anymore, no matter how much they've been there for you in the past" (327). What the novel fails to consider is that perhaps a girl can improve her mental health without a lover of any kind. Despite the preposterousness of Guy's boastful and naive statement, Willow throws her blades in water. "The curtain is drawing closed over the past seven months, and her brave new world with Guy beside her is beckoning" (329). *Willow* propagates the damaging notion that not only does Willow need saving, but she cannot do it without a man by her side.

It is, like Warga's novel, a massive oversimplification of recovery. A single moment of emotional confrontation impelled by newfound love does not erase months of anguish and pain; yet, the novel paints recovery as a one-time fix that is easily attained once the right guy (Guy, of course) is met. As this chapter shows, in YAL, recovery erroneously means cure – absence of mental health symptoms rather than life lived alongside them – and cure is essential to the happy ending. The positivity and hopefulness embedded in these novels echo the inspirational messages within the Recovery Narrative, with both showing a life free from mental illness as ideal. Getting better is the only acceptable outcome, and experiences that challenge this are left out of each genre. The (self)diagnosis-love-recovery trope within YAL elevates the very mental health paradigms that much of mainstream fiction is working to subvert, and instead increases stigma among those whose mental illness experiences sit outside this pathway. While I can see some merit to showing mentally ill young people that life can get better, to depict the unrealistic eradication of symptoms, and to render it so easily achieved, sends a dangerous, and I argue unethical, message to vulnerable teenagers. This further entrenches contemporary YAL as a modernised version of the problem novel, which in 1976 author Jane Abramson condemned for succeeding "only in mirroring a slick surface realism that too often acts as a cover up," resulting in novels that "set out to tackle painful subjects" but ultimately "turn into weak testimonies to life's essential goodness" (38). Hoban's failure to acknowledge Willow's continued risk of both self-harm and suicide forces a happy ending that isn't rooted in reality and misleads young readers about the ease and extent to which one can move beyond self-harm as emotional regulation.[18] For the majority of young adults with mental illness, recovery will not be so effortless nor so complete, and the proliferation of novels that depict closure and cure rather than chaos and complexity are perpetuating damaging misinformation in the name of entertainment.

While I have in this thesis been quick to criticise the medicalisation of mental illness, arguing for a more person-centred approach in which empowered individuals advocate for themselves, I can't ignore the potential value of professional help in assessing and assuring young people with mental health issues. Adolescence is a confusing time of profound growth and change, of hormones and heartbreaks, and mental illness is not something I would recommend a young person navigate independently. That said, a medical professional need not be the only avenue of assistance, and a parent, guidance counsellor or teacher might offer sufficient support. This connects to questions posed earlier in the chapter: Given that YAL may be an adolescent's first encounter with mental illness, is it damaging to suggest to naïve, inexperienced readers that they can, and should, be able to surmount mental health issues on their own? Teacher and librarian Diane Scrofano calls for novels "that mirror teens' experiences of clinical illness, including visiting the psychologist's or psychiatrist's office, trying out different medications, dealing with side effects, having conflicts with family members, and all the rest that a modern-day diagnosis of mental illness entails" (15); yet, like *My Heart and Other Black Holes*, *Willow* eschews therapy and medicine in favour of love and secrecy. While I certainly am not suggesting a unilateral medical approach to mental illness, it is concerning to see novels quickly shut this pathway down when many young people might find value in it. Just as Aysel and Roman agree to talk to each other rather than a psychiatrist, Willow's reliance on Guy as

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[18] As Samantha Woodley et al. explain in their 2021 study on self-harm, "mental health difficulties and increased risk of suicide" remain "even if the self-harm has stopped" (Woodley et al); yet, Hoban's novel has the reader believe that Willow is completely cured and her journey with mental illness is in the past. Barton-Breck substantiates this sustained danger of self-harm, highlighting the risks of prolonged self-harm and noting that "those who self-hurt are up to 30 times more likely to commit suicide than those without such a history" (Barton-Breck 448). Not only does *Willow* fail to address any of these complications, it romanticises cutting by tying Guy's attraction to Willow's self-harm.

the keeper of her secret has dangerous implications for her long-term mental wellbeing. As Barton-Breck notes, one of the most damaging by-products of using self-harm to mitigate emotional pain is that the "underlying difficulties remain unmanaged" and "deferring the mental pain of confronting such issues [is] achieved at the price of having to live on-and-on with them" (459). Willow's parents died only seven months ago, and she is ill-equipped to fully process this with only the help of Guy. While she purports to be done with cutting, she has shifted her dependence on physical pain as an outlet for her sadness to reliance on her emotional connection with Guy instead. It is an exchange of coping mechanisms, not proof of growth. It is easy to visualise Willow – when her relationship with Guy hits low moments or vanishes altogether – returning to cutting as a numbing agent.

This 'love will save the day' trope permeates many young adult novels beyond those discussed above,[19] exposing a frustrating trend toward trivialising mental illness. As Thaller explains, "While happy endings offer invaluable hope to young readers in the confusion and chaos of adolescence, it is crucial that these closures be realistic in their portrayals of serious illness or mental health issues" (145). Scrofano echoes this sentiment, explaining the importance of showing what happens *after* diagnosis and treatment, responding to 'What next?' rather than providing tidy conclusions that require cure and focus on romance (18-19). In a troubling number of young adult novels, the love story is at the forefront, with mental illness serving simply as a conduit to bring two potential romantic partners together; by relegating depression, anxiety and self-harm to perverted 'meet-cutes' and painting mental illness as a solvable inconvenience that can be mitigated by romance, these books spread harmful messages about the seriousness and longevity of mental illness.

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[19] Sophie Kinsella's 2015 novel *Finding Audrey* falls prey to the same cliché, with Audrey's severe anxiety and panic attacks quickly vanishing once she meets Linus. Within three weeks, Audrey shifts from wearing dark sunglasses, refusing to touch anyone or even leave the house, to meeting Linus at Starbucks, kissing him, talking to strangers and announcing to her therapist that she is "cured" (194). *A Million Little Snowflakes*, Logan Byrne's 2013 novel, features tough girl Lacey whose rough exterior melts after meeting Oliver in the psych ward of a Chicago hospital. Within ten days, she goes from snapping, "I don't really give a shit about living anymore" to falling in love with Oliver, smiling, proclaiming that she is doing "great" and planning a post-hospital date with Oliver when he is released (Byrne).

The intentions behind these ill-begotten, euphemistic narratives can only be surmised. Perhaps YAL authors are unsure how to address mental health within the liminal space of adolescence, and thus play it safe by introducing the general idea of mental illness, but without the details – the chaos, fear and uncertainty embedded within it. But I would argue, if this is the case, that telling reassuring half-truths about something as serious as mental illness is more perilous than saying nothing at all, and underestimating the emotional maturity of contemporary teenagers results not in protection but endangerment. If, as Lynch suggests, “authenticity” is paramount and “there’s nothing to be afraid of” (38) when broaching thorny subject matter, then the entirety of a topic must be open for exploration – the hope and reassurance, but also the ambiguity and apprehension. Where authors do address the darker side of mental illness, it is relegated to Author’s Notes buried at the end of the text, warnings and statistics that ring hollow on the heels of stories that glamorise mental illness. Warga’s contention that “the road to recovery is long and ongoing” (302) and “you should treat [suicidal thoughts] as a medical emergency” (303) belies the novel she has written, reading more like a tacked-on legal disclaimer than genuine guidance. It is clear that Sutton’s call for YAL to provoke young people to ponder, “What do I, the reader, do now?” (35) has yet to be answered by the literature of mental illness, which seems reluctant to engage with this level of self-reflection, to challenge readers to act, to question, to sit with and make space for unsettling messages of uncertainty. While “confrontation of this kind can upset and disturb adolescent readers,” it is a necessary byproduct of producing adolescents who can face the world with strength, knowledge and empathy, and, as Sutton proclaims, “I wish it would happen more” (35). Happy endings may seem more “finished” (Sutton 35), but the love-cures-all trope is irresponsibly harmful, and young people’s understanding of mental illness is not expanded by these representations but hampered.

Romanticising Suicide

In addition to the portrayal of mental illness as alluring and love as its healing tonic, another problematic shortcoming of recent YAL is the widespread mistreatment of suicide, which ranges from depicting suicide as a valid form of revenge to rendering it fodder for a protagonist's self-discovery. Similarly to *My Heart and Other Black Holes,* novels like Gayle Forman's *I Was Here* and Jay Asher's pop-culture phenomenon *13 Reasons Why* consign suicide to a plot device that sensationalises suicide rather than highlighting the desperation and hopelessness of those who see no way out. As Simon Critchley explains in *Notes on Suicide*, "Suicide needs to be understood and we desperately need a more grown-up, forgiving and reflective discussion of the topic" (13), and while fiction offers an intriguing and complex avenue for such a conversation, it is clear that recent YAL hinders this call for a progressive philosophical shift in attitudes by continuing to present suicide in a restrictive, idealistic manner.

In *I Was Here*, Cody is confined to a life of cleaning houses in small-town Washington, living with her flighty mother Tricia, unable to afford university, until her best friend Meg unexpectedly kills herself; the novel focuses on Cody's quest for answers, with Meg's suicide never fully explored, instead used simply as impetus for Cody's adventure and self-discovery. Meg's death has value only in as far as it affects Cody, with her suicide ultimately liberating Cody from a life in Meg's shadow and allowing Cody to become the person she so desperately wants to be. The glimpses Forman offers from Meg's perspective are limited to rambling emails and exchanges on the online pro-suicide community Final Solution, both of which feature flowery language and philosophical quotes masquerading as deep thought, and these ultimately serve to not only validate suicide as a viable alternative to help-seeking, but glamorise it as rebellious and brave. These aspects of the novel merge to form a precarious depiction of suicide that side-steps actual mental illness and instead focuses on suicide's ability to improve the lives of those who are left behind.

The novel's plot is a prime example of children's literature scholar Eric Tribunella's notion of melancholic maturation in which "the experience of loss is transformative" (xv) and the trauma of losing someone or something dear is “an enabling injury, one that both triggers maturation and constitutes maturation” (xiv). While lessons of maturation are important in YAL, with loss and trauma often entangled with this growth, this thesis exposes a worrying trend in which mental disability is exploited as a means to achieve this; in *I Was Here*, Meg is a sacrificial lamb whose sole purpose is to prompt emotional growth in her ‘normal’ friend Cody. By relegating Meg’s suicide to “an enabling injury” that impacts Cody, Forman disregards Meg’s anguish and fails to acknowledge – with any kind of empathy – that mental illness has prevented Meg herself from ever reaching maturation. As Thaller adds in her own discussion of melancholic maturation, too often the literary martyr is a character “who cannot be socialized into culture, who cannot mature, and who, because of psychological or behavioral ‘abnormalities,’ society would prefer to discard” (154). Meg’s mental illness and self-inflicted death makes her a character whose passing can imbue change in Cody without causing a sense of large-scale social loss. Meg’s suicide is a catalyst – a clear example of narrative prosthesis – relevant only in its repercussions, and her depression is tacked on as a last-minute detail to tie up the mystery of her suicide, relieve Cody and others of unnecessary guilt and justify her death.

Meg is not a character but a prop, her suicide treated as an enticing mystery that Cody must solve to get closure and forgive herself for the jealousy that caused a lapse in their friendship. “Meg was my best friend, and I thought we were everything to each other. [. . .] But it turns out, I didn’t know her at all” (54). Fuelled by anger and disbelief, Cody sets out to uncover the truth, unwilling to accept that Meg deliberately killed herself, disturbingly blind to the possibility that Meg was unwell and saw no other option. At various points in the novel, Cody suspects that Meg’s one-night-stand drove her to suicide, that Meg was coerced into killing herself and even that she was possibly murdered. Though grounded in grief, Cody’s investigation frees her from the monotony of her humdrum life, and while her adventure is ostensibly undertaken in service of her deceased friend, Cody repeatedly focuses on herself. “Tragic Guitar Hero” (30) Ben, who Cody initially accuses of sleeping with Meg (which he did), abandoning her and essentially driving her to suicide (which he did not), becomes Cody's co-detective and eventual boyfriend. When Cody embarks on a cross-country drive to confront a man who gave Meg advice on Final Solution, she decides to take a detour to visit her own estranged father, finding resolution in an aspect of her life that has always been marked by uncertainty. The novel ends with Cody finally mustering the courage to leave her small town to attend university in Seattle, with Ben by her side. The epitaph on Meg's grave reads "I WAS HERE" (270), but Meg's only legacy, as far as the novel is concerned, is that of Cody's success. Rather than painting Meg's suicide as tragic or untimely, or using her novel as an opportunity to elucidate the realities of depression, Forman restricts Meg's suicide to its intersection with Cody's orbit. Her suicide is, at its core, emancipating, not disheartening, with Cody living her best life in the wake of her friend's death.

Forman's failure to adequately address the role of depression in Meg's suicide within the novel and instead relegating her discussion of mental illness to her Author's Note is a missed opportunity; focusing on the aftermath of Meg's suicide – in which Cody is inarguably better off – while glossing over the hopelessness and fear that brought Meg to end her life is the perfect tinder for romanticising suicide. When Cody's investigation leads to the realisation that Meg *did* intend to kill herself, she relays the bad news to Meg's parents only to find out that they already knew. Meg's mum, Sue, explains that Meg had depression, which she inherited from her: "I've struggled with this for such a long time, not only depression but the stigma of it in a small town, and I didn't want her saddled with that at age fifteen. [. . .] So we kept it quiet" (258). But keeping the truth behind Meg's suicide a secret only perpetuates the stigma of mental illness, that it is shameful and best hidden from public consumption, just as consigning information about depression to the Author's Note suggests that the nitty-gritty of mental illness isn't worthy of narrative exploration and is more suitably tucked away in an addendum.

Despite Cody's ignorance of her friend's depression, Forman peppers clues throughout the novel. Meg apparently had mono in tenth grade and stayed home from school for months, with Cody not even allowed to visit. Cody relives the night that Meg supposedly got sick:

> She'd done a bunch of Jagermeister shots and had been making out with Clint Randhurst. Things went too far too fast. And though she didn't exactly say no, she definitely hadn't said yes. To make matters even worse, Clint must've been the one to give her mono. Because after that was when she got sick. (87)

Meg never had mono, and the date-rape incident led to her first spiral in depression. Despite being the impetus for Meg's depression and a weighty topic in and of itself, this date rape is never mentioned again, nor the link between the two ever remotely explored. As psychiatrist Kay Redfield Jamison writes, "Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated" ("Night" 24), yet Forman breezes past Meg's despair at every opportunity. When Meg is mentioned, she is venerated as 'cool' and beautiful and wise beyond her years, the private pain within her muted in favour of presenting her external light. But, as Jamison suggests, "If the suicide completer's problems are not acknowledged along with these laudatory statements, suicidal behaviour may seem attractive" (Jamison, *Night* 282), and this representation of Meg does more harm than good.

When Meg's depression is addressed, it is a one-dimensional representation devoid of sympathy and compassion. The only symptom of Meg or her mother's depression depicted is excessive sleeping: "I've never met anyone who spent so much time in bed," (174) says one of Meg's university acquaintances; Cody notes that Meg's mum "would disappear into one of her moods" (11) and similarly spend days on end asleep. It is a conflicting presentation of depression that limits its symptoms to sleeping too much – a comparatively innocuous side effect – while simultaneously showing it as the driving force behind Meg's suicide. Cody's mother, Tricia, is far from moved by Meg's suicide, telling her daughter, "You had a pile of rocks, and you cleaned them up pretty and made a necklace. Meg got jewels, and she hung herself with them" (151). Tricia's condemnation is a perpetuation of a stereotype which, like Aysel's appraisal of Roman in *My Heart and Other Black Holes*, seems to suggest that those who are seemingly privileged – with money or friends or good looks – have no right to be depressed. In her Author's Note, Forman writes about the inspiration behind Meg's character, a woman called Suzy who, Forman laments, might have gone on to do great things "had she gotten proper treatment for the condition that had put her in such pain" (272); yet, Meg's "condition" takes a narrative backseat to Cody's maturation and, rather than showing Meg seeking the help that she argues is essential, Forman depicts Meg's death as beneficial to those around her. By ignoring Meg's depression and date-rape in favour of Cody's growing confidence and bourgeoning love life, Forman attempts to write a novel about the perils of mental illness but falls short of doing so effectively.

Forman's inclusion of the Final Solution website, coupled with Meg's rambling emails to Ben, further sensationalise suicide by depicting it as 'deep' and enticingly defiant, flaunting what Crichtley refers to as the "strangely compulsive beauty to suicide" (70). Meg engages in an online relationship with a stranger who uses the moniker All_BS, and he offers support, both philosophical and practical. He preys on Meg's desire to be unique and rebellious, quoting Lao-Tzu: "Life and death are on thread, the same line viewed from different sides" (106), adding, "You have taken your first step, not toward death but toward a different way of living your life. That itself is the definition of fearless" (106). His insistence that suicide isn't an end but simply the beginning to a new way of living downplays the permanence of suicide, furthering Forman's depiction of it as magical and cathartic. All_BS reassures Meg that she needn't worry about leaving anyone behind: "You have to decide if you're willing to grab your freedom, and if in doing so, you might inadvertently set others free" (111), a prescient message that echoes the self-discovery that Cody eventually finds through Meg's suicide. The Final Solution messages focus on suicide as what Andrew Bennett describes in *Suicide Century* as the "ultimate assertion of identity and agency" (2), imbuing it with a poetic and emboldening beauty that masks the destruction, pain and despair inherent in killing oneself.

Meg has clearly been influenced by All_BS's philosophical prattling, as she writes in a lengthy email to Ben, "We are so narrow in our thinking, and once you understand that, once you decide to not abide by these artificial constraints, anything is possible and you are so liberated" (135). Meg views suicide as romantic and freeing. This ties in with Cody's description of Meg as a non-conformist who "hung her freak flag high" (9): "She never wore clothes from chain stores, always listened to bands no one else had heard of. Naturally, she found some obscure poison to swallow" (8). At its worst, *I Was Here* seems to suggest that Meg killed herself because she thought it was something else edgy and different to try. Meg's interaction with All_BS and her emails to Ben paint suicide as a viable, strong and beautiful end to pain, which alongside Cody's self-discovery following Meg's death, ultimately serve to represent suicide as a positive solution in which everyone benefits. There is no suggestion that Meg – or anyone – would have been better off if Meg had lived.

By depicting suicide as a successful problem-solving mechanism that propels surviving friends into improving their own lives, *I Was Here* is at risk of inadvertently contributing to the suicide contagion phenomenon in which such positively skewed portrayals of suicide are mirrored by a rise in real-life suicides,[20] thus invoking the ethical questions raised earlier about the moral duty of YAL. Research conducted by the American Academy of Child and Adolescent Psychiatry and the American Foundation for Suicide Prevention found that "presenting simplistic reasons for suicide, [. . .] providing suicide instructions, [. . .] portraying suicide as a means to certain ends; glorifying suicide; [. . .] and focusing solely on the successful suicide's character" (Becker et al. 112) all increase suicide contagion. Through its emphasis on the aftermath of Meg's suicide – in which Cody finds her inner strength (and a boyfriend) – at the expense of exploring the causes, and its inclusion of a pro-suicide website without which Meg may not have killed herself, *I Was Here* is guilty of each of these. A 2009 study conducted by Katja Becker et al. found that websites like the fictional Final Solution offer the "opportunity to discuss views about a taboo and an anonymous cost/benefit analysis of a possible suicide," serving as a triggering stimulus that can and often does tip the "precarious balance between a chosen life and a chosen death" (Becker et al. 113) in favour of suicide. One could

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[20] Though much research about the suicide contagion involves media and news report of factual suicides (Carmichael and Whitley, CDC, Ortiz and Khin Khin, "Samaritans," Sudak, Velting and Gould), the much-documented Werther effect, in which Goerthe's 18th century novel *The Sorrows of Young Werther* prompted numerous copycat deaths among young men, demonstrates that the phenomenon stretches to fictional suicides as well.

certainly argue that by depicting Final Solution's complicity in Meg's death and the encouragement Meg receives from it, Forman is sharing a road map to suicide for vulnerable readers. There is little doubt that *I Was Here,* published by Simon and Schuster's children's division, is targeted toward young adults; Forman's romanticising of Meg's suicide can easily be read as ethically irresponsible, with potentially fatal consequences.

Despite quoting in her Author's Note that more than 90 percent of people who kill themselves have a mental disorder, Forman's *I Was Here* removes mental illness from the narrative, instead configuring Meg's suicide as the driving force for protagonist Cody's emotional growth. Juxtaposed against her failure to fully delve into Meg's depression and represent her pain, Forman's attempt to promote suicide prevention falls flat. She writes, "If you're in the dark, it might feel like you will always be in there. Fumbling. Alone. But you won't – and you're not. There are people out there to help you find the light" (Foreman, "Author's Note"); yet, she depicts Meg reaching out to a nurse who dismisses her depression as Seasonal Affective Disorder. Forman claims to advocate getting help and finding ways to grapple with suicidal thoughts, but her configuration of Meg's suicide as freeing and empowering, and her depression as secretive, is anathema to this. Forman derides the pro-suicide message boards, yet she portrays them as addictively alluring. Even Cody is drawn into the cyber world when trying to flush out All_BS and finds "telling the truth" (144) to strangers comforting and the messages so persuasive that she begins ideating suicide herself. *I Was Here* is a novel about suicide, but not mental illness, and the separation of the two leads to a damaging romanticisation of suicide that subverts the author's intention while disserving the mental illness community. As Critchley notes, in our confrontations with suicide, "We are either desperately curious about the nasty, intimate, dirty details of the last seconds of a suicide and seek out salacious stories whenever we can. Or we can't look at all because the prospect is too frightening" (13). *I Was Here* somehow manages to do both; it gives the gory details of Meg's death – the hotel room, the poison, the tip for the maid – and yet stops short of actually exploring her death. "Instead we peek through the slits between our fingers with our hands on our face, as if we were watching a horror movie" (13), chides Critchley. Forman's novel is one such shrouded glimpse, offering an incomplete representation of suicide that focuses solely on plot-enhancing elements while concealing those, like Meg's depression and date-rape, which would put a damper on the novel's ill-conceived message of hope and self-discovery.

Jay Asher's 2007 novel *13 Reasons Why* offers an equally damaging representation of suicide by painting it as an effective revenge strategy through which protagonist Hannah teaches those who have wronged her a lesson. By structuring the narrative around 13 cassette tapes that Hannah leaves behind chronicling her reasons for killing herself – her 13 reasons why – the novel ties Hannah's suicide to a finite number of events caused by others, reducing her suicide to external motivation while never mentioning the words 'depression' or 'mental illness' or giving any insight into Hannah's internal struggle. Through its portrayal of Hannah's death as successfully vengeful and its failure to address mental illness, *13 Reasons Why* romanticises suicide, ascribing Hannah hero-status for owning her story instead of allowing those around her to continue to impact her life negatively. This toxic depiction of suicide is intensified through the novel's treatment of Hannah's potential support system; Asher villainises the adults in positions of power as well as Hannah's peers who turn a shoulder to her cries for help, problematically insinuating that asking for assistance with mental health is pointless, and suicide is the only option.

The novel, released in 2007, was met with a mixture of adoration and criticism, rising to the number one position on the *New York Times* bestseller list while simultaneously becoming the third most banned book in the United States, echoing the controversy surrounding the problem novels of the 1970s, which Cart explains enjoyed "enormous success with young adult readers" despite "receiving scorn and disapproval from adult reviewers" (26). Teens flocked to what they considered a gripping, emotional story of a bullied girl's revenge, while parents, teachers and mental health professionals derided it for showing Hannah's suicide as an impulsive, permanent and vengeful solution to very common – albeit distressing – teenage problems. Netflix adapted the novel to the small screen in 2017 and was met with an equally divisive reception, garnering an impressive six million viewers and a Golden Globe nomination for Best Actress amid scathing articles in major publications like *Rolling Stone* magazine and *The Washington Post* (Curtis and B. Butler, respectively), chiding the show for its irresponsible, romanticised depiction of suicide and its potential contribution to the suicide contagion phenomenon. Given the youthful target audience and the success of both the novel and the show, *13 Reasons Why*'s "remarkably, even dangerously, naïve [. . .] understanding of suicide" and its reverence for a "teenager who fantasizes how everyone will react when she's gone" (Stuever) is all the more dangerous.

By posthumously leaving tapes behind for those complicit in her death, Hannah manipulates the narrative to cause the most harm to her listeners, to make each feel that he or she is somehow responsible for her suicide, whether through bullying, assault, an act of omission or as part of the snowball effect of common teenage behaviour. "Every single event documented here may never have happened, had you, Alex, not written my name on that list" (41) she denounces, indicting Alex for putting her down as having the "Best Ass" in the "Who's Hot/Who's Not" list (39) that is passed around school. It is a relatively minor indiscretion, but not only does Hannah refuse to forgive, she highlights this moment as the driving force behind her suicide. Hannah weaponises her death, orchestrating her story for the sole purpose of inflicting pain. Her intent is clear: "Rule number one: You listen. Number two: You pass it on. Hopefully, neither one will be easy for you" (8). She threatens that a second set of tapes exists and will be published publicly if her rules are not abided by, warning, "Do not take me for granted [. . .] again" (10). Hannah wants to feel important through her death, to be noticed and acknowledged as more than the "best ass," and she wants those she deems responsible to pay the price. And that they do. Tyler, the peeping Tom, gets his house vandalised by others who have listened to the tapes, Alex gets pushed in the hall, and Bryce and Jenny, whose wrongdoings were more unlawful than simply unsavoury, will undoubtedly face longstanding consequences. Hannah's suicide has evoked change – and more will come as the tapes make their way to everyone on the list – but by showing Hannah's tapes as effectively vindictive, the novel doesn't serve as a cautionary tale of a life taken too soon but rather an advocacy of suicide as payback and resolution; this is exacerbated by the strong presence of Hannah's voice throughout the novel, which rather than disappearing after her suicide, is now louder and more confident than ever.

13 Reasons Why is a revenge fantasy seen to fruition, but one whose effects Hannah is not alive to witness. As Alexa Curtis writes in *Rolling Stone*, "In real life, when someone commits suicide, their story ends there. *13 Reasons Why* failed to end Baker's story, since she lives on through the tapes. We become captivated by the drama of the suicide rather than the actual suicide itself" (Curtis). Hannah's tapes give her life after death, belying the permanence of her suicide and empowering her from beyond the grave; by giving Hannah influence in death that she never had in life, the novel sensationalises her suicide, bypassing "the utter emptiness and grief that occur after someone commits suicide" (Curtis) in favour of the drama caused by her recordings. It is a mistreatment of suicide that not only shows Hannah's voice stronger than ever in her tapes, but focuses on a person's ability to retroactively cause remorse and pain – not through suicide itself, but through the posthumous sharing of secrets.

The title of the novel indicates a vast oversimplification of Hannah's suicide by tying it to 13 concrete reasons; it is these specific incidents and individuals that Asher depicts as triggering Hannah's death, and not the more likely culprit of mental illness, which is completely missing from the narrative. The incidents of bullying, assault, rumour-spreading and betrayal of which Hannah speaks, while disturbing and hurtful, are regrettably common among high school girls, and yet most high school girls do not commit suicide because of them. As David Wiegand explains in the *San Francisco Chronicle*, "Relatively minor misperceived slights seem to send [Hannah] into an emotional tailspin" (Wiegand) – things like Courtney not saying good-bye, or a teacher innocuously mentioning a yearbook photo, or a date showing up late – suggesting deeper underlying mental health issues are at play, causing these slight frustrations to propel Hannah down the path to suicide when others may have found less extreme recourse. These events, in the absence of mental illness, do not often lead to suicide. As critical theorist Julia Kristeva recounts in her treatise on depression, *Black Sun*, "A betrayal, a fatal illness, some accident or handicap that abruptly wrests me away from what seemed to me the normal category of normal people. [. . .] What more could I mention? An infinite number of misfortunes weigh us down every day. [. . .] All of this suddenly gives me another life" (Kristeva 4). In the mind of the depressive, small events can loom large, with a wave of sadness crashing over at a random moment, leading to "a life whose burden constantly seems unbearable" (Kristeva 4). When put in this context, Hannah's suicide over a string of events seems plausible, but by failing to discuss any depression or mental illness, the novel reads simply as a vendetta realised rather than a manifesto on well-being, and any message about the dangers of depression is lost.

The novel's entire structure hinges on Hannah's logic, her reasoning that these people, these tangible events, have caused her death. But as Andrew Solomon explains in *The Noonday Demon*, "Suicide is not logical. [. . .] The reason given is seldom sufficient to the event. [. . .] If they killed themselves, they did it because they were suicidal, and not because it was the obvious outcome of such reasoning" (262). A. Alvarez, in *The Savage God* adds that "the real motives which impel a man to take his own life are elsewhere; they belong to the internal world, devious, contradictory, labyrinthine, and mostly out of sight" (123). *13 Reasons Why* ignores Hannah's inner plight, the mess and chaos, the tears and the despair, instead packaging up her reasons into a carefully composed narrative of external events. Despite the fact that Hannah is narrating the tapes, giving the reader a first-person perspective, her account is factual, not emotional, and we are left to connect the dots between the events of the tapes and her ultimate decision to die. By describing the thirteen events and Hannah's solution to them – a revenge suicide – without showing the depths of Hannah's inner struggle and the truth behind her harrowing decision, the novel pre-empts a conversation on mental health before one can even begin, and Hannah's suicide seems less like an escape from a permanently intolerable life and more like a naïve, impulsive mistake rooted in retribution.

Another noticeable issue with Asher's novel is its portrayal of key adults as woefully unsupportive and Hannah's peers as judgmental and flippant, propagating the belief that asking for help is futile and one is better off keeping feelings bottled up. It is a hazardous lesson to be passing on to a target audience of teenagers, but one that is far from new. Criticising the bleak books of the

90s, Sara Mosle argues that the most troubling aspect of the novels is their “depiction of adults as almost unrelievedly materialistic, self-absorbed, irresponsible, distrustful, physically or verbally abusive or uninterested or incapable of communicated with their children – despite literal cries for attention” (35), and Asher’s novel confirms that this worrying trend of adult ineptitude is still rampant in contemporary YAL. Hannah reaches out during her Peer Communications class by posting an anonymous message about her suicidal ideation, but rather than prompting the meaningful discussion that Hannah hopes it will, everything her classmates say is “tinged with annoyance” (171). Many of her peers want the sordid details, explaining that “it was going to be hard to help without knowing why the person wanted to kill himself” (171). Another chimes in, “It’s like whoever wrote this note just wants attention” (172). Hannah’s teacher, Mrs Bradley, rattles off suicide statistics and hands out a flier discussing the signs of suicide, but her involvement ends there. She makes no effort to seek the identity of the anonymous poster, nor do Hannah’s classmates, despite the fact that the warning signs includes “a sudden change in appearance” (173), and with Hannah having just chopped off her long hair, it doesn’t take much to read between the lines. It is hard to believe that a teacher wouldn’t follow up on a student’s mention of suicide, especially since most schools have protocols requiring them to pass along information like this. Mrs Bradley could have had one-on-one conversations with each student, sent out a message to parents, invited in a professional to speak to the class – the list goes on and on. And yet, because it better propels the plot of his story, Asher has Mrs Bradley do nothing and Hannah’s classmates shun her cry for help.

As Curtis says, “Had *13 Reasons Why* showcased other forms of outreach, like therapy, teens [. . .] might realize that there is always an option that doesn’t include self-harm” (Curtis); yet the closest Hannah comes to seeking profession help is through Mr Porter, the English teacher and part-time guidance counsellor who is similarly inept. Hannah tells Mr Porter she feels “empty” and “lost” (271), that she wants her life to end, that the “snowball effect” (273) is too much, and Mr Porter offers her tissues instead of support. When Hannah tells him Bryce assaulted her, Mr Porter says that unless she wants to press charges, she has two choices: “You can confront him” (277) or, “You can move on" (279). These are far from Hannah's only options, and Mr Porter is dangerously remiss to reduce her choices to two equally unpleasant possibilities. Hannah storms out of his office, saying that her life is at risk, and Mr Porter lets her leave. "I think I've made myself very clear, but no one's stepping forward to stop me" (280), Hannah explains as she concludes her final tape. This is shocking behaviour from an adult in a position of authority – a guidance counsellor, no less. Why, for example, does Mr Porter not immediately phone her parents? Why does he not chase after her? By writing Mr Porter as callous and ineffectual, Asher sends the message that seeking help is a waste of time, or worse, affirmative of internal negativity. Rather than showing Mr Porter – or Mrs Bradley or Hannah's classmates – engaging in a healthy discussion of suicide and depression, one that could resonate with readers and could have prevented Hannah's death, Asher portrays them as complicit in her suicide through a lack of action. And Mr Porter, like Zach and Ryan and Courtney and the others, will learn about the implications of his behaviour when he receives Hannah's tapes; his is the final name on her posthumous hit list.

Suicide prevention advocate Elana Premack Sandler explains, "By presenting suicide as the only option in Hannah's situation (we know the ending from the beginning), *13 Reasons Why* doesn't tell the much more common story of people living with (struggling with, but living with) difficult emotions and experiences and figuring out, with support and help from others, how to survive" (Sandler). Instead, the novel sensationalises Hannah's death by focusing on the chaos and guilt brought on by her tapes, and it is the information within the tapes, not the fact that Hannah is no longer around, that has a profound effect on those in her life. This, along with Hannah's goal of revenge, the novel's structure around external events and Asher's failure to include mental illness, combine to form a distressingly misbalanced view of suicide that devalues and disregards the lived experiences of those who have considered or attempted suicide and those who have lost someone to it.

As Jamison explains in "To Know Suicide," an Op-Ed she penned for the *New York Times* in 2014, "Suicidal depression is a state of cold, agitated horror and relentless despair. The things you most love in life leach away. Everything is an effort, all day and throughout the night. There is no hope, no point, no nothing" (Jamison, "To Know Suicide"); yet, this hopelessness and desolation is absent in too much YAL,[21] as are support routes that may help guide one through this darkness. By depicting suicide as beautiful and freeing, the impetus for a friend's self-discovery or a successful revenge tactic, these novels are ethical inadequacies that fail to relay the seriousness of suicide to an audience that is at high risk of succumbing to it.

Demonising Schizophrenia

YAL's characterisation of schizophrenia, a severe mental illness marked by periods of psychosis,[22] as demonic and violent is equally problematic, perpetuating harmful stereotypes and misinformation that exacerbate the "personal, family, social, educational [and] occupational" ("Schizophrenia," World Health Organization) injustices already facing those with this condition.[23] The "stigma against people with [schizophrenia] is intense and widespread" ("Schizophrenia," World Health Organization), resulting in social exclusion that is predominantly tied to underlying assumptions of

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[21] The mistreatment and romanticisation of suicide seen in *13 Reasons Why*, *I Was Here* and *My Heart and Other Black Holes* is sadly not restricted to these three texts. Stephanie Meyers' popular series *Twilight* features Bella risking her life to hear Edward's voice once he abandons her; after he believes Bella has died, Edward travels to Italy where he embarks on a suicide attempt that is only at the last minute foiled by the very-much-alive Bella. Their behaviour is intended to show the depth of their love – one cannot live without the other – but the reality is that Bella and Edward are merely two teenagers blinded by passion and first love who are willing to die for someone they have only recently met; through their suicidal ideation, Meyers promotes rash and permanent action to cope with momentary sadness. *All the Bright Places*, Jennifer Niven's 2015 novel, features – like *My Heart and Other Black Holes* – two teenage protagonists who meet while contemplating suicide. Violet harbours survivor's guilt over the car accident that took her sister's life, and Finch has a history of erratic behaviour and mood swings. While the novel's depiction of the characters' inner turmoil is touching, for example, Finch's desire to feel alive while simultaneously obsessing over suicide, its treatment of suicide is nonetheless problematic. Violet overcomes her suicidal contemplation simply by falling in love with Finch, and Finch's suicide serves as an impetus for Violet's emotional development, much like in *I Was Here*. After his death, Finch bequeaths a trail of whimsical messages to Violet, leaving the reader not with a message of loss or caution, but rather, as reviewer Alex Townsend writes, the notion that "if you die the right way, you can end up being an inspiration to others" (Townsend).

[22] significant impairments to an individual's grasp on reality

[23] Many with schizophrenia will experience pervasive human rights violations both inside and outside of medical care, with NIMH adding that schizophrenics have an increased risk of premature mortality and commit suicide at a higher rate than the general population ("Schizophrenia," National Institute of Mental Health).

hostility and endangerment, largely unfounded stereotypes[24] that are bolstered by exaggerated depictions within YAL. Representations of psychosis are particularly valuable in their ability to challenge public opinions and shift the reception of schizophrenics from a fearful distancing to an empathetic acceptance; portraying those with schizophrenia as evil and violent reinforces preconceptions, intensifies stigma and does nothing to ease the burden on an already at-risk community. Pop culture representations of schizophrenia often corroborate the perception of increased violence, with characters like Two-Face, The Joker, Norman Bates and Gollum exhibiting dangerous behaviour within their fictional universes, furthering the need for new representations of schizophrenia that call this relationship into question. As a whole, YAL fails to wield its power to evoke change and fulfil this need, with many recent novels, including *Finding Alice*, *The Summoning* and *A Danger to Herself and Others* contributing to the damaging stereotype of ‘the violent schizo’ for the sake of narrative and drama.

Melody Carlson’s 2003 novel *Finding Alice* features university student Alice and her descent into schizophrenia. The symptoms of Alice’s illness – the visions, hallucinations, paranoia – are heavily infused with religious symbolism and fuelled by a fear of damnation that permeated her upbringing within the Church of Salvation. The novel fluctuates between its portrayal of schizophrenia as evil and dangerous, through Alice’s visions and her attempted exorcism by Pastor John, and simultaneously benign and easily treatable, with many characters laughing off Alice’s clearly unhinged behaviour as merely a cute personality quirk. Despite the severity of Alice’s

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[24] While the relationship between perceived violence and mental illness stigma is well documented (Corrigan et al.; Pescosolido et al.; Rabkin; Varshney et al.), with schizophrenics the cohort most likely to be viewed as aggressive and dangerous, the truth behind this correlation is far less clear-cut. Studies involving the connection between schizophrenia and violence vary in their findings, largely due to methodology, but the consensus seems to be that while there is more violence within the schizophrenic community as compared to the general population, the vast majority of schizophrenics are not violent; additionally, violent episodes are restricted to certain subgroups of the condition and are largely linked to comorbidity with substance abuse (Angermeyer; Cho et al.; Fazel et al.; Silverstein et al.). Moreover, several studies (Frankle et al; Krakowski et al) found that proper treatment and medication all but eradicate instances of violence among those with schizophrenia, while another (Wehring and Carpenter) discovered that schizophrenics are 14 times more likely to be the victims of violent crimes than the perpetrators.

symptoms, she is ‘cured’ within only 10 months of the onset of schizophrenia. The novel is unable to adequately conflate these two conflicting views, and ultimately, it presents a mottled view of schizophrenia as gravely perilous, and yet avoidably so if only one meets the right people; equally problematic is Carlson’s insistence that improving mental health necessitates a relationship with God and regular prayer.

Following an unexpected break-up, Alice begins seeing visions of Amelia, a young woman dressed “like Loretta Lynn” (10), who initially says she is “here to help” (9) but quickly begins feeding Alice’s paranoia; so profound is Alice’s belief that everyone is trying to poison her that she stops eating altogether and drinks only scalding water. Amelia repeatedly tells Alice to kill herself to avoid being captured. Alice’s break with reality hinges on her belief that God is speaking directly to her and preparing her for something important: “God is giving me the answers” (21), she explains. Alice believes she is the “chosen one” (31) and that she is able “to interpret the ancient Scriptures, discern God’s deepest mysteries, and even write prophetic inspirations” (49). This connection to God, while initially rooted in Alice’s belief that she is a prophet and can evoke change, takes a more ominous turn once she is admitted to Forest Hills mental institution, and she is soon plagued with visions of Hell: “I have seen Satan and his demons in these moments. I have smelled their sulphurous smoke. I have even felt their fire melting the flesh from my bones.” (75). The visions of damnation continue once she escapes the hospital and hitchhikes to a peace rally, where she believes the speaker is Satan himself and is trying to bring her on stage to “humiliate [her] and have [her] thrown into the pit of burning flames” (98).

This demonisation of schizophrenia is furthered through Alice’s interaction with the church elders at the Church of Salvation, a cult-like organisation where Alice’s mother takes her after she is evicted from her apartment. Alice is both fearful and angry, believing Pastor John is the devil and screaming that “God is going to demolish both of you and your church [. . .] by fire” (36). Pastor John is taken aback by Alice’s outburst, viewing it as the work of evil spirits, and immediately begins to exorcise her: “We cast you out, O demon spirits” (37), he cries as he and four others place hands on her and loudly pray. “In the powerful name of Jesus, we bind you and cast you out into the fiery pit of hell” (37). Mrs Knoll, an avid churchgoer, furthers substantiates the pastor’s connection between schizophrenia and malevolence, telling Alice that “demons are trying to destroy you. [. . .] They want you to suffer and die” (39). She then shifts to victim-blaming: “What did you do to invite this evil into your heart, Alice? What sin have you partaken in that’s opened you up to this wickedness?” (40). The suggestion that Alice is possessed by demons that she has allowed into her body through sinfulness is a destructive one, a perpetuation of an archaic stereotype of schizophrenia that situates it outside the socio-medical realm and instead places blame upon the individual’s morality.[25] By giving this backwards viewpoint space in her novel, Carlson gives new life to a presentation of schizophrenia that advocates have spent decades trying to overcome.

Not only is Carlson’s portrayal of schizophrenia as inherently evil both extreme and harmful, she complicates the issue by simultaneously representing it as innocuous and trivial. Throughout the novel, Alice exhibits concerning behaviour – talking to herself, responding to voices, a complete lack of self-care – and yet, she repeatedly encounters people who are unfussed by her unsettling demeanour. When she tells her neighbour that she has been diagnosed with schizophrenia, he responds: “It’s kind of cool. I mean I feel sorry for people who are, you know, all ordinary and boring-like. I think life’s way more interesting with a few kooks around” (66). At the end of the novel when Alice meets with her former landlord – the man who discovered her surrounded by pages of biblical scrawling, shouting about being following and poisoned – he simply laughs and says, “I think we’re all a little crazy sometimes. It’s all in how you look at things” (358). These reactions, while affirmative and reassuring, reduce mental illness to an innocent quirk along the lines of wearing mismatched

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[25] The relationship between morality and insanity has wide-reaching roots, with psychiatrist Henry Maudsley (1771-1831) believing that “individuals are born with madness and badness already in them” (Appignanesi 109) and his contemporary Jean-Étienne Dominique Equirol noting that “delirium is a sickness of the soul” (Appignanesi 60). The term ‘moral insanity’ was first mentioned by physician James Cowles Prichard in 1835 in his *Treatise on insanity and other disorders affecting the mind* but was inspired by the work of physician Philippe Pinel, who “believed that the chief cause of insanity was ‘moral’ (which his contemporaries explained as insanity due to strong emotions)” and “also insisted that the best cures were moral” (Grange 443).

socks, contributing to a worrying YAL trend in which mental illness is an attractive marker of individuality; but rather than serving any beneficial purpose – challenging the medical model of mental illness or mitigating the stigma surrounding schizophrenia, for example – laughing off the severity of Alice's symptoms and downplaying her diagnosis instead sends damaging misinformation about the seriousness of the condition to a target audience who is unlikely to have the knowledge or experience to question its validity. The reality is that those with schizophrenia are often pushed to the outskirts of society rather than welcomed with open arms,[26] and by having Alice receive nothing but acceptance, Carlson belittles a serious illness that, for many people, is met with fear and avoidance and results in a harrowingly lonely experience.

Carlson has the opportunity to explore the intersection between mental illness and homelessness – a very real and pervasive problem – but falls short of a meaningful investigation by having Alice 'saved' without experiencing any major hardships or mistreatment during her journey; like the problem novels and bleak books of previous generations, which Sutton criticised for their "unduly hopeful outlook[s] on problems and their consequences" (33), *Finding Alice* reads like farfetched "soap opera" rather than "legitimate drama" (Cart 25). Everyone Alice meets after escaping Forest Hills is friendly and helpful,[27] and at no point does anyone hurt or take advantage of Alice, despite her being an attractive woman alone on the streets of Portland. While I applaud the novel's attempt to create a positive representation of schizophrenia, it ends up trivialising mental illness by steamrolling – or in this case, completing omitting – the very real obstacles that those with schizophrenia face. This may feed into Reid and Stringer's desire to reassure young readers that

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[26] A recent study by Angermeyer and Matschinger found that those with schizophrenia "face more rejection" (334) in the 21st century than ever before, with more than a third of respondents expressing reluctance to live near someone with the condition and nearly two-thirds reporting that they would not rent a room to someone diagnosed with schizophrenia. A 2005 article published by Rüsch, Angermeyer and Corrigan substantiated this desire for social distance by discussing cases of lost employment and housing due to fears of violence (Rüsch et al.); in fact, entire organisations (Open the Doors, Living with Schizophrenia and Schizophrenia and Psychosis Action Alliance, for example) exist to help mitigate stigma and improve the day-to-day lives of those with schizophrenia.

[27] Phil, who picks her up hitchhiking and takes her to the peace rally; Mock Turtle, who drives her to Portland; Cal and Martin, teen boys whom she meets on the streets and introduce her to the shelter; Faye who feeds and clothes Alice and allows her to live with her; and Faye's nephew (and Alice's future boyfriend) Simon, who works at Golden Home, the site of Alice's eventual rehabilitation.

"most situations are safe and most people today are well-intentioned" (Reid and Stringer), but this optimism fails to account for the very real dangers surrounding female homelessness.[28] Even more unsettling is that Carlson writes off Alice's unbelievable good luck – and it is certainly unbelievable – as God watching out for her, building a precarious connection between piety and protection that would see prayer as a solution to homelessness.

Similarly, Alice's road to recovery is implausibly serendipitous and swift. Faye's nephew Simon is conveniently a psychology student who volunteers at Golden Home, a progressive mental health facility run by an independently wealthy doctor who believes that people can "heal themselves" (205) through "mental, physical, emotional and spiritual" (205) treatment involving only minimal medicine. Dr Golden and his wife, Julia – who met Dr Golden when she was his patient, in yet another troubling aspect of the novel – are eager to take Alice on board and allow her to skip the year-long queue for residency; she won't even have to pay for treatment, as fees are charged on a sliding scale according to need. Within 10 months of first seeing Amelia, Alice has been admitted to and discharged from Golden Home, has re-enrolled in university and is creating a documentary about her experience with psychosis. Despite the realities of schizophrenia – a team of doctors and clinicians are needed to administer life-long care, which almost always includes medication – Alice is rapidly 'cured' and easily overcomes any obstacles in her way; her hasty and relatively painless recovery trivialises the severity of the disease as well as the lived experiences of those who fail to manage it by simply changing their mind-set or asking God for help. One can imagine Alice's documentary filled with details about her inspirational – and expeditious – recovery, much like the problematic Recovery Narratives that Woods et al. criticise for their "compulsory positivity" (222) and skewed depictions of mental illness.

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[28] Recent research by charity Crisis, which focuses on ending homelessness, reveals that "people sleeping on the street are almost 17 times more likely to have been victims of violence and 15 times more likely to have suffered verbal abuse in the past year compared to the general public" ("New Research"). The National Sexual Violence Resource Center's research shows that 1 in 3 teens are lured into prostitution within their first 48 hours on the street, and 1 in 3 engage in survival sex (National Sexual Violence Resource Center); additionally, 78.3% of homeless women in their recent study reported being raped, physical assaulted or stalked (Wells).

Carlson’s intention behind Alice’s lack of difficulty is unclear – does she view her reader as too naïve and impressionable to be exposed to violence and strife? Is she attempting to inspire hope among those with schizophrenia by portraying a world filled with understanding and those eager to help? Regardless of Carlson’s objective, the vulnerability inherent to living with schizophrenia is essential to painting a holistic picture of the condition, and showing only positive outcomes leaves young readers with a dangerously unbalanced view. While fiction authors are certainly under no directive to write a realistic depiction of anything, even mental illness, when a distorted view puts young people at risk and refutes the lived experiences of those facing homelessness or mental health issues, it needs to be questioned and challenged. As Cart explains, YAL “must take creative [. . .] risks to present hard-edged issues of relevance so that it may offer its readers not only reality but also revelation and, ultimately, that desired wisdom” (Cart 43-44); Carlson’s depiction of homelessness as harmless and schizophrenia as quirky and curable offer not wisdom but dangerous idealism.

The final line of the novel, “I am not content to live a merely ‘normal’ life or settle for an average existence. No, I am destined for more – much, much more” (371), proposes that Alice is better off for having schizophrenia, that it has elevated her above the bore of normality and made her a more interesting person. This feeds into what Catherine Prendergast explains is the public’s desire for a “stable schizophrenic,” one who is “easy to incarcerate, or easy to celebrate” (288), and in turn furthers the “exceptionalizing of schizophrenics” (295) as either geniuses or killers; Carlson makes it clear that Alice’s triumph is tethered to her schizophrenia, and thus stories of the “ordinary” schizophrenic who lives within the spectrum are again muted in favour of those belonging to the “exemplar schizophrenic” (Prendergast 295). While Alice’s success is an attempt to add a positive spin on mental illness, it also erases the truth of the schizophrenia: it cannot be cured, only treated, and many who have it would do anything to simply lead an “ordinary” illness-free life; the exceptional schizophrenic is, by definition, not the norm, yet its proliferation within YAL suggests otherwise.

While Carlson's novel presents schizophrenia as both evil and benign, *The Summoning* (2008), the inaugural novel in Kelley Armstrong's *A Darkest Power* trilogy, demonises mental illness by portraying it as uncontrolled, dangerous and mysterious; Armstrong's narrative also ties schizophrenia to burgeoning womanhood in an antiquated throwback to the Victorian notion of female hysteria. *The Summoning* opens with a flashback to protagonist Chloe as a young child in the basement of her old house, plagued by disturbing visions of ghosts, including the terrifying Mrs Hobbs, whose skin falls off in chunks, and a man hanging from the ceiling, "his face all purple and puffy" (3). The action fast-forwards to present day, where a now 15-year-old Chloe suddenly begins seeing ghosts again: a little boy darting out into traffic, a girl crying in the school toilet, and a custodian with a burnt face who chases her through the school corridor. The menacing apparition is unrelenting in his pursuit, and several teachers rush to restrain Chloe as she continues to scream in fear at someone who isn't there. Chloe ends up in hospital, and after a variety of tests, finds herself at Lyle House, a home for mentally disturbed teens, for evaluation.

The novel is riddled with stereotypes about mental illness that begin as soon as Chloe arrives at her new home. Chloe says Liz doesn't "look crazy" (37) because she has neatly brushed hair and designer clothes, and at any moment Chloe expects her housemates to start "speaking in tongues or screaming about bugs crawling over [their] plate[s]" (53). Chloe comforts herself by saying that Lyle House, while still a holding zone for mentally ill children, is nonetheless "better than padded rooms and endless hallways filled with *real* zombies, shambling mental patients so doped up they couldn't be bothered to get dressed, much less bathe" (45). While Chloe's flawed expectations of mental illness are undoubtedly fuelled by her penchant for horror films, the conflation between mental patients and zombies is a disturbing one that only magnifies the stigma of mental illness. Armstrong's portrayal of Chloe's housemates is equally rife with negative stereotypes, particularly the insinuation that mental illness equates to violence; each adolescent at Lyle House is dangerous in his or her own way. Liz is filled with rage and regularly hurtles objects when angry, Derek is diagnosed with "antisocial personality disorder" (129) and has a history of breaking his peers' bones, Rae has “pyromania” (78) and Tori has a mood disorder that leads her to lock Chloe, bound and gagged, in a crawlspace.

While Armstrong’s depiction of mental illnesses as unsafe is disappointing, her portrayal of Chloe’s schizophrenia is initially admirable. Dr Gill shares Chloe’s diagnosis with her, adding that “a patient must know her condition, understand and accept it before we can begin treatment” (64) in a promising advocacy for openness and knowledge. The doctor goes on to explain Chloe’s schizophrenia with refreshing accuracy: it is usually not diagnosed until late teens or twenties, and while there is no cure, it is “not a life sentence” but a “lifelong condition” (66) that can be treated with medication, albeit, not without side effects. Dr Gill notes that it is a medical condition and not caused by anything Chloe has done. Chloe’s struggle with acceptance is similarly genuine, with the teen explaining, “If I saw two guys on the sidewalk, one in a wheelchair and one talking to himself, which one would I rush to open a door for? And which would I cross the road to avoid?” (70). Chloe is aware that disability is a diverse categorisation, and while many disabilities include external markers, those associated with schizophrenia – talking to oneself, gesturing to people who aren’t there – generally evoke unease and fear.

Had the novel gone on to show Chloe’s growing acceptance of her mental illness and her path toward managing it, *The Summoning* would have been a welcome addition to the repertoire of YAL; however, as it turns out, Chloe doesn’t actually have schizophrenia, and in a twist, she is actually a necromancer who can converse with the dead. In fact, none of the children at Lyle House are mentally ill, but rather various magical beings – a sorcerer, a werewolf, a witch, a shaman. While Chloe isn’t immediately reassured by her new diagnosis, noting that “having a label should have come as a relief, but I wasn’t sure this one was any better than schizophrenic” (167), by replacing mental illnesses with supernatural powers, Armstrong suggests that not only are the latter preferable, but they make for a more interesting story. Before Chloe has a chance to adjust to her diagnosis and take on board what a life with schizophrenia might mean, she learns that she is imbued with a magical ability that makes her special and powerful, rather than the outcast she feared her mental illness would render her. While Chloe does, of course, have to come to terms with her role as a necromancer, acceptance in this capacity does not equate to acceptance of a mental illness – for a supernatural ability laced with unknown mystical power is not the same as an alienating mental health condition – and any parallel that Armstrong is trying to draw here falls flat.

Instead, Armstrong pathologises unwelcome difference as mental illness, reinvigorating an outdated, sexist diagnostic practice[29] that scholars, medical practitioners and patients have spent generations trying to overcome. Chloe explains how so many supernatural teens ended up in a home for the mentally ill: “Our symptoms could be massaged to fit known psychiatric disorders, and, since everyone knew it was impossible to contact the dead or to burn people with your bare hands [. . .] – the obvious solution would be that we were mentally ill” (318) Sorcerer Simon more succinctly clarifies that “some supernatural powers [. . .] can’t be explained, so humans chalk them up to mental illness” (204). This notion of writing off complicated or unfamiliar medical issues as mental illness is nothing new. Misdiagnosis is a reality for many women, even today, with Phyllis Chesler noting, “Women with disabling medical illnesses are being psychiatrically diagnosed and sedated rather than tested or treated for a non-psychiatric illness (Chesler 17). Women continue to fight for accurate medical diagnoses and are too often told that their lupus, multiple sclerosis, Chronic Fatigue Syndrome or food allergies are merely psychiatric issues, and their very real physical symptoms are dismissed as psychosomatic. Armstrong misses the opportunity to link the misdiagnoses of the supernatural as psychological with the reality of the female medical experience; instead, Simon’s explanation doesn’t move beyond the depiction of mental illness as a catch-all for the inexplicable and unexpected and is more reminiscent of the Victorian era (when headstrong, defiant women were institutionalised for living outside the boundaries of patriarchal culture)[30] than

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[29] Chesler’s accusation that woman are “punitively diagnosed for having a normal human reaction to trauma” (19); the greater range of acceptable behaviours in men: “Since women are allowed fewer total behaviours and are more strictly confined to their role-sphere than men are, women, more than men, will commit more behaviours that are seen as ill or unacceptable” (Chesler 99).

[30] ‘The Case of Hersilie Rouy’ (Appignanesi 101 – 105) who was institutionalised for “incurable pride” (Appignanesi 103); Elizabeth Packard, Elizabeth T. Stone and Phebe B. Davis who were institutionalised in the mid-1800s each for “daring to think for herself” (Chesler 9)

the twenty-first century. Disability theory is pushing beyond this idea of difference as madness[31] and it is disappointing to see this connection reiterated in YAL. Armstrong's use of stigma-laden language is equally disturbing; her constant use of terms like "crazy" (31, 72, 78, 80, 82, 93, 115, 145, 185), "schizo" (58, 64, 69, 70, 72, 79) and "nuts" (230), isn't subversive or freeing, but rather smacks of appropriation, given that none of the characters who use these derogatory words actually have mental health conditions.

The timing of Chloe's 'mental illness' is likewise problematic, with her visions of ghosts beginning on the day she has her first period, in a reactionary depiction that pathologises womanhood and female biology. As Elaine Showalter explains, during the Victorian era, insanity was "confidently linked to the biological crises of the female life-cycle – puberty, pregnancy, childbirth, menopause – during which the mind would be weakened and the symptoms of insanity might emerge" (55). "Menarche was the first stage of mental danger" (Showalter 56), particularly if menstruation began late, as it does in the case of 15-year-old Chloe. Chloe refers to her new powers as a result of "stockpiled hormones [that] had exploded" (33), and at another points laughs that they are "super PMS" (77). By showing Chloe's mental break as concomitant with her first period, Armstrong is progressing the notion that women are naturally unbalanced, emotional and ultimately unable to navigate puberty without losing control. Armstrong's representation unearths the damaging Victorian belief that simply having a uterus makes one preternaturally susceptible to mental illness and that women are fundamentally inferior to men.

The Summoning is, at its core, a damaging representation of mental illness that fails to address the true adversity of having one, and instead casts the quest for meaningful portrayals aside in favour of a supernatural story that more closely aligns with late-noughties YAL trends, which were marked by an insurgence of paranormal thrillers like the *Twilight* series (Haupt). As publisher

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[31] Alice Halls writes of challenging representations of disability that configure it as "evil, exoticism, weakness or ugliness" or use it as a moral barometer against which to judge the behaviour of non-disabled characters, arguing that such depictions "fail to do justice to the complexities of disability as an identity, a way of being in the world, or an embodied, lived experience (Hall, *Literature* 32).

Casover explains in "The Evolving World of Young Adult Literature in 2024," thrillers are still an increasingly popular sub-category of YAL, with their "blend of excitement and unpredictability" offering readers an "immersive escape into worlds filled with suspense and unexpected twists" ("Evolving World"). While *The Summoning* is undoubtedly suspenseful and exciting, its sudden shift to the supernatural suggests that the world of mental illness is not a worthwhile "immersive escape." According to Casover, "Authors are increasingly incorporating narratives that address social issues, diversity, and equality, reflecting the growing awareness and advocacy for change among young readers" ("Evolving World"); sadly, Armstrong falls short of achieving this with her outdated, stereotypical representations of mental illness that are abandoned before they can be fully explored. Rather than showing young people with schizophrenia that they are "a viable part of a larger community" (Cart, "The Value") as Cart suggests, Armstrong rejects them altogether.

Alyssa Sheinmel's *A Danger to Herself and Others* is yet another YA novel that falls short of Cart's expectations of truth and empathy, beginning with 17-year-old Hannah's arrival at a mental institution following an accident involving her roommate, Agnes. The story unfolds to reveal that Hannah has schizophrenia – though Sheinmel is careful to refer to it only as "psychosis" (253), Hannah's "condition" (199) or her "disease" (307) – and has hallucinated Agnes' boyfriend Jonas as well as her roommate at the institution, Lucy, both of whom encourage Hannah to engage in dangerous behaviour.[32] Throughout the novel – more than two dozen times, in fact – the reader is reminded that Hannah is "a danger to herself and others," and Hannah's condition leads not only to Agnes' traumatic brain injury, but to several violent outbursts, including Hannah's assault on Dr Lightfoot and an unsuccessful suicide attempt.

A Danger to Herself and Others is an all-too-common, disappointing representation of schizophrenia as dangerous, violent and fearful, with Hannah fulfilling society's desire for a "stable schizophrenic" (Prendergast 288) who is easy to villainise; yet, in her Author's Note, Sheinmel

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[32] Jonah suggests she instigate the game of Truth or Dare that ends with Agnes in a coma, and Lucy's voice tells Hannah to give Agnes "a little tap" (207) as she stands on the balcony railing.

purports that her novel "is a work of fiction and is not meant to educate readers about mental illness or institutionalization" (338). Sheinmel admits to taking several liberties with Hannah's diagnosis and treatment, including the degree to which Hannah is kept isolated, the expeditiousness of Hannah's discharge and the speed with which her medication works. While there is certainly no legal requirement to present mental illnesses with veracity within works of fiction, one could argue that there is a moral one, particularly when such novels are marketed toward impressionable young adults and the misrepresentations within them evoke harmful stereotypes that dramatise schizophrenia for the sake of storytelling. By admittedly distorting key aspects of a condition and treatment and fixating on the violence of Hannah's mental illness, Sheinmel's manipulates a real-life experience to serve her plot in another example of Mitchell and Snyder's narrative prosthesis. Sheinmel purposely avoids using the term 'schizophrenia' in an attempt to distance herself from an obligation to medical authenticity, but it is clear from the details of Hannah's illness that this is what she is diagnosed with. By removing the terminology of mental illness from her novel, Sheinmel has co-opted a very real disease for the purpose of plot while shedding herself of responsibility; *A Danger to Herself and Others* is a novel whose portrayal of mental illness is detrimental to the community actually affected by it.

In many ways, recent YAL is rooted in the past, with its depiction of mental illness – in particular schizophrenia – as violent and dangerous, leading to characters that echo Brontë's Bertha Mason and Braddon's Lucy Graham more than modern-day teens. *Finding Alice*'s protagonist faces exorcism for inner demons, every character in *The Summoning* is uniquely violent, and Hannah in *A Danger to Herself and Others* is repeatedly referred to as just that; together, these novels paint a damaging picture of mental illness as Othering and demonic, advocating for the confinement of the mentally ill to the outskirts of society. These novels perpetuate backwards thinking and pervert the modern agenda of disability theory, which focuses on inclusivity and eradicating social and cultural barriers, and instead utilise schizophrenia for narrative purposes without doing justice to the complicated condition. The message these novels send is loud and clear: The madwoman is most certainly best kept in the attic.

The Future of Mental Illness in YAL

While it is important to encourage conversations on mental health among young adults, by limiting the dialogue to worn-out tropes and misguided stereotypes, many novels reinforce unrealistic, out-dated and noxious ideas about mental illness that do nothing to prepare adolescents for “the realities of impending adulthood” (Cart, “The Value”). As Wahl explains, when images of mental illness “are unfavourable and inaccurate, as they often are, they contribute to the stigma and discrimination that represent formidable barriers to treatment and recovery” (ix), and too many contemporary YA novels fall prey to this damaging cliché. YAL has yet to depict mental illness in a way that fosters the empathy, recognition and truth that Cart sees as the tenets of YAL, instead mirroring the problem novels and bleak books that trivialised the momentous issues of previous generations. Today’s novels expose young readers to mental illness but without bringing the gravity and complexity that the topic demands, instead romanticising or demonising these conditions, ultimately impeding social progress and arguably putting teens at further risk.

With the link between inaccuracy and stigma well documented, the proliferation of misinformation within YAL is baffling. As Thaller theorises, it may be that “temporary conditions or easy cures are featured because they are [deemed] more appropriate for young readers than the alternative,” going on to suggest that “to acknowledge mental illness [. . .] as random, undeserved, and complicated would be entering into a conversation beyond what adults believe young people are able to comprehend” (149). But, like showing a bloody crime scene but not the murder, this gives an incendiary glimpse while masking the truth, and deciding for teens what they can and cannot handle is both belittling and dangerous. If as Lynch suggests, “There’s nothing to be afraid of” (38), then a balanced view that embraces the uncertainty and grit inherent to mental illness is needed. Many young people are living with these conditions right now, and the censoring and sensationalising of these lived experiences through fictional accounts that paint them as transitory, alluring or demonic is a worrying trend in YAL.

In contemporary YAL, mental illness is a de facto Chekhov's gun: if a character has mental illness, it's going to be essential to the plot. While more subdued representations that include tacit acceptance and genuine support may not sound particularly riveting, these issues can be included in a way that bring depth to mental illnesses without relying on them to drive the plot. YAL needs novels that don't call for the erasure of mental illness but rather depict life *with* mental illness, including characters seeking out adult guidance and engaging in activities not tied to their conditions. Like the Bechdel test for films, which examines whether two female characters speak about something other than a man, so too does YAL need a test for mental illness that asks, "Does the novel include one or more mentally ill characters discussing something other than their conditions?" Too often the answer is no. It seems to be all or nothing in recent YAL, with novels either focusing entirely on mental illness or avoiding it altogether; by including characters with mental health issues but not structuring the entire plot around their 'journey' – or worse, the eradication of their illness – novels can further normalise mental illness, and such representations would be a welcome addition to the genre.

YAL would also benefit from an expansion of its repertoire to include a wider representation of conditions as well as non-white and LGBTQ+ protagonists. In the extensive list of YAL books I encountered during my research, none featured protagonists from ethnic minorities or those seeking non-heteronormative relationships, a revelation echoed by Antero Garcia, who notes that a "large portion of YA is focused on the interest of white, affluent teenagers" (5), with YA authors historically being asked by publishers to "'straighten' gay characters" (4). Likewise, the vast majority of novels focused on depression, anxiety or schizophrenia, and while books on other conditions, like bi-polar disorder and obsessive-compulsive disorder, do exist (Emery Lord's *When We Collided*, Eric Lindstrom's *A Tragic Kind of Wonderful*, and John Green's *Turtles All the Way Down*, for example – though these books are not without their problems), they are in the minority. By widening its breadth to include stories that encompass a more varied range of young people and experiences, YAL can further fulfil Cart's goals of recognition, empathy and truth.

As a current primary educator and parent to two voracious readers, I can't help but wonder if parents should be kept in the loop, if there is an obligation to inform carers of the rampant misrepresentation of mental illness within YAL. As Claudia Mills argues, "Ethical criticism of books can be employed not to justify censorship but to encourage sensitivity, not to silence conversation but to stimulate," going on to explain that "there may be considerable value in sharing books that express problematic values, if these are the subject of ongoing dialogue among readers "(8-9). Rather than suggesting parents prevent access to these books, could their involvement perhaps be used to mitigate some of this damage? While I have been quick to criticise these novels, I can see value in using them – alongside the right resources – to start conversations about mental illness that might not otherwise happen. Including a "To Parents and Carers" section at the start of novels could make adults aware of the themes and depictions within and include questions to ask their child after reading; to this end, YAL could be a springboard to meaningful adult-child interaction surrounding mental illness. Educators could be equally involved in these conversations, using form time and PSHE[33] lessons to discuss mental health. Likewise, moving the Author's Note to the beginning of the novels would make young readers aware of mental illness helplines, facts and statistics before the novel begins and increase the likelihood that adolescents read the novel as fiction rather than a realistic representation of mental illness and recovery. Monitored online threads where the novels can be discussed and misconceptions addressed would also be beneficial, and these could be signposted in the Author's Note. Banning books is never the answer, and perhaps leaning into young people's penchant for these novels and incorporating teachable moments is a more realistic avenue of defence.

While the majority of this thesis is dedicated to progressive novels that offer more complex and unrestrained representations of mental illness that address issues like psychopharmacology,

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[33] Personal, Social, Health and Economic

institutionalisation and the chaos of recovery, it is important to understand that inaccurate, one-dimensional and damaging portrayals of mental illness are still pervasive, particularly within YAL, and in many regards, there is still much work to be done within the fictional realm of mental illness.

Conclusion: Opening Up a Dialogue

This thesis has shown how contemporary fiction intervenes in mental health discourse by challenging destructive, outdated perceptions of mental illness and confronting the social, political and medical enterprises that negatively influence female health; today's authors denounce, provoke and disrupt on a scale not seen in previous eras, with the novels in this thesis depicting a range of representations that successfully unpick the twenty-first-century woman's mental illness experience. I asked in the introduction, "What are women saying when they write about mental illness today?" and the answer is simple but resounding: *We have had enough*. Enough manipulation, enough judgment, enough control. Enough shame, enough ignorance, enough ineptitude. Contemporary authors have made it clear that women have been repeatedly and unapologetically let down by doctors, by mental health services, by society at large, and are calling out these medical and social failures for their complicity in women's mental illness. Moshfegh, Britsch, Allan, Kirshenbaum, Roy, Oyeyemi and Lee aren't merely ruminating or criticising; they are putting their feet down and demanding justice – the equality, attention and transformation that women deserve.

The texts within this thesis are not "compulsory positiv[e]" (Woods et al. 222) novels of overcoming illness, of hope, of faith, of cure, but rather complex and candid stories that portray mental illness for what it often is – chaotic, uncertain and interminable. By disrupting the diagnosis-treatment-recovery paradigm normalised by the Recovery Narrative and memoir, today's fiction democratises mental illness, offering varied perspectives that underpin a plurality of experience. These works encompass women from all walks of life – black, white, Asian, wealthy, poor, gay, straight, old, young – articulating the intersectional experience of mental illness and reflecting the indiscriminate nature of disability. While recent fiction is certainly answering media scholar Simon Cross's 2004 call for "representational formats that refuse to settle for a highly restricted public image of mental illness" (213), these novels do not limit themselves to the destabilisation of stereotypes, instead engaging in large-scale attacks against the barriers to women's mental wellbeing – the pharmaceutical industry, mental health services, the recovery agenda, social expectations – that amount to literary warfare. By widening the horizon of investigation beyond individual stories and clinical encounters, this thesis has explored fiction's capacity to further tease the social and political meanings of disability, promote acceptance and activism, and ultimately, evoke social change.

Read together, the novels in Chapters Two through Four reveal how neoliberal feminism's promise of empowerment through self-management and productivity is inextricably bound to exclusion and erasure. By centring characters whose lives are defined by incapacity, uncertainty or resistance, the texts expose what Hedva calls the "political" (3) significance of illness and withdrawal, foregrounding the limits of a cultural logic that demands resilience and positivity at all costs. Whether through *Poppy Shakespeare*'s satirical account of institutionalisation, Bunny's fragmentary refusals in *Rabbits for Food*, Gloria's self-acceptance in *The Fat Lady Sings* or the caustic withdrawal of Moshfegh's narrator, these works complicate the novel's traditional association with intimacy and empathy, instead embracing difficulty and estrangement as critical strategies. In doing so, they demonstrate how contemporary women's writing between 2000 and 2020 both reflects and resists neoliberal conditions, offering alternative modes of care, solidarity and being that empower twenty-first-century women.

The novels examined in this thesis exemplify a broader trend in twenty-first-century fiction, in which experimental narrative strategies are used to explore intimacy, empathy and difficulty in the representation of mental illness. Critics have long associated the novel with the cultivation of recognition and identification, a form that draws the reader into another's interior world (Felski; Keen; Wood); yet, contemporary works frequently disrupt this expectation, employing formal fragmentation, non-standard narration and withholding strategies that produce ambivalent or resistant intimacy. As Ngai has argued, literature often mobilises "ugly feelings" (3) – irritation, boredom, despair – which resist catharsis or easy emotional engagement. These formal choices foreground the challenges of accessing marginalised subjectivities, reflecting how mental illness unsettles not only cultural narratives of wellness but also the literary conventions of the novel itself.

Poppy Shakespeare and *Rabbits for Food* exemplify this approach through linguistic and structural experimentation. In *Poppy Shakespeare*, N's non-standard dialect immerses the reader in her psychiatric experience while simultaneously creating interpretive difficulty, producing a form of intimacy that requires effort and engagement. *Rabbits for Food* fragments its narrative into satirical, vignette-like episodes, combining dark humour with structural discord. Both texts resist conventional empathic identification, revealing how depression and institutional marginalisation challenge narrative closure and the reader's desire for comprehension.

My Year of Rest and Relaxation and *Sad Janet* continue this experimental engagement through caustic, withholding narrators who refuse the wellness culture promoted by neoliberal feminism. Their protagonists' withdrawal, apathy or deliberate unhappiness produces a claustrophobic intimacy that unsettles conventional sympathy while critiquing the cultural expectation that women should self-manage, optimise and remain resilient. Lee's *Everything Here is Beautiful* situates mental illness within familial and diasporic networks, showing how interiority is mediated by cultural stigma and transnational pressures, while Oyeyemi's *The Icarus Girl* employs Gothic-inflected, fragmented narration to dramatise the psychic tension of dual heritage and postcolonial identity. Roy's *The Fat Lady Sings* explores the loneliness engendered by sexual invalidation and cultural nonconformity in 1990s Britain, using a reflective, interiorised style to expose how marginalisation shapes the female experience of mental distress.

Taken together, these seven novels demonstrate how early twenty-first-century fiction experiments with narrative form to unsettle traditional modes of empathy and recognition. Through fragmentation, withholding, dark humour and stylistic innovation, they create intimate but challenging engagements with the interiority of female protagonists experiencing mental illness. This formal experimentation mirrors the novels' critique of neoliberal feminist imperatives of resilience, positivity and self-optimisation; just as the protagonists resist cultural expectations of wellness, the novels resist conventional literary expectations of narrative closure, readability and easy affective identification. As Ngai suggests, “Noncathartic feelings [. . .] could be said to give rise to a noncathartic aesthetic: art that produces and foregrounds a failure of emotional release [. . .] and does so as a kind of politics (Ngai 9). *MYRR*, *Sad Janet*, *Poppy Shakespeare* and other works within this thesis deny the reader closure, satisfaction, release, just as the mental illnesses the characters deal with resist easy solution and simplification; in doing so, these novels offer opportunities for alternative understandings of vulnerability, incapacity and refusal, showing how both literary form and narrative coalesce to highlight the complexity of mental illness within contemporary women’s writing.

While teeming with “ugly feelings” and non-traditional narrators, the novels within this thesis nonetheless offer the reader opportunities to connect with what Rita Felski describes in her manifesto *Uses of Literature* as four modes of textual engagement: recognition, enchantment, knowledge and shock; by fostering connections with each of these conduits, contemporary fiction has the power to influence public attitudes toward female mental illness in a meaningful and compelling way. Depicting mental illness experiences that sit outside of the diagnosis-treatment-recovery paradigm, novels like *Sad Janet* and *Rabbits for Food* bolster a reader’s chance “to recognize oneself in a book” to latch onto “a flash of connection” (Felski 23) that allows “for parsing the complexities of personhood” (Felski 26). Though outlandish and unpleasant, Moshfegh’s narrator employs a level of “introspection and soul-searching” that can encourage readers “to engage in similar acts of self-scrutiny” (Felski 25), including the analysis of their own mental well-being and contributory factors. Well-written and thought-provoking, the novels discussed within this thesis certainly provide opportunities for enchantment, “of total absorption in a text, of intense and enigmatic pleasure” (Felski 54), and writers like Allan and Kirshenbaum create anti-heroes that we root for, even if we don’t like them; by constructing captivating fictional worlds, the knowledge that accompanies the texts – the ability to “apprehend truths previously unseen” (Felski 79) – comes effortlessly and fruitfully. The novels within this thesis challenge larger institutions of injustice –

social conventions, psychopharmacology, mental health services – allowing readers to "augment our understanding of how things are" (Felski 86) and in turn to reflect, question, act. Many of these novels do so through shock and exaggeration, employing a satirical lens to facilitate "an encounter with the unexpected" (Felski 113) imbued with "emotional force" (Felski 114); the proliferation of drugs in *MYRR* and *Sad Janet*, the professional ineptitude and bureaucratic red tape in *Poppy Shakespeare*, the dismissal of trauma in *Rabbits for Food* – all serve to outrage the reader, to disgust, to frustrate, to provoke, and most importantly, to call for change.

Felski argues that "literary works can boast a measurable social impact" (8), and one place this influence becomes particularly visible is in the paratextual space of Goodreads, where large communities of readers share interpretations and opinions. While not scholarly analyses of texts, these comments are invaluable in that they expose the kinds of meanings non-academic audiences attach to the novels. Across hundreds of reviews, certain themes recur. Readers emphasise, for example, that the ambiguous ending of *Rabbits for Food* resonates because it resists closure, while others praise Kirshenbaum for dismantling the neoliberal notion that depression is an individual failing. Novels like *Sad Janet* are described as altering long-held assumptions about medication, while *The Fat Lady Sings* provokes feelings of guilt, anger and recognition about societal neglect of mental illness ("Reviews"). Such responses reveal the extent to which readers experience these works as validating, disruptive and socially urgent.

These comments reveal a strong desire to be seen, to have the experience of female mental illness elevated and understood; this feeds into Chesler's call for a feminist therapist who "does not minimize the extent to which a woman has been wounded" (30) and instead acknowledges the pain, frustration and loneliness that come with living in a patriarchal society in which women have "failed if they're not successful at *everything*" (329, emphasis hers). The fiction itself suggests that this need for a feminist therapist has yet to be filled; none of the novels in this thesis provide examples of effective quality healthcare or of practitioners – male *or* female – who listen with empathy and impartiality. But it would certainly help. Janet would undoubtedly benefit from being told "that it's normal to feel sad or angry about being overworked, underpaid, underloved," just as Roy's Merle could be empowered by the admission that "it's hard to break free of patriarchy" (Chesler 30). Moshfegh's narrator would profit from a therapist who, unlike Dr Tuttle and her ever-present prescription pad, might instead explain to her that "no one [. . .] can rescue a woman but herself" (Chesler 30). Equally, Lee's Lucia would certainly find relief in learning that "it's healthy to harbor fantasies of running away when the needs of others [. . .] threaten to overwhelm her" (Chesler 30). These characters need someone to truly listen, to be told that what they feel is valid, real, acceptable, and their mental health is adversely affected in the absence of such reassurance.

While there may be a paucity of feminist therapists in the fictional realm, I argue that literature is – at least in part – fulfilling this need for a female therapist in the real world by providing landscapes in which the female experience of mental illness is laid bare. These novels are promoting honesty instead of shame, validating women's unhappiness and shifting conversations about mental illness front and centre. The diversity of experiences within contemporary fiction allows an increasingly large number of women to feel represented, understood and valued. By breaking with the diagnosis-treatment-recovery paradigm, contemporary fiction gives voice to women whose experiences are untidy, unresolved and uninspiring, thus providing the support and acceptance that the feminist therapist is envisaged to bring. While there is much exciting work being done in the realm of bibliotherapy (Ahmandipour et al.; Béres; Brewster; Cacchioli; Ellis; Galvin and Montgomery; E. Hutchinson; Mojiri et al.; Monroy-Fraustro et al.; Simpson; Troscianko et al.), a literature review conducted by Grewal and Peterkin in 2017 found "a lack of empirical studies examining the therapeutic effect of poetry or fiction in a mental health context" (175), a dearth that continues today, and I would welcome more studies that could more concretely measure the way in which fiction impacts both mental health and opinions on mental health. This thesis has recognised the power of fiction to evoke change, and it would be beneficial to continue this investigation.

While contemporary fiction is unquestionably changing the way that female mental illness is perceived – and positively so – there is much work still to be done. Given the negatively skewed depictions of mental health services within contemporary fiction, novels that conceive and depict effective care – however speculative – would be a valuable addition to the literary repertoire. What might the interactions between a woman and a true feminist therapist look like? In what ways does constructive, quality care differ from the care provided to women today, and how might fiction suggest improvements and evidence their success? Though much of this thesis praises recent representations of mental illness, the detrimental impact of YAL cannot be ignored, and more needs to be done to acknowledge and address the stereotypes and romanticisation within these novels, as well as the absence of minority and LGBTQ characters within the genre.

I would also welcome more integration of mental illness into the realm of disability studies. Though the literature of mental illness is clearly able to further disability politics and challenge social exclusion, disability studies continues to focus largely on the disabled body. Many texts on disability (Barnes et al.; Hall, *Literature and Disability*; Siebers; Snyder et al.) feature copious chapters on physical disability, and more recently cognitive impairment, which has also been overlooked, but none on mental illness. While works that integrate mental illness into disability certainly exist (Davis, *Disability Studies*; Hall, *Routledge*; *Journal of Literary and Cultural Disability Studies*), they have only recently done so and not to any great degree,[1] suggesting that mental illness is not yet fully incorporated into disability theory and more often seen as a separate entity. I argue that it needn't be so challenging for mental and physical disability to occupy the same critical space; this thesis has shown the many ways that the literature of mental illness contributes to disability studies and furthers the conversations already happening within that community. Contemporary fiction has engaged with Wendell's notion of the "unhealthy disabled" (161), depicting characters like Roy's Gloria and Moshfegh's narrator exerting control and independence in their own lives, belying the

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[1] Lennard Davis's *The Disability Studies Reader* features no articles on mental illness in its 1st edition; the 2nd edition (2006) adds "A Mad Fight: Psychiatry and Disability Activism" by Bradley Lewis; the 2010 3rd edition adds Catherine Prendergast's "The Unexceptional Schizophrenic: A Post-Postmodern Introduction"; the 4th edition (2013) adds "When *Black* Women Start Going on Prozac" by Anna Mollow; the 4th edition, out of 42 chapters, has only 3 on MI; in the first five years (2007-2011), *The Journal of Literary & Cultural Disability Studies* had only 2 articles out of 84 on MI; in the most recent 5 years (2021-2025), it has only 3 articles out of 100 ("List of Issues").

belief that mental illness must by definition lead to a life as “unhealthy disabled;” likewise, characters who do perhaps fit Wendell’s description of “unhealthy disabled” – Merle, Lucia, N, Bunny – still have lives worth living and are motivated, empowered, loving, intelligent. Furthermore, illness is perhaps better positioned than physical impairment to comment on the abuses and manipulation within the pharmaceutical industry, as evidenced in *Sad Janet* and *MYRR*. The same could be said regarding stigma and stereotypes, which continue to surround popular culture representations of mental illness. While physical disabilities are still largely absent from media, television and film (though this is finally beginning to change), mental illness is an increasingly common feature on the screen, and usually one that is negatively portrayed as villainous, dangerous or incapacitating in a perpetuation of damaging stereotypes. Novels like *Poppy Shakespeare* and *Everything Here is Beautiful* show the effects of this stigma, advocating for inclusion and acceptance rather than avoidance and fear. Barnes et al. argue that “disabled people will not judge disability theory by its contribution to academic or research discourses, but ultimately by its role in initiating social change (Barnes et al. 11)” and this thesis makes it clear that the fiction of female mental illness is primed to change the outdated social, political and cultural enterprises that are oppressing those with disability.

As Sami Schalk suggests, “contemporary women writers are creating more complex and empowered disabled women characters, characters who cannot as easily be interpreted as pure metaphors for oppression” (174), and the characters discussed within this thesis are not merely metaphors for oppression but actual resistors. They are resilient, empowered women who take control of their madness, advocate for themselves and stand up to those who seek to undermine and subjugate them. Moshfegh’s narrator concocts a plan – however outrageous – to pull herself out of her misery; Merle defies her doctor’s advice and leaves her controlling husband; Janet resists peer and familial pressure to take anti-depressants; Bunny denies her Creative Writing teacher the catharsis she craves. Today’s authors are writing women who understand what they are up against – a toxic pharmaceutical industry, unrealistic expectations of cure, a society that expects positivity and happiness – and are actively pushing back. These novels are giving voice to experiences that are too often occluded, the chaotic, uncertain, non-linear experiences left out of memoir and the Recovery Narrative. By expanding representations of mental illness and calling out the medical, social and cultural issues that impact mental health, contemporary fiction is actively combating stigma, promoting acceptance and challenging stereotypes, contributing to Garland-Thomson's call to "denaturaliz[e] disability by unseating the dominant assumption that disability is something that is wrong with someone" ("Integrating" 6).

Stuart Murray argues that the academic framework of medicine, health and disability will continue to evolve over the years, but "what won't change is the central role that medicine, health and disability have in people's lives and to the social and cultural formations that surround them" (Murray 16-7); while Murray explores the relationship between disability and health in life writing, fiction – with its focus on a character's experience rather than an author's retroactive reflection, on a chaotic now and uncertain future rather than a distilled past – is equally well positioned to show the way that illness, medicine, society and culture interact. By offering "insight into social rituals, patterns of conversation, and lifestyles – the total milieu [that] characters occupy," fiction offers "a superior window on the world" (Couser 173) through which readers can make connections and draw their own conclusions. Memoir is prone to self-analysis and meaning-making, pointing out cause-effect relationships and scrutinising events, feelings and relationships, whereas in fiction, this important work is more often left to the reader. Where memoir is rife with answers and explanations, fiction is laden with lingering questions. Has Moshfegh's narrator been impacted by the events of 9/11 more than she is admitting to herself? Will Poppy's mental health continue to deteriorate within the walls of the institution? How will Merle navigate the outside world without Gloria or her husband? Trusting the reader to make sense of the interaction between a character's mental illness and "the social and cultural formations that surround [her]" gives way to a multiplicity of readings that can spark conversations and broaden understandings. Murray argues that stories are "modes of theory that amplify an academic focus and give it sharpness and depth. [. . .] They disturb even as they clarify; indeed, they clarify *because* they disturb" (15); while Murray is primarily concerned with life-writing, I argue that fiction – with its narrative and structural freedom, with its loose ends and ambiguity – is another powerful vehicle of truth that can offer further "sharpness and depth" to medical humanities.

Accordingly, this thesis has intervened in critical medical humanities by showing the role that readers can play in shaping perceptions of mental illness and challenging the (inadequate) status quo of care. As Viney et al. explain, "Embracing the complex role of critical collaborator – a role based on notions of entanglement, rather than servility or antagonism, and so reflexively constituted and reworked – will, we suggest, enrich and develop the imaginative and creative heterodox qualities and practices which are the field's core strengths" (7). This notion of medical humanities as partner is essential to second wave conceptualisation, and fiction is primed to expand this role by turning the reader into collaborator as well, empowering her to question her medical care, to consider the way her health interacts with cultural and social precepts, to disrupt, to challenge, to self-advocate. Fiction democratises the work of critical medical humanities by shifting conversations of health from the clinic and classroom to the living room and the coffee shop. It is not just researchers and academics who can "address difficult, more theoretically charged questions" (Whitehead and Woods 2) but mainstream authors, who can confront these complex issues with their entertaining and engaging narratives, which can, in turn, encourage everyday readers to ruminate, discuss and respond.

The landscape of mental illness fiction is finally changing, purveying a multiplicity of experiences that destabilise stereotypes, confront barriers and shatter paradigms. The madwoman, who has for generations been locked in the attic, is front and centre, a force to be reckoned with. And we are all better for it.

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