

THESIS

‘I GOT BETTER’:

NARRATIVE CHALLENGES TO CONTEMPORARY PSYCHIATRY

Submitted by

Michelle Wilk

Department of English

In partial fulfillment of the requirements

For the Degree of Master of Arts

Colorado State University

Fort Collins, Colorado

Summer 2016

Master’s Committee:

Advisor: Doug Cloud

Sarah Sloane

Jennifer Bone

Copyright by Michelle Wilk 2016

All rights reserved

## ABSTRACT

‘I GOT BETTER’:

### NARRATIVE CHALLENGES TO CONTEMPORARY PSYCHIATRY

Mental illness is receiving significant amounts of attention, both via the media and via the medical system. Narratives are a way for people diagnosed with mental illnesses to share how they recovered from their illness. This study combines thematic narrative analysis as described by Arduer and a sample of narratives from the site *I Got Better*. Personal agency and rhetorical agency within the narratives are analyzed for a critical look at how much agency these narratives have. Their personal agency is analyzed through three recurring tropes: personal triumph, curating of relationships, and journey metaphors. The narrators’ rhetorical agency is analyzed in light of the website’s goals; even when they post on a site that states to be a collection of mental health recovery stories, they participate in a non-neutral forum. *I Got Better* builds an argument against the mental healthcare system, and in doing so imposes rhetorical limitations on the narrators. This analysis highlights how the narrators build agency for themselves and how they navigate the limitations and expectations of the website.

## ACKNOWLEDGEMENTS

I would like to thank the following people:

Dr. Doug Cloud, thank you for being incredibly patient as I struggled with my health, and for putting up with all the unforeseen consequences of my lung infection. Not only do I appreciate your patience, but also the supportive but critical conversations we had.

Dr. Lisa Langstraat, thank you for being such an important support person. Your demands to sit me down and make me talk about how I was doing helped me evaluate my priorities.

Dr. Sarah Sloane and Dr. Jennifer Bone, thank you also for your patience, both as I struggled with my health and as I struggled to finish up my thesis. Thank you especially to Sarah for outright telling me she would use me as a cautionary tale in years to come. I appreciate your honesty.

To my parents, thank you for teaching me to refuse to back down. Thank you for supporting me and helping me and giving me the sense of humor to see this through.

And finally, my sister, thank you for suffering through my text rants and for sending me enough pictures of our parents' cat to help me complete this thesis without pulling out all my hair.

## DEDICATION

For my parents, who silently wondered why I chose to study English but are proud of me anyway

For my sister, who vocally wondered why I chose to study English

## TABLE OF CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
DEDICATION.....	iv
LIST OF TABLES.....	vi
LIST OF FIGURES.....	vii
Introduction—The Thorns of the Project.....	1
<i>I Got Better</i> : Background and Overview.....	5
Literature Review.....	12
Methods and Narrative Analysis.....	21
Analyzing the Tropes.....	31
Discussion.....	56
Conclusion.....	65
Works Cited.....	68

## LIST OF TABLES

Table 1. Presence of trope within each narrative .....	26
Table 2. How often the tropes appear .....	31

## LIST OF FIGURES

Figure 1. Screenshot of <i>I Got Better</i> homepage.....	6
Figure 2. Screenshot of <i>I Got Better's</i> video page .....	7
Figure 3. Comparative pain scale.....	61



## INTRODUCTION—THE THORNS OF THE PROJECT

Given current stigma surrounding mental illness, platforms for people diagnosed with mental illnesses to share recovery narratives are limited. Some of the platforms that do exist have an additional motive, like collecting these narratives to support a claim they make. Additionally, social stigma can reduce the autonomy and agency a diagnosed person has, which they may attempt to reclaim through sharing their recovery narratives. People diagnosed with mental illnesses need a place to share stories of alternative treatments to the contemporary psychiatric system. By having a place to share their narratives, people are able to shape their narratives to give themselves agency and to challenge contemporary psychiatry. As a researcher, my interest is in agency and how subaltern groups attempt to gain and/or reclaim agency.

This project is thorny. I analyze a relatively vulnerable population: people diagnosed with a mental illness. Their vulnerability stems from stigma, stereotypes, and the assumption of dysfunction. “People with mental illnesses are responsible for mass shootings.” “People with mental illnesses are a danger to themselves.” “People with mental illnesses are unable to take care of themselves.” Yet these people tell stories of a resistance to those stereotypes and assumptions. The narratives I study are hosted on a site called *I Got Better*, and all the stories are written from the perspective of someone who received medical treatment for a mental illness. Combined with the credibility of the narrators and the stigma surrounding mental illness, the idea of agency is difficult to gauge. So instead of looking at the amount of agency people want to give these narrators, I look at the agency they give themselves.

Everyone has a connection to mental illnesses: whether they know someone or have a family member with one or, more and more commonly, have one themselves. Mental illnesses are disabling; they alter reality, interfere with sleep patterns, and disrupt social interactions.

When mental illnesses become visible, we become uncomfortable because the actions and thoughts of a mentally ill person do not conform to social expectations. The stigma of mental illness as dangerous still exists in nearly the same breath that argues our society is overmedicated. While many people classify mentally ill people as a danger to themselves and others, there are also many who identify an increase in mental health diagnoses as a means to overprescribe medication. The connections we have to mental illnesses often lead us no closer to understanding them; even people diagnosed with a mental illness experience their illness in very different ways because mental illnesses manifest uniquely and in various forms. Bipolar disorder is not the same as schizophrenia, which is not the same as posttraumatic stress disorder (PTSD). Yet we continue to offer well-intentioned but often ill-informed advice (such as positive-thinking exercises to someone with psychotic depression) to those who suffer from mental illnesses.

The thorns of this project, however, do not start and end at the mental health of the narrators. But this does make caution all the more necessary. The credibility of people with mental illnesses are suspect because of their diagnoses; how much credibility these people have is not a question I intend to answer, but their diagnoses affect our perception of their recovery. Their diagnoses of mental illness do not make them fully unreliable because although psychosis distorts reality it does not destroy it. While the reliability of a mentally ill person's first-hand account is questionable, so too are the reliability of non-mentally ill people's narratives. Even the most psychotic rambles contain modicums of truth. These narrators participate in the creation of a subaltern counterpublic, as Fraser defines it: "parallel discursive arenas where members of subordinated social groups invent and circulate counterdiscourses, which in turn permit them to formulate oppositional interpretations of their identities, interests, and needs" (67). People diagnosed with a mental illness participate in a counterpublic to "reduce...the extent of [their disadvantage] in official public spheres" (67). Though people may see people diagnosed with a

mental illness as not credible sources, our perception of credibility is already skewed; preconceived notions may discount their credibility because these assumptions adhere to social stigma and misunderstanding to justify that discounting. Mentally healthy people can be just as discreditable as people diagnosed with a mental illness.

*I Got Better*, the site host for the narratives I analyze, is another thorn. The narrators publish their stories on a site that also puts into question their credibility. The discreditable nature of the *I Got Better* site is more difficult to explain than the effect of mental illness on credibility. Using the archive, however, allows for access to an online forum in which people publicly and willingly participated; while interviews would provide interesting insight into mental illness and recovery, this particular archive already possesses narratives that complicate the idea agency in multiple ways. Even by existing, this archive reveals a conversation being held regarding psychiatry and people who do not participate in socially approved medical intervention. Interviews and disability feel too much like a doctor's intake questionnaire: the person answers the questions provided, being led by the interviewer to reveal whatever information is necessary to diagnose and treat. Are you a smoker? Does your family have a history of blood clots, high blood pressure, high cholesterol, liver failure? There is an irony to interviewing people who resist medical intervention in a way reminiscent of doctor's visits.

*I Got Better's* political stance against psychiatric and other medical intervention also brings up the question of truth and credibility. If we accept these narratives as true, then we accept that the psychiatric system is abusive and domineering. If we do not accept these narratives as true, then we risk discrediting stories about abuse and corruption of a system that may in fact be harming a multitude of people. The political stance is one that may be built upon actual experience, or one that may be built upon the experience of someone with a distorted sense of reality. We have invariable truth that psychiatric abuse has occurred and still can occur;

yet viewing psychiatry as a necessary evil does not alleviate the problem. While psychiatry has undergone considerable amounts of reform in the past fifty years, psychiatric abuse still happens and discrediting narratives that challenge the psychiatric system is a risk that can affect others within the system. In this thesis, the truth is important, even though we have no means of gauging what is or is not true within the narratives. Instead, I discuss briefly the risk of mistruth within the stories.

Disability studies is another thorn. Building from political activism and interdisciplinary in nature, disability studies is a growing field with many disciplinary disagreements. Because my research is situated within Rhetoric and Composition, I suspend additional research that can be conducted with these narratives. I focus not on the sociological factors involved in these narratives nor on any psychological state of mind that can be perceived through the writing; instead, I analyze the narratives in light of the argument the site attempts to make. I look at the construction of the narratives and the narrators' attempts to maintain agency within a site that acts as gatekeeper for the narratives that get published. Despite the considerable ways this project could have gone, I narrow down my focus onto an important factor within these narratives, but that focus is directed by my research background and the limitations of a Rhetoric and Composition Master's thesis. Rhetorical agency limits us all.

## *I GOT BETTER: BACKGROUND AND OVERVIEW*

Both personal agency and rhetorical agency surrounding the mental health recovery narratives will be analyzed within this thesis. By focusing on one platform that publishes mental health recovery narratives, I can provide a more in-depth critique of rhetorical analysis and the available platform. This platform is *I Got Better*, a website that collects recovery narratives and makes them publicly available.

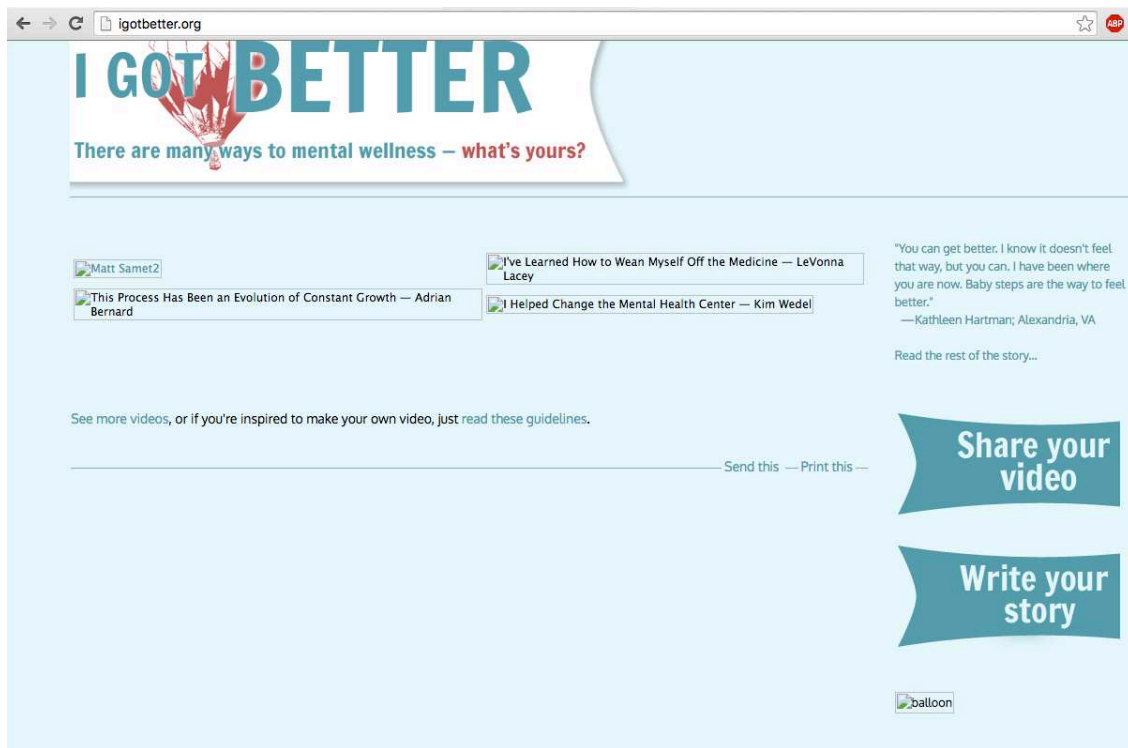
### *The Site*

*I Got Better* (IGB) is a site maintained by MindFreedom International, supported with a grant from the Foundation for Excellence in Mental Health Care, and a donated domain from United by Humanity<sup>1</sup> (“About”). Their establishment date is not publicly posted, but the executive summary of a study listed on the “Learnings” page states that MindFreedom International received funding in February 2012 to launch the program. *I Got Better* works as an archive for recovery narratives; they state that this site is to build a community and to provide options for people in similar situations. How often the site is maintained and when the site was last updated is unknown. The website itself leaves a little to be desired, from broken links to missing images. The host site has little upkeep and almost no quality oversight. Updating the website’s code to include some of the missing image files is actually a fairly quick fix, yet it has not been fixed. These narrators are already at a disadvantage because they have been diagnosed as mentally ill; the site puts them further at a disadvantage because of its unsupervised state. There are five links on the front page that are supposed to lead to different stories; only two links work: the story in the sidebar and the link titled “Matt Samet2.” The other three contain broken

---

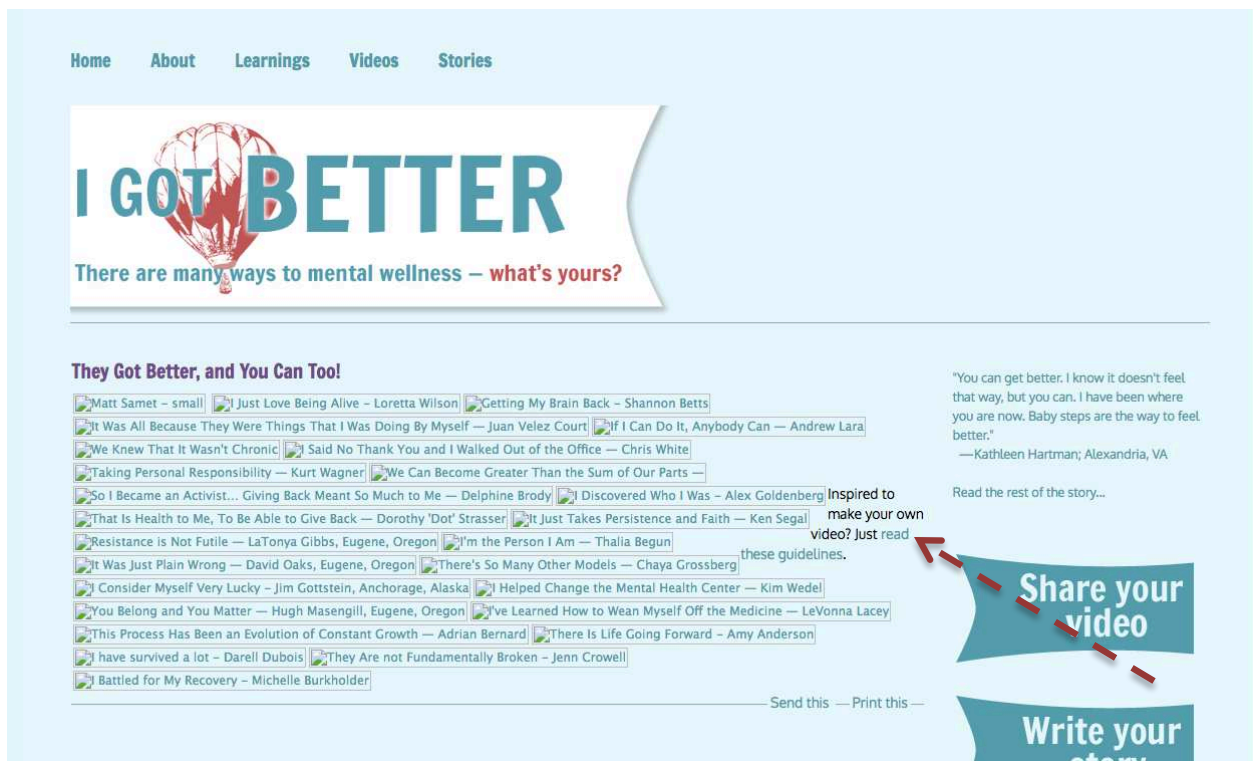
<sup>1</sup> United By Humanity appears to no longer exist or operate. Their website [unitedbyhumanity.org](http://unitedbyhumanity.org) reroutes to the option to purchase that domain.

images and no hyperlinks. Another broken image appears in the sidebar below the links to the story and video guidelines.



**Figure 1. Screenshot of *I Got Better* homepage**

IGB offers two ways to submit narratives: written stories and video stories. Each has different submission guidelines, with recommendations on how to make the narrative appear more readable/viewable and digestible. These recommendations include length limits (time and word count) as well as ways to make their videos/stories conform to the site, by video tagging and titling the story (many titles share similarities such as Elizabeth's "I am the architect and the builder," Crystal D. Choate's "I created an environment I love to live in," and Cynthia's "Creator of my life"); and by recommending ways to make the story more visually appealing ("video"; "written story"). The video collection webpage looks like this:



**Figure 2. Screenshot of *I Got Better's* video page**

Every thumbnail for the videos is unavailable. To the side, marked with an arrow, is where the link to the video submission guidelines appears. The prompt for the video stories is the same for the written stories:

Just be yourself and tell your personal story, with as many details as you feel comfortable sharing. Say something about your dark times, and then share about how things got better. What did you do to regain hope and move your own life forward? What support did you get? How do you achieve wellness, and what does it mean to you? If you've been a mental health activist and that has been part of your recovery, you can mention that as well. *Use any style of writing you like (poetry is fine, too!).*

Every day, there are countless people in despair who have been labeled as mentally ill and believe that they'll never get better, often because someone told them this. Imagine you are speaking through the camera to them, or to just one person. It could be a teenager, a boss, a worker, a musician, male or female, they could be any kind of person from any walk of life, someone you know or someone you just met, but someone you want to offer your story to, to give them hope.

Your story can help someone in a similar situation to survive and to thrive, and together our stories can change our whole society's dominant narrative about mental health — from hopelessness and chronic illness to wellness, resiliency, and hope! (“video”; “written story,” italics only in “written story” guidelines)

An analysis of the prompt is located below. The additional information for the video guidelines is technical suggestions about how to shoot a video. Interestingly, when submitting a video story, the author does not submit the actual video file but rather a link to an external video-hosting site (such as YouTube). With YouTube especially, ad revenue and copyright claims can affect the viewing and monetization of these videos. One upside to the external hosting is the ability to comment (or at least, the option to allow comments), which is not available as an option for any of the written stories, as they are hosted directly on the site. The written stories become static narratives that are anthologized but cannot be interacted with beyond reading them.

The stories page contains 107 total stories, with sixteen of the submissions labeled anonymous. All links work and direct the reader to the appropriate story. This web page is one of only two web pages that have the working image of the balloon in the sidebar; the other is the submissions guidelines page for written stories. Unlike YouTube and other video hosting sites, IGB does not contain any space for commentary, which likely explains why there are a considerable number of anonymous submissions; however, since part of the goal of the site is to develop a community, this inability to comment limits how people can interact with the story. Additionally, while YouTube, etc. marks the upload date for a video, there are no publication dates for these stories. While the genres between the written and the audio-visual allow for varying methods of storytelling, the prompt remains the same.

### *I Got Better's argument*

The site itself is an argument and attempts to make that argument through the findings on their site, the submission guidelines, and the narratives themselves. IGB states that they are a collection of recovery narratives; however, they imply they curate the narratives that support their resistance to the mental healthcare system. The narratives I analyze combine to reveal tropes that also support the argument made against mental health care systems. Though the



narrators are offered a place for the recovery of agency, they are still bound by the bias of the site. Since the guidelines reveal the particular resistance to the mental health system, there is the implication that the narratives will be structured to support that resistance. For the site, mental illness is a temporary disability and recovery should indicate that recovery from that illness is not only possible but manageable.

IGB has compiled research to further solidify their intentions with these narratives, pointing not towards the efficacy of receiving treatment but rather to how these narrators developed alternatives to treatment (“Learnings”). Within the executive summary found on the “Learnings” page, page five indicates that additional research from family members, allies, and even mental health professionals were conducted and would be available soon. However, as of May 2016, only the results from the surveys completed by people who identify as being diagnosed with a mental illness were available online. The highlighted results from the surveys indicate most of the messages of hopelessness stem from the mental health care system.

The submission guidelines cited above indicate considerably directive objectives for the narratives. The guidelines contain overt suggestions on being “yourself” while maintaining any kind of distance the author wants while also providing a story of recovery that others may learn from. “Dark times” implies that the stories do not necessarily have to discuss recovery from mental illness, but from the mental health system. In fact, a majority of the narratives resist psychiatry and frame their recovery around that resistance (many times in favor of psychology). The site contains a bias towards peer support without providing any disclaimers on the risks of following the suggestions made in these narratives. In addition, the guidelines state how these narratives may work to change society by making alternatives to a generally undefined dominant narrative, with the assumption that the dominant narrative does not support surviving and thriving.

This forum even within the submission guidelines works to make an argument against the mental healthcare system. Their guidelines include a statement that questions the kinds of stories that may be accepted for publication. In the guidelines, IGB states that people diagnosed with a mental illness may “believe they’ll never get better, often because someone told them this.” IGB does not expand on how they define “someone.” Though the implication is that the “someone” is a mental healthcare worker, the lack of specificity leaves an in to people who may wish to seek validation for their refusal to see a professional. The implication that the “someone” is a mental healthcare provider highlights the bias that IGB holds in favor of alternatives to the medical system. Although the “dark times” and how the narrators got better indicate a restructuring of illness narratives into recovery narratives, the site works to attribute illness narratives to the medical system. However, on the “about” page, IGB states its goal is to “challenge the dominant narrative of hopelessness in mental health care by making stories of hope and mental wellness widely available through a variety of media.” IGB, through these narratives, attempts to make an argument against the mental health care system. Throughout the rest of this thesis, whenever a reference to IGB’s argument is made, I speak about this inferred argument:

- *I Got Better* aims to support MindFreedom International’s goals to challenge mental health care systems, with no differentiation between psychiatric and psychological practices. They do so by providing the narratives published on their site as evidence in support of that challenge. By resituating illness narratives into recovery narratives, *I Got Better* places mental health care systems as barriers to recovery because these systems regulate a sense of hopelessness.

*I Got Better* is likely unsupervised and maybe even abandoned. Yet the narratives still stand, and this lack of supervision influences how people perceive these narratives. Their perception influences the effectiveness of *I Got Better*’s argument. Because the narratives work as evidence

in support of *I Got Better*'s argument, the state of the site cannot be dissociated from the narratives.

## LITERATURE REVIEW

I situate my literature review around agency and rhetorical agency: how I use the terms and what the terms mean in relationship to antipsychiatry and the models of disability. Although agency as a concept is different from rhetorical agency, I build both definitions from some of the discussion on rhetorical agency. Briefly, both agency and rhetorical agency are rooted in the ability to make decisions.

### *Personal Agency and Rhetorical Agency*

This thesis differentiates between personal agency and rhetorical agency to further explore how these narratives interact with the development of agency; this interaction is two-fold: retroactively attributing agency to past events included in their recovery narrative (personal agency), and selecting what events are included and excluded within the written narrative in order for IGB to publish the narrative (rhetorical agency). Personal agency is attributed by the narrator to the story, how the narrator gains agency through certain realizations or events; rhetorical agency is the limitations the narrators have regarding what they include in their narrative for it to be published. This distinction is important to note; while a narrative may be personally agentic, it is still limited by the rhetorical demands of the site.

Although agency stems from the ability to make decisions, agency is limited in many ways. The interference of social expectations with expression alters how much agency we have in any given situation, but it does not necessarily alter how we define agency. The translation of expression into writing and genre conventions influences our ability to tell stories the way we want. Carolyn Miller states:

Rhetorical agency is important because it would give voice to the voiceless, empowering subaltern groups, and thus, presumably weakening structures of institutional, corporate, and ideological domination. This set of concerns tends to produce resistance models of

agency, models that usually rely on a metonymy between agent and agency. (144)

In an ideal moment, rhetorical agency is the power otherwise powerless people possess. Miller's explanation of rhetorical agency is a bit idealistic because no moment exists in which a person is able to speak without having to navigate social and ideological explanations. However, this does not preclude Miller's point: rhetorical agency is a means of empowering group resistance to social structures. The people writing these narratives attempt to reclaim agency and gain control over their representation by controlling the discourse spread about them. The narrators have found a platform that they can submit to that provides them with the opportunity to voice their own recovery narratives.

Marilyn Cooper contests Miller's explanation of rhetorical agency based upon Miller's idea of kinetic energy as the agentive force between agency and agent. Cooper's basis for this contestation builds upon responsibility, that the inclusion of kinetic energy removes responsibility from the agent performing the act (438). While kinetic energy as an external force does pose the risk of alleviating responsibility, social factors and cultural influences cannot be separated from an agent; this kinetic energy, or action, is also not separate from the agent. Many of the narrators build a narrative in which a lack of agency is a driving force for their illness; they not only take agency but also responsibility for their recovery. Responsibility and agency go hand-in-hand.

Cynthia Lewiecki-Wilson discusses how rhetoric itself needs to change in order to include different forms of communication, as these forms of communication affect rhetorical agency. Rhetorical agency must be achieved to strive for the avoidance of turning subjects (people) into objects of sentimentalization, exploitation, and essentialism for the benefit of society. Each mental disability manifests individually, and rhetorical agency must be established individually and in conjunction with that person's immediate surrounding caretakers, so as to no

longer be independent or dependent, but rather interdependent. Rhetorical agency must be achieved by developing a means of communicating with another person. Mediated rhetoricity involves rhetorical listening (thoughtful attention) in which the audience must interpret what the rhetor addresses (161). Rhetorical agency within people who do not communicate in socially approved manners or in ways that may undermine hegemonic or socially oppressive powers is difficult to manage. Much in the same ways that people who build rhetorical agency through body movement and emotional displays rather than verbal or written communication, people with mental illnesses are often times deprived of the agency via the circulation of stigma.

### *Models of disability*

Disability studies integrates previous work by disability activists, particularly by differentiating between the medical model of disability and the social model of disability. These models of disability have been built from British activism dating into the 1970s (Barnes 578; Shakespeare 214). The models of disability, described by Barnes, formed after rejecting the World Health Organization's classification of disability as disability activist groups pushed towards "a two-tier construct: 'impairment', the biological condition, and 'disability', society's failure to address the needs of people with perceived physical impairments" (578). These models differ in the conceptualization of what a 'disabled person' is, whether that person is disabled because of physiological, intellectual, and/or psychological deviations from the norm or if that person is disabled by social constructions, expectations, and limitations. The amount of agency each model provides to the disabled person factors in how that model defines disability.

By focusing on the development, the strengths and the pitfalls of the social model of disability, Shakespeare identifies some of the major dichotomies currently present in disability studies. The social model claims that disability itself is socially constructed because of the inaccessibility to society. This social model demands material change in order to allow for

community and accessibility. The British model (the social model and the medical model) has thus become a model discussed throughout much of the English-speaking disability studies scholars. Within the social model are continuations of dichotomies in which impairment and disability are inherently different; doctors treat impairments while disability is the social construction of barriers against people with impairments. Another dichotomy is the separation between the disabled and the non-disabled; in this sense, disabled people are more credible and better suited to provide insight into what barriers exist. Some of these dichotomies do present some of the strengths of the social model as it strives for community and pride, rather than isolation and internalized ableism; the social model also identifies major (yet basic) concrete barriers that which could be remedied, though not without expense. However, there also exist flaws in which the individual, and the individual's narrative, seem to be erased in the discussion of these socially constructed barrier; in addition, the social model erases the impairments of people who view their own impairments as problematic. The social model's main dichotomy between impairment and disability also stands on shaky ground because of little evidence to support a clear distinction between the two; as such, no identification of the differences in the terms has ever officially been identified. In fact, the term "disability pride" itself identifies many of these issues as claiming disability as an identity to celebrate, which not only undermines their own wording of "impairment" but also proves difficult to celebrate as disabilities themselves can be debilitating. The social model also does not allow much room for discussion of complexities in environmental and individual factors that are interspersed within people who have disabilities.

Despite very contemporary and even scattered criticism, the social model of disability is upheld as an empowering critique of how disability is perceived in our culture. Barnes, without explicitly identifying the social model, provides a strong definition:

[Disability studies] focuses exclusively on the socio/political/cultural forces, which structure and influence societal perceptions of and responses to perceived impairments, and the consequential experiences of people labelled 'disabled'. (579)

The social model critiques the physical structures at play that disable people; for instance, a building is only accessible via stairs, and no ramp is provided for people in wheelchairs. Another tangible disabling social structure is actually the type fonts we use, which can make it particularly difficult for people with dyslexia; though there are some fonts available that better distinguish letters, they are not widely available and definitely not widely used. Because of the focus on the surround, the social model of disability appears more empowering. It is not the disabled person who is unable to do something; it is instead society's imposition of limitations. In this model, people have the ability to reject those societal impositions. There is no longer a form of dependence to treat the impairment, but instead an outward goal of fixing a social injustice. The person with the disability is no longer "at fault" for having the disability. Instead, they regain agency of their representation, situating themselves as members of society rather than patients in the medical system.

The social model of disability has been heavily criticized by people researching mental impairments, especially regarding mental illnesses, for its focus on social barriers as a construction of disability at the expense of the individual (Beresford 156-157; Flower 143-144; Shakespeare 217-220; Shildrick 36). Shakespeare identifies that physical and sensory impairments (like deafness) are significantly more manageably accommodated than certain mental disabilities; for example,

Reading and writing and other cognitive abilities are required for full participation in many areas of contemporary life in developed nations. What about people on the autistic spectrum, who may find social contact difficult to cope with: a barrier free utopia might be a place where they did not have to meet, communicate with, or have to interpret other people. (219)



The difficulty accommodating people with mental disabilities and mental illnesses is one of the weaknesses for the social model; the extrinsic factors that cause the impairment to become a disability are not as present in mental disabilities as they may be in physical and sensory disabilities. Accommodating deafness through writing and sign language is significantly more manageable than accommodating communication through nonverbal cues and body movement. While the amount of interpretation necessary for that form of accommodation emphasizes the need for rhetorical listening skills (Lewiecki-Wilson), the difficulty with accommodating someone who does not cope well with social interaction emphasizes the limitation of the social model. While Barnes highlights the social construction of disability, he does not address mental illness as a disability. This may be attributable to the antipsychiatry movement's distancing from disability as a term, but many more scholars have begun to identify the need for additional research into mental illness as a disability (Beresford; Lewis; Price).

Often outright rejected as dehumanizing and disempowering, the medical model of disability cannot be disregarded completely given how prevalent modern medicine is. The medical model of disability pathologizes and uses subordination methods for the treatment of certain conditions or set of symptoms (Beresford 152; Lewis 117, 120). The medical model focuses on the individual as a set of symptoms rather than a holistic human being in the middle of a potential health crisis. In consequence, the medical model supports a dependency on the medical system in order for recovery to happen. Disability is something to be researched, something to be cured, or given current genetics research potentially even prevented (Hubbard 74; Saxton 87). The medical model is often purported as an individualizing and isolating means of controlling people with impairments. As such, there is little empowerment provided to people within a medical model.

In an attempt to fill in some of the theoretical gaps in the disability models, scholars have coined critical disability studies, an integration of intersectionality to disability research (Goodley); this further factions disability activism into groups advocating for specific identities or specific disabilities. In doing so, however, the individual's experience is still not as important as the group. Even within critical disability studies, narratives follow conventions and are used for the benefit of an agenda.

### *Antipsychiatry*

Before defining antipsychiatry, it is pertinent to identify what contemporary psychiatric practices are. Throughout this thesis, whenever psychiatric intervention is used, I refer to these practices. According to the American Psychiatric Association (APA), psychiatrists have multiple roles: diagnostic, treatment provider, and preventer. Because they are medical doctors, they have the training necessary to diagnose illnesses and prescribe medications. The APA also lists different kinds of treatments psychiatrists are trained to use: psychotherapy, medications, psychosocial interventions, and electroconvulsive therapy. In light of this, however, there exists criticism that psychotherapy and psychosocial methods are being superseded by pharmacological interventions (Vázquez 412). Vázquez has a list that offers a different view of psychiatric practices:

- 1) increasingly brief clinical assessments;
- 2) reliance on simplified and potentially misleading diagnostic schemes based largely on symptom checklists and somewhat arbitrarily rigid criteria for growing numbers of proposed but inadequately established psychiatric disorders;
- 3) the increasingly routine assumption that picking the right psychotropic is the main therapeutic task; and then,
- 4) brief and infrequent follow-up encounters (413)

Though it is difficult to identify specifically how IGB uses the phrase “dominant narrative of hopelessness in mental health care,” contemporary psychiatric practices are receiving criticism for the dehumanizing nature of their services (“About”). By using diagnostic checklists and

prescribing medication rather than interacting with their patients in a psychotherapeutic and psychosocial manner, psychiatrists are reducing their role in treatment to one that can be accomplished in a matter of minutes. Psychologists then become responsible for the somewhat neglected psychotherapy and psychosocial methods for treatment (American Psychiatric Association).

Antipsychiatry is a term regarding certain radical movements for justice advocacy for people with mental illnesses. Thomas Szasz and RD Laing began similar antipsychiatry movements in America and England, respectively. Szasz's most notable contribution to antipsychiatry is his argument that "mental illness is a metaphorical illness," even writing a book titled *The Myth of Mental Illness* (Szasz 27). Foucault supports that same notion of metaphorical and socially constructed illness in his analysis of power structures and power relationships within the psychiatric system (276). One contemporary iteration of antipsychiatry is MindFreedom International, the nonprofit that runs the site *I Got Better*. IGB builds its argument from antipsychiatry's rejection of mental illness and the necessity for medical intervention.

Szasz's criticism of psychiatry, as well as the advent of medications used and approved to treat psychiatric conditions, sparked the antipsychiatry movement that is sometimes known as the consumer/survivor/ex-patient (c/s/x) movement. He identifies his attempts in 1961 to work against the psychiatric system and their forcible treatment of and incarceration (in psychiatric wards) of their patients. As it is now and was at the advent of antipsychiatry, people within the psychiatric system sacrifice much of their freedom for treatment and for the apparent infallible knowledge of the medical system. The antipsychiatry movement identifies issues with and about agency in treatment. The movement was the first attempt at providing agency to patients in mental institutions. Since both psychiatry and psychology purport public interest as well as

individual care, these overlap in the sense that many of the same issues may present themselves as a potential for reduction or elimination of patient agency.

From the person who worked to help create the antipsychiatry movement, it is interesting that he began this work for the idea of freedom within a system in which people have grown to rely upon as a means to freedom. “Incarceration of law-abiding individuals in an insane asylum-- ostensibly a form of preventive and therapeutic medical practice--constitutes the backbone of psychiatry. Abolishing psychiatric coercion and the threat of such coercion would spell the end of psychiatry as we have known it in the past and know it today” (25). This was and still is a major ambition of the antipsychiatry movement. Although medications have improved, psychiatry’s reliance on them to treat conditions can alienate people who react poorly on those drugs. In addition, some people have developed a mindset that biological and chemical “fixes” will help essentially cure their ailments without taking into consideration coping strategies, validation, and other means of treatment provided by psychologists. The abolishment of coercion for treatment is a major goal of MindFreedom, and the narratives’ reclamation of agency are examples that this abolishment is (at least on a small scale) possible and successful.

## METHODS AND NARRATIVE ANALYSIS

The aim for this thesis is to answer this major question: How do people diagnosed with mental illnesses maintain ownership of their representation in the face of a disabling discourse? More specifically, how do the narrators on the website *I Got Better* represent themselves in a way that grants them agency? I analyze the first fifteen written narratives available on the site. This thesis is not a comprehensive look at all the narratives; instead, I select a couple narratives that trace multiple different iterations of the same trope and how those iterations affect the amount of agency the narrators believe they possess; each narrative analyzed uses the trope in a different way. Additionally, I analyze the limitations of rhetorical agency that occur because of the publishing guidelines on the *I Got Better* site. In the following section, I focus mainly on the image of agency the narrators construct, while I briefly mention their rhetorical agency; in the discussion that follows, I combine the narrators' images of agency and the rhetorical agency they possess by posting their narrative on the *I Got Better* site.

This study considers how these narratives can provide insight into agency as it pertains to recovery from mental illness. By employing thematic narrative analysis, the tropes identified both act as story arcs and reveal potential limitations and moments for agency; the tropes themselves resemble different story arcs that the narrators sometimes weave together in the telling of their story. The definition of narrative ranges from the construction of psychological case studies (Berkenkotter 18) to person oral retellings of pieces of life stories (Linde 11). In this case, I identify narrative through Bruner's definition:

We organize our experience and our memory of human happenings mainly in the form of narrative—stories, excuses, myths, reasons for doing and not doing, and so on. Narrative is a conventional form, transmitted culturally and constrained by each individual's level

of mastery and by his conglomerate of prosthetic devices<sup>2</sup>, colleagues, and mentors. Unlike the constructions generated by logical and scientific procedures that can be weeded out by falsification, narrative constructions can only achieve “verisimilitude.” Narratives, then, are a version of reality whose acceptability is governed by convention and “narrative necessity” rather than by empirical verification and logical requiredness, although ironically we have no compunction about calling stories true or false. (4-5)

This definition highlights multiple important and relevant points within my analysis. Through the organization of memories into narratives, we lose the accuracy of the moment and the chaos of non-reason by forming connections and applying reason to otherwise nonsensical actions.

Linde’s definition for narrative also includes this reconstruction of memory for the purposes of relaying information to others in an understandable and familiar format (12). However, Bruner goes beyond the cultural relevance of personal storytelling by identifying limitations in the construction of a coherent narrative that occur not by a breakdown of cultural expectations but through personal levels of mastery. Indeed, the social plays part in the narrative’s circulation and revision, but the narrator’s ability to navigate the social through association is influenced by mastery over organization and narrative structure. The level of mastery gives the narrative credibility and believability. Since we rely upon the narrator’s ability to construct a story, our sense of truth is altered based upon that construction. The logic of fact is replaced with the subjectivity of believability.

However, as I stated before and expand on in the discussion, how truthful and accurate the retellings of these recovery narratives can have significant health consequences; if pertinent information that has heavily influenced their recovery is excluded from a narrative, then the possible consequences of replication of their methods can be dangerous. The audience for these narratives is important to keep in mind, particularly when discussing dangers. For this reason, the

---

<sup>2</sup> By “prosthetic device,” Bruner refers to the use of knowledge as a tool; there is an applicability to different kinds of knowledge, and the use of a kind of intelligence in one situation does not mean that same intelligence will be useful in another.

truth and accuracy of these recovery narratives do matter. The narrators do not build verisimilitude through persuading readers that the mental healthcare system is bad. Instead, the narratives work best as stories of justification for those nervous about psychiatric care and for those who've had similar experiences. Little verisimilitude is needed to persuade those of the same opinion. The believability of these narratives can be mistaken for truthfulness. That is not to say that the narratives are immediately discreditable because their truth is suspect. Rather, the suspension of the truth to look at how these narratives construct their recovery can reveal the level of mastery these narrators possess and the cultural conventions they may ascribe to in order to tell their story. In fact, the organization of experience and memory within these narratives potentially disrupts verisimilitude because of the credibility of the narrators. Each narrator is connected with the mental health care system because they have been diagnosed as mentally ill. Their mental illnesses (whether or not they agree with the diagnosis is irrelevant) do not assist them in helping readers believe their story. The similarities between the narratives reveal how the narrators navigate the development of their portrayal of recovery. These narratives are restricted by convention and regulated through *I Got Better*.

### *Narrative Analysis*

Given my research question, a thematic approach to narrative analysis helps identify similar tropes that appear within the narratives. Arduser identifies that thematic narrative analysis can “be useful for theorizing across a number of narratives, such as in a collection of stories...In a thematic narrative analysis, the researcher collects stories and inductively creates conceptual groupings from the data” (4). By reading through these narratives, I identify similarities in how the narrators build their stories. The conceptual groups are classified as tropes. The tropes work to reveal how the narrators present personal agency, as well as how the narratives are regulated through the IGB website. The similarities across the narratives help

identify agency (or lack of) within the stories; for instance, the use of the word “recover” identifies not only that these narrators believe themselves to be recovered or in recovery but also that they learned to use this specific word because of the language on the website. More broadly, these tropes represent both agency given to the narrator by the narrator and also the influence of the site on the narrator.

Narrative analysis fits well for this project because these narratives act as a space for people diagnosed with mental illnesses to describe and explain their recovery. Ritivoi explains:

Because it concentrates on the individual actor, the narrative approach has been particularly attractive to theorists interested in rescuing agency as a category of analysis and in documenting individuals’ efforts to control the representations in which their experiences are featured. (27)

Individual agency can be a thorny subject for people with mental illnesses as considerable discourse surrounds mentally ill people and the “dangers” they may pose to themselves and others (Bernheim 54). There are, of course, moments when individual agency must be suspended, such as in the event of a person in a potentially deadly situation; but these moments occur often enough with people who are not mentally ill. Having a space in which people diagnosed with mental illnesses can control their own representations poses another question about agency: who provides that agency?

Narrative analysis has a connection to agency and identity: how the narratives reveal the agency someone may have to shift reality to differently represent themselves (Ritivoi 32).

However, the connection between narratives and agency has not been uncontested, especially when a mediator is involved in the collection and dissemination of the narratives (Arduser 21).

Arduser parses through the ideas of narrative, narrative analysis, and agency in her article “Agency in Illness Narrative: A Pluralistic Analysis.” By analyzing a corpus of diabetes narratives solicited and collected by the Oxford Centre for Diabetes, Endocrinology and



Metabolism (OCDEM), she concludes that perhaps narratives are not the most agentive way for people to describe their illness; this is particularly the case here because these narratives are gathered through interview techniques closely resemble the kinds of questions the interviewee would be asked during doctors' visits (e.g., "Tell me about your background," "How did your diagnosis come about?") (Arduser 9). The main intention for Arduser is to analyze these narratives through three different types of narrative analysis: structural analysis, thematic analysis, and positioning analysis (2). Through these different analyses, it becomes apparent that "because narratives take multiple forms and have multiple purposes, links between chronic illness, identity and agency are not as unproblematic as much of the scholarship on illness narrative analysis might suggest" (2). This thesis adds to scholarship that identifies the problematic aspects of narrative, chronic illness, and agency. While these narratives are intended to "challenge the dominant narrative," the agency each narrator possesses is complex and changing ("About"). The complexity and change occur in the differences between personal agency and rhetorical agency.

By narrowing narrative analysis to thematic analysis, I do not discount the relevance and importance of how these narratives are structured. Structural analysis dissects how the narratives are constructed, questioning the rhetorical moves someone makes while creating a narrative (Arduser 4). For this project, thematic analysis focuses on how the content within the narratives is constructed; this expands on the structural conventions by considering the rhetorical moves the narrators use to represent themselves. Further, the tropes operate within the narratives in ways that support the argument of the IGB site.

### *Tropes*

The three tropes I identify are personal triumph, the curating of relationships, and the journey metaphor. These tropes act somewhat like story arcs: the narrators move from ill to

recovered by themselves, with the help of others, or as an ongoing process. They, however, do not function solely as story arcs and often the tropes appear in conjunction with one another; the tropes are not isolated from each other within the narratives. Additionally, these tropes do not exclusively operate as a story arc. They sometimes are a piece of their recovery, but given the context of the site, the tropes also play a role in how the narratives interact with IGB’s goals. I use Crystal D. Choate’s narrative to provide examples and context for how I identify and classify each trope, as well as a brief analysis of how the example fits the trope. Her narrative’s inclusion of all three tropes allows for a narrower look at how each trope manifests.

**Table 1. Presence of trope within each narrative**

Author	Personal Triumph	Curating of relationships	Journey Metaphor
Kathleen Hartman	X	X	X
Crystal D. Choate	X	X	X
Anna Leonide Brown	X	X	
Charles Hughes	X	X	
Anne Costa	X		X
Kerry Brown		X	
Jennifer Morris		X	X
Johnny			X
Melinda James	X		
Matti Salminen	X		X
Jennifer Hill	X		
Elizabeth	X	X	
Cynthia	X	X	X
Marylou	X	X	X
Pat Hayes	X	X	

Personal triumph occurs when the narrator takes responsibility over their recovery, in the face of a system they believe does not want them to recover. The presence of personal triumph appears in multiple ways: 1) Epiphanies, in which the narrator realizes that their treatment is not working, an otherwise mundane moment that breaks through the narrator’s perception of themselves and restructures their view of their personal identity. These epiphanies reject medical

intervention, reject their diagnosis, or reject the current kind of medical intervention; 2) Slow realizations that can occur over months or years; 3) Determination to recover and determination to prove people wrong. Personal triumph is the narrator's triumph over their illness and sometimes even mental healthcare system. The narrative is set in opposition to obstacles, typically social obstacles that disable them through denying them access to jobs or social support. Social support, in this case, does not mean providing disability services, but quite the opposite. Instead, I refer to the support necessary to succeed rather than the pessimism that they will never be able to succeed.

Choate's personal triumph appears as "Well I tell you I will get better. Don't tell me there is no fixing this problem." Through her determination to recover and determination to prove people wrong, she takes responsibility for her recovery. She views her illness as a problem and recovery as the fix. By fixing this problem, she will triumph over her illness and over the psychiatric system for telling her that she cannot recover.

Personal triumph's story arc often consists of starting in an assumed dead-end space in which recovery is either not an option or the narrator is completely stunted because they do not believe they will be more recovered than they are in that moment. The struggle for agency occurs as the narrator rejects these previous assumptions and works to reclaim their representation and recovery. In doing so, the narrator persists in recovery efforts and attributes their recovery to triumph over those personal struggles.

The curating of relationships affect how the narrator frames their story, as the inclusion of people often outside the medical system reduces the isolation the medical system can impose. Most of these relationships are personal in some way: family members, friends, caretakers, etc. By curating relationships, the narrators are able to select whom they believe support their recovery and whom they believe has harmed them. They can cull the medical system if they

believe that it is causing more harm than help (e.g., Anna Leonide Brown: “Freedom from believing doctors, nurses, anyone, really, outside of myself who presume to know what I need to be successful in my life.”). Not all relationships in these narratives are supportive; how the relationships are utilized affects the kind of story arc these narratives portray. Relationships often refer to groups of people that the narrator can rely upon for help. The help given is often peer support in situations when symptoms or mental distress are present. The narrative is set in opposition to isolation, which is filled through developments of relationships. The positive relationships that appear most frequently are: friendships, peer support, and community support. Many narrators identify receiving some form of support, be that peers, communities, or spouses. The amount of credit they give to these groups varies depending on how useful they find the groups; for example, one highly praised a support group he was involved in because it led to a job opportunity (Hayes). No other narrative of the fifteen praises support groups as much. By developing peer support systems, these narratives also provide agency towards their entire groups. The peer groups are self-supported, separate from professional/psychiatric intervention, and they are only relied upon if necessary. Since these relationships are peer-based rather than professionally run, they have more agency in terms of how they approach support and assistance; they are not bound by legal obligations that psychiatric professionals may be.

Choate’s curating of relationships helps her develop a community of support: “By hanging around with others who have [mental health] issues, I learned a lot of good stuff on how to cope and have Hope.” She credits a considerable amount of her recovery to the group of peers that she has selected. Choate’s curation leaves her to interact with people in similar situations and with similar viewpoints; the selective nature of her groups of peers rejects people that may intervene and question her methods of recovery.

The curating of relationships as a story arc revolves around the development and importance of relationships. The narrators do not overcome obstacles by themselves; they overcome the obstacle of isolation by developing relationships. The agency to select the relationships and how the narrators used the relationships rejects the impersonal nature of the psychiatric system. The story arc is the curation of those relationships.

The journey metaphor most closely resembles a progression, as the story arc traces the goals and difficulties of recovery. Most often, the narrators do not believe their recovery to be complete. By accomplishing specific goals or by learning specific lessons, the narrators are closer to recovery. Gaining insight is part of the story arc, finding what goals are achievable and motivate recovery. Because the narrators determine those goals, they take agency of their recovery by applying their personal insights.

The journey metaphor as a trope is the broadest because of the seeming overlap of every narrative; however, the journey metaphor does not end at the story arc. References to journeys outright and to goals are the identifier for this trope (e.g., “little by little,” “slowly but surely”). These phrases break the recovery process into manageable goals that make recovery more like a journey: by accomplishing goals, the narrator continues to recovery from mental illness. They all possess a similar pattern by using these phrases even if the phrases themselves are different. These progress narratives posit an outlook towards a future rather than their medical treatment, which is relegated to the past. Their current and future “treatment” (since they likely do not consider it treatment) is self-regulated and self-supported. Breaking up the recovery process into something generally agreed upon as small, manageable, and yet still a milestone makes recovery appear more possible rather than some daunting never-ending task. This provides an alternative to the dominant idea that recovery from a mental illness is generally considered not possible, even though control of the illness may be.

Choate's journey metaphor actually manifests through her use of a different metaphor: "Fifteen years of examples [of accomplishing goals and/or getting better from mental problems] could go in a book. It is a roller coaster ride." A roller coaster ride is the substitute for the journey metaphor; a roller coaster has literal ups and downs and twists and turns (and is absolutely terrifying, depending on the person's view of roller coasters), but there is an end. Choate equates her recovery to a progression and traces her recovery as difficult but manageable.

The backgrounds and situations of many of these narratives at first appear vastly different, but the narratives mention certain consistencies in which they begin to take ownership over the telling of their recovery. Together, personal triumph tends to reject psychiatric intervention. The narratives not only reject the medical model of disability but also may even outright reject their diagnosis as disabling, despite that a diagnosis of a mental illness can affect them in the future, regardless whether or not they recover. Focusing on the similarities within the narratives allows the comparison of the ways in which narrators create "coherence for similarly problematic chains of events" (Linde 52). One similarity between certain narratives is epiphanies, or a moment of realization that marks a shifting of their representations. This shifting leads to personal triumph by moving away from a dependency on psychiatric representations of their diagnoses and instead working towards a personal representation of their struggles. Another similarity is how certain narratives portray the development of relationships outside the psychiatric system and outside the constraints of the medical system. Yet still another similarity is how some narratives reorient their recovery into goals, some immediately accomplishable while others long-term and demanding of dedication. Each of these tropes is described in more detail in the following chapter, with examples of how they appear in some specific narratives.

## ANALYZING THE TROPES

As these narrators attempt to create a narrative in which they have agency over their own life and their own recovery, they must also navigate their lack of rhetorical agency; by posting on this site, they become part of *I Got Better's* argument and may even alter their narrative to support that argument. To further complicate this, the narrators write these stories to overcome the lack of agency they have within the medical system; the taking of doctors' notes is very different from telling a story of recovery. With all the connotations surrounding antipsychiatry and the numerous different movements within antipsychiatry, these narratives also fight against some of the forces that support antipsychiatry (such as scientology). However, all the narratives end positively and end on a form of recovery, and these narratives all seem to create an image of agency. They create this image in multiple ways that I classify and explain: personal triumph, the curating of relationships, and goal-oriented thinking. In the next chapter, I analyze the similarities each of these tropes to cognitive behavioral therapy and the complications of agency that presents. Of the fifteen narratives I analyze, each of these tropes occurs in well over half of all the narratives, and each narrative presents at least one of the three tropes.

**Table 2. How often the tropes appear**

Personal triumph	12
Curating of relationships	10
Journey metaphor	8
Total narratives	15

The tropes are described in more depth below, but the basic definitions are as follows:

- Personal triumph: often coinciding with epiphany, personal triumph is an indication that narrator takes responsibility for recovery.

- Curating of relationships: the curating of relationships is split into two different sections. The first is identifying people who have had a negative impact on their life, their mental health, and their recovery and finding ways to move beyond the relationship that appears to be fostering negative thinking. The second part of this trope is a community of peers that allows for a positive atmosphere and fosters a more positive worldview.
- Journey metaphor: the journey metaphor is also split into different sections. While nearly all the narratives trace their recovery as a continuing process, the journey metaphor involves phrasing reminiscent of a journey. It also involves phrasing that breaks the recovery into multiple goals, such as “little by little” and “slowly but surely.”

Together these tropes help the narrators build an image of agency that both provides them with the sense that they have taken control of their recovery and also restricts their agency because their narrative ultimately supports the website’s intentions.

### *Personal Triumph*

Personal triumph is the most common trope within the narratives, appearing in twelve of the fifteen narratives. Personal triumph, in this sense, is defined as the indication that the narrator is predominantly responsible for their recovery. Personal triumph as a trope is closely tied to agency because sections of these narratives emphasize when the narrators begin to control their treatment and when they control how they are represented. The narrators triumph in certain ways, including triumph over the illness, particularly over the symptoms and debilitating aspects of the illness; and triumph over the psychiatric system that took away their agency and attempted to present them as mentally ill. They build agency through attributing their recovery to



themselves rather than to psychiatric intervention; many narrators even condemn psychiatry, stating that psychiatry impeded their recovery. Personal triumph within these narratives often appears as twofold: an epiphany followed by reclamation of agency. Frank discusses the relevance and connection of epiphany to illness:

Epiphanies are moments that are privileged in their possibility for changing your life. But insofar as changing your life is an historically defined project, so the general possibility of epiphanies is also socially constructed. To experience an epiphany requires a cultural milieu in which such experiences are at least possibilities, if not routine expectations. (42)

Frank's implication here is that epiphanies are constructed and re-imagined identities and that illness in particular can cause a changing in epistemology. Because we consider our lives as evolving and not static, we inscribe meaning to an experience. This inscribed meaning builds from culture understandings that any moment can turn from mundane into life changing. A reflex may be interpreted (or reinterpreted) to indicate an immediate realization of danger. A simple phrase heard often can be remembered as a realization of resistance (e.g, the realization that one may never wish to be "lady like"). We construct ourselves through a supposed instance of insight that we classify as meaningful; a mundane experience can be shifted to become an epiphany in which pieces of our identity are either revealed or changed. The *I Got Better* (IGB) narrators' experiences with the psychiatric system have caused epiphanies that they identify as a stepping-stone to recovery.

The relationship between mental illness and epiphany can be found within case studies at the beginning of psychoanalysis. Freud's case studies contain similar findings in that his patients appeared unable to recover from their ailments until after they identify the root cause, an "epiphany" on the cause of distress (Berkenkotter 103). As nearly all Freud's patients were middle-class women, Freud identified the causes of their illnesses to stem from sexual desire for a male in the woman's life (Berkenkotter 106). The internal epiphany for the illness, that

epiphany guided by Freud, places the onus on the patients to work to better themselves. Instead of developing a type of community relationship with others to discuss these situations, these women depended upon Freud to help them recover. In the IGB narratives, their epiphanies come less from personal “fault” and significantly more from external forces that identify them as ill. Their rejection of their label as unable to recover from mental illness also rejects the medicalized dependency for treatment. For people with disabilities, this rejection can be both empowering and dangerous. They can become empowered through taking control over their treatment and finding alternatives that a doctor may not overtly offer. This empowerment can also be dangerous for many reasons: they are not medical professionals and may not understand the consequences of stopping treatment; they contain no disclaimers regarding the safety of their decisions; and they have the potential to dissuade people from getting treatment that they may need and that may help them. The epiphanies in these narratives are an epistemological shift in understanding both themselves and their illness. Sometimes the epiphanies go a step further and reveal a shifted understanding of the psychiatric system; for example, Anna Leonide Brown blames her medication for making her worse, Melinda James learns that she is normal despite what psychiatrists taught her to believe, Marylou sees her abusive psychiatric treatment as the cause for her mental distress, and Johnny recounts considerable abuse while hospitalized as a teenager. The biomedicalization of psychiatry attempts to identify the cause of illness as within the patient because of the research done on chemical imbalances within the brain (Adame and Knudson 161; Lewis 115); the psychiatric epiphany then comes in two parts: diagnosis and treatment. In other words, an understanding of what is wrong with the person’s brain via chemical imbalances and the efficacy of medication to treat that particular illness (in the hopes that the patient has no adverse side effects and in the hopes that the first treatment is effective enough with perhaps a few minor alterations).

Externalized epiphanies completely shifts the understanding of “I got better,” from one of medical dependency to one of personal triumph over the expectation of dependency. The narratives work to claim agency over their own treatment as well as over their representation. While psychiatrists and psychologists use notes to identify progress/treatment for a person, these narratives provide alternatives to these notes by removing themselves from a clinical setting. They reclaim who gets to write about their condition. These epiphanies mark that shift towards reclamation of representation. The way in which I identify these epiphanies builds from Jost’s first set of criteria for epiphany:

The first set of criteria for epiphany can be seen to pertain to the existential relationship between the precipitating outward event and the realization it brings about. Thus an epiphany is (1) a sudden change in *outward conditions* that produces a shift in *perception*, (2) a shift that is *instantaneous*, a privileged moment of insight, one which is (3) incongruous with the quality of what produced it, out stripping it in depth, importance, and value. (315, emphasis in original)

Jost’s second set of criteria revolves around the literary nature of fiction and poetry. These three criteria work to identify how an epiphany is constructed within a narrative, and how it translates to the reader developing a deeper understanding of the self. The IGB narratives describe the consequences of their epiphany more than a literary piece of poetry/fiction may do so, as they describe an internalized epiphany and focus on how this epiphany led to their recovery, eliciting the importance of analyzing how these epiphanies influence their representation. These epiphanies are rhetorical moves, constructed by the author, to give credibility to their narrative and their decisions. The truth of these epiphanies are constructed and reconstructed in such a way that supports narrative consistency as well as supports their argument against the medical system’s narrative that they cannot recover from mental illness.

Marylou’s story encompasses multiple commonalities between many of the other narratives: she identifies that medical intervention caused her more harm and that the psychiatric

system lied to her; she claims a background of abuse as the harbinger for her illness. Moreover, she describes her recovery as beginning at an epiphany:

While in nursing school, I came across a table in my pediatric nursing textbook that described the normal behaviors of children at different ages. I then realized that I was a “normal” child who was brought into a household where parents could not regulate their responses towards her. In that moment, my world simultaneously came apart and opened up.

Epiphanies build from the mundane to rupture a person’s perspective (Jost 315). Marylou’s epiphany stems from the mundane and chance study of pediatric nursing. Her personal realization of self outstrips that study by providing insight into identity and insight into the agency of how her life narrative has been constructed up to that point. This shift in perception alters how Marylou views her illness; she no longer believes she is ill, or was even ever ill. This instantaneous realization that she is “normal” disrupts her life narrative and consequently provides opportunity for her to claim agency. This epiphany and her narrative are constructed in such a way that she builds an image of agency in which she is able to take control over her life. Marylou provides cohesion between the two events: reading a table in a pediatric nursing textbook and the upheaval of her life. The particular importance for this epiphany is the consequential actions, in which she explains how she reconstructs her life. Marylou’s epiphany becomes somewhat representative of the epiphanies in the other narratives analyzed. That image of agency within Marylou’s narrative provides potentially more insight into her personal triumph than her epiphany. Though she proclaims to live a more fulfilling life, she is still constrained in a multitude of ways: her diagnosis is still on her medical records and could affect her in the future; she writes her narrative in such a way that it would be published on a site with very directive guidelines; and she is fully aware that she is constrained by societal factors. Instead, her personal triumph is a triumph over the medical system and their attempts to make her believe that she “was defective and sick.” She triumphs in a manner that some would see as dangerous,

discounting what medical professionals have told her about her illness in the firm belief that she knows herself better than a doctor knows her diagnosis. Her agency comes in two parts from this personal triumph: 1) agency over her life in a very material way, in which she begins to make decisions for the betterment of her life, and 2) to create that image of agency, in which she is able to make those decisions. Whether this image of agency is her authentic belief that she is no longer influenced by her family and the psychiatric system or if her agency is actually mimicking the site's argument to resist the medical system is unknown. Either way, her narrative builds an image of agency over her life.

Anna Leonide Brown adds to the list of commonalities by describing in her narrative the negative side effects of the medications she was placed on. She criticizes the psychiatric system for its inability to provide her with a treatment plan that would work. Her epiphany occurs in relationship to those medications as she explains,

The turning point was a personal moment when I was about to take my medication and I gagged on it; something told me, instinctually, that I had to stop taking the pills that were making me sick. I slowly weaned myself off of the meds because I had lost my insurance and the writing was on the wall about my ability to buy the medications without insurance. I was right, despite all the people around me telling me I had to take medicine for the rest of my life.

Her daily routine, perhaps more regularly than that, is disrupted by an epiphany; whether the medications truly caused her to gag is irrelevant when the epiphany makes the moment meaningful. She attributes this epiphany to instinct and a very physical reaction to something that caused her to be sick. This sudden disruption of a mundane occurrence becomes a moment in which her perception shifts. Brown's epiphany not only outstrips the reality of how her medication affects her but also outstrips the reality that her financial situation would not have supported her ability to pay for those medications; her insurance problems become secondary to a somatic response that rejects the medications. Instead of an outside factor like insurance

influencing her decisions, she constructs her narrative to create an image of agency in which she quits her medications based upon personal factors. The attribution to instinct rather than affordability (though that is a factor) emphasizes her trust in her epiphany. Like Marylou, Brown restructures her perception of the psychiatric system, under an impression that she knows herself better than a psychiatrist knows her diagnosis. While she does attribute some of her reasoning due to economic means, she emphasizes her instinctual understanding that the medications were doing more harm than good as the particular moment of realization. Her image of agency reconstructs her potentially dangerous decision as justifiable because of the payoff (she recovers). The image of agency that Brown constructs is contingent upon pharmaceuticals as harmful to her, when in fact she describes common side effects to antidepressants/antipsychotics that can usually be treated with an adjustment to the dose or switching to a different medication (NIMH “Mental Health Medications”). Brown triumphs over the people and the medical system that told her she cannot recover from mental illness. She empowers herself to recover by making dangerous decisions, but she is limited in her ability to express that empowerment; her ability to construct her narrative as agentive is dependent upon the existence of the IGB platform because she promotes quitting medication without providing any form of disclaimer. Quitting her medications resists the medical system and places the responsibility of recovery on herself. Brown is able to triumph over the expectation that she will be on medication her whole life.

Not all narratives rely upon epiphany to motivate their personal triumph. The way many of the narrators construct their images of agency is a personal triumph in itself; they are able to select and arrange information to support their recovery narrative, even though their recovery narratives support the site’s stance. Melinda James, alternatively, develops an image of her *lack* of agency. In the longest of the fifteen narratives I analyze, James bends some of the conventions and guidelines for the site: her narrative is well over the suggested word limit; and she describes

her “dark times” in significant detail and provides little exposition into how she developed her own agency and how she recovered. Her continual use of “I found out later” and “20 years later” indicates that she had no control over her situation at the time and had no agency in her decision-making, as demonstrated here:

I found out later that what happened to me was that I went into a state of shock, but at the time I did not know what that felt like. I was numb and could not speak very well...My mother took me to the admitting room, and the admitting nurse held out some form for me to sign. I could not make myself sign it, I put the pen down. Then my mother threatened me, saying, “If you don’t sign it, I will.” I picked up the pen again, pushed down all my protest and forced myself to sign it.

In developing an image of her lack of agency, James still constructs her narrative in a way that is both empowering and dangerous. Her fear and anger at the psychiatric system is dangerous, not just because her treatment was dangerous and life threatening but because she portrays psychiatry in such a negative light that may cause fear in people who might actually benefit from participating in the psychiatric system. The IGB site gives James the agency to express her disempowerment within the system and her disillusionment with it. Interestingly, James’ narrative is the only one of the fifteen that provides not only a plausible alternative to her psychiatric diagnosis (Epstein-Barr virus) but also support from (unnamed) medical professionals to back up the claim that she had never been ill. Her personal triumph then is not recovery from her mental illness, but rather the treatment she incurred at a psychiatric facility fifty years ago. While James’ narrative elicits anger at the way she was treated, many changes have been made with much stricter regulation; pharmaceuticals have also made significant advancements within the past fifty years. James’ image of her lack of agency is further highlighted by her concern that her narrative would not be published on the IGB site, when her narrative acts as evidence and perhaps even justification for the antipsychiatric movement.

The narratives that heavily emphasize personal triumph often do so by positioning their triumph in spite of the psychiatric system. In doing so, the narrators take agency of their recovery and place themselves as responsible for that recovery. More broadly, these representations of personal triumph work as evidence to support the subtle antipsychiatry slant of the site and the site's sponsors. The image of agency within the narratives also reflects the potential limitations of rhetorical agency the narratives possess while telling their stories of recovery. The narratives participate in a site that publishes potentially dangerous representations for recovery and for personal triumph. By participating, they may also share liability; the agency the narrators have in this situation is then split between wanting to tell their stories and doing so in a way that will get their stories published. Perhaps those potentially dangerous strategies worked for their recovery but by publishing their narratives on IGB, they become another personal triumph narrative working to persuade people who may be struggling with mental health issues to reject (or not seek but may need) medical intervention. The narrators may feel triumph over the control and expectations of the mental healthcare system, but how much of that triumph actually occurred is unknown. This triumph may be the narrators following the site's directive guidelines, the transition from "dark times" to hope.

### *Curating of Relationships*

As these narratives map out their stories, many of them identify other characters within their recovery. Interpersonal relationships navigate certain dynamics based upon the power structure between the two actors. Based near exclusively upon their interaction with the psychiatric system, these narrators will be treated differently and their diagnosis and experience with psychiatry will follow them (Wilson and Beresford 145). These narrators are already marked by society and this colors how they interact with others within the community and outside the community. Given how these narratives are publicly posted, many narrators appear



eager to begin a conversation and interact with a community; however, the site acts more like a depository than a means for community and conversation. Instead, the curating of relationships defines and describes the relationships within the narratives. Their agency, in this sense, stems from who they choose to interact with and how they choose to represent other people. They have the rhetorical agency to represent others that may have positively or negatively attempted to represent them previously. This trope appears often in the form of narrated interactions between the narrator and someone of importance in their life. The type of relationship is implied, a kind of literary reading of tone to provide insight into the narrator's emotions. The epiphanies described above do more than mark the turning point for recovery; they also often mark a line that on one side has the "before epiphany" relationships (most often abusive or particularly negative) and on the other side, an "after epiphany," look into relationships that are either abstract or positive.

These narratives work to build a community of peers as well as distance them from toxic relationships. Toxic relationships often occur briefly within the narratives, especially those who talk about abusive situations (e.g., Marylou's relationship with her mother, Johnny's relationship with his father, Jennifer Morris' relationship with her mother, Jennifer Hill's reference to abuse calls out the psychiatric system). Some of them identify their mental illnesses as caused by abusive relationships<sup>3</sup>. The toxic nature of these relationships is sometimes not expanded upon. Additionally, these narratives develop relationships with others by participating in community building. Each of these narratives works to build a community that embraces what is stigmatized in ways that can be dangerous. These narratives try to build a community of support in which

---

<sup>3</sup> Interestingly, the majority of these abusive relationships identify the mother as the abuser.

they can relate to others; they attempt to participate in a community with like-minded individuals. Whether this community building works or not is questionable.

This trope emphasizes an externalization of their recovery, which originally appears at odds with the presence of personal triumph. They work in separate but not opposing ways: personal triumph identifies that the narrators chose to engage in their recovery and not that they were complicit in a medicalized dependency for treatment; the curating of relationships identifies either a breaking of relationships that were toxic to the narrators and impeding their recovery, or how these relationships build a support group and community upon which the narrators can maintain their recovery without needing medical intervention. For this reason, community building is key to the narrators' agency because of the implicit resistance to medical treatment and medicalized dependency. Since they participate in this community by sharing stories, they attempt to develop a community that is open and inviting (some people even offer advice to others who may similarly be struggling with the mental healthcare system, though the advice is usually some iteration of "don't give up!"). Instead, they participate more in an anthology or "a collection of stories" as the IGB site puts it ("About"). However, this does not fully eradicate the narrators' agency because they still have at least some control over the information they choose to include in their narratives. I take into consideration Long's brief explanation about community literacy narratives and the development of a local public:

From a rhetorical perspective, then, *community* refers not to existing geographic locales as the idea of a *neighborhood* would suggest (Barton and Hamilton 15) but to symbolic constructs enacted in time and space around shared exigencies—in other words, *local publics*. People construct these communities—at once discursive and physical entities—around distinct rhetorical agendas...(15, emphasis in original)

Though Long states that her work does not translate well to a digital space, there are multiple similarities between a physical geographically-bound local public in which the community participates based on their values and their needs and the digital space of IGB, which also has a

community that develops based upon their values and the exigency they see in publishing narratives that resist psychiatry. The separation of time and distance no longer limits who can participate rhetorically in this community, which appears to provide justification and support for those who resist participating in medical treatment; instead, the rhetorical limits are imposed by the IGB site.

The trope externalizes recovery to a community effort and the necessity of peer support. Their participation in a discourse community may help them curate their relationships. Porter identifies a discourse community as:

A discourse community shares assumptions about what objects are appropriate for examinations and discussion, what operating functions are performed on those objects, what constitutes “evidence” and “validity,” and what formal conventions are allowed. A discourse community may have a well-established *ethos*; or it may have competing factions and indefinite boundaries (39)

The narrators share and participate in the same discourse communities (*I Got Better*, antipsychiatry, mental health recovery), and by doing so are able to curate those who fit into the community. Their relationships are based upon similar goals and similar viewpoints regarding mental illness. The danger then comes that the narrators may select only those who enable them and cull anyone who might challenge their recovery methods. While some narratives state that they receive this support in structured support groups, such as Alcoholics Anonymous (Jennifer Morris), many others do not disclose if their community is built on a structure or if it is a group of close individuals<sup>4</sup>. I identify sections within multiple narratives to see how the relationships the narrators build affect their representation of agency. The image of agency and the image of the lack of agency depend upon the relationships they describe. They maintain the agency in their recovery by finding a support system not necessarily associated with the medical system.

---

<sup>4</sup> I find the potential relationship between these communities and group therapy interesting but tangential.

Charles Hughes' narrative identifies how a support system works as part of his recovery. His relationships are very personally directed, especially how he selects and maintains those relationships. He portrays his relationships as an alternative to medication since he states that medications made him worse until he stopped taking them. The relationships themselves are not grounded in any kind of structured support group:

For the last 20 years I have been monitoring myself and whenever I start to have strange thoughts I stop what I am doing and start finding a counsel of my peers. Not necessarily a counselor [sic] of peers in recovery but anyone that I have things in common with. Then my symptoms will start going away...If I don't keep my symptoms in check I would just keep getting worse until I find the right people to hang out with till I start functioning "normally" again.

Relationships with others are in many ways positive, if the relationship is supportive. Group therapies exist as a way to develop relationships with peers across levels of treatment and recovery, usually united with a similar goal (Tomes 723). Hughes' relationships occur outside this context and instead develop because he selects whom he includes in his peer support group. In fact, these relationships appear less therapeutically selected and more as friendships. These friendships are an image of agency that Hughes builds; he constructs a social network to double as his support group. Not only through refusing medications does Hughes resist medical dependency, he also goes outside the medical system to develop positive relationships. He posits the relationships in such a way that we do not know what criteria he uses to select his peers (other than common interests), and perhaps he selects them subconsciously; this move is empowering because of the personal agency he highlights to develop a "counsel of peers" and to use this counsel to resist medical intervention. However, we also do not know the nature of these relationships and how positive an influence they truly are. Supportive relationships can still be enabling. His image of agency resists a medicalization of his diagnosis, not because he resists the diagnosis itself but because he resists the way in which the medical systems has attempted to

treat him. The very existence of this alternative support group puts into question the necessity Hughes has for any kind of medical/psychiatric intervention, even though mental healthcare providers commonly recommend support groups. However, this is not to say that he may not truly need any form of medical support; but it does beg the question of if people can find relationships and peer support through personal selection rather than through a structured medical system, why would someone need a counselor or group therapies? This is a dangerous notion because people who may be looking at these narratives for advice might develop the assumption that their friends can constitute a peer group that can provide them with the appropriate amount of support. Yet for Hughes, he has the personal agency to build these relationships, and he constructs an image of agency by portraying these relationships as an alternative to psychiatric treatment.

Pat Hayes, on the other hand, builds his relationships through a more structured approach. He attends and attributes a large amount of his recovery to community support groups. These groups are less personally agentic as he cannot select the people who participate in this community, but he does choose to participate and even lauds them as transformative. While Hayes builds an image of agency in which he determines the kind of support he receives (community rather than medical), he also builds a narrative that supports the website's intentions to build a community of narrators to provide alternatives to dominant medical treatment, even at the ignorance of safety.

I continued to pray and spend time in nature even though I was suffering. Thankfully, I met and became involved with community support groups and the Illinois recovery movement and this put my recovery in a new direction. Their support helped me.

Hayes participates in a community support group, moving away from the particular looseness of Hughes' relationships with others and towards more formal relationships. The image of agency he presents is his willingness to join this group and participate in it more significantly than just

attending the meetings; in fact, he later states that his participation led to a job. We are not given much information about the Illinois recovery movement nor about how the community support group operates. Though at first the group appears more credibly supportive than Hughes', we are actually provided with fewer details about Hayes' support group than Hughes'. Hayes provides little context for the group as he does not elaborate on the ways in which he uses the support group nor on the kinds of support that group offers to people recovering from mental illness. This lack of elaboration puts into question the efficacy of the support group. The group helps him, as he says, but his idea of help may also be, and likely is, influenced by his employment. Hayes develops his image of agency through his decision to participate in a community support group, which empowers him to focus on his recovery and maintain his recovery. The only mentions of the mental health care system are negative, so it is likely that this support group is also separate from the medical system. His portrayal of relationships he builds may pose a danger that assumes all support groups are equal, and that they are all positive atmospheres and will be helpful. Though this encourages people to participate in their community, the support group Hayes minimally describes is provided as an alternative to medical treatment rather than as supplemental.

Jennifer Morris' narrative of her development of relationships with others is one of the few narratives that discuss relationships within the medical system. These relationships mark a distinct difference from suffering, ill, and isolated to recovering, thriving, and maintaining health relationships.

I was hospitalized for 9 days and things began to change for me in a way that they never had before in my 30 years of suffering with severe depression. I began to feel hope because I was not alone anymore when eating, I did silly crafts with peers, I talked with others on the ward, I cried to some of the nurses I trusted, and they told me I was very bright.

Morris' narrative begins with her in a situation in which she has no agency, and she is involuntarily hospitalized. She makes no reference to medications and attributes her recovery to the development of relationships while in the hospital, but the hospital stay itself is only the context within which she realized that she should develop relationships and no longer isolate herself. While she may not have had the agency to choose to be hospitalized, she does choose to participate in a manner that does not involve attributing her recovery to medication; there is still medical intervention to put her in a situation in which she can safely develop those relationships. She is still critical of psychiatric hospitals' treatment of patients, expressing disgust at the poor treatment patients receive. Yet she finds people within the health care system and confides in them. Her image of agency comes from the decision to develop relationships of any kind. The isolation stops her from recovering, and she takes control over that recovery by developing relationships. Morris also identifies Alcoholics Anonymous as one way in which she begins forming bonds with other people. She takes control of her recovery by seeking out support groups to keep her accountable and help her recover. The relationships Morris builds empower her to "maintain [her] recovery with the tools [she] began learning in the hospital where peer support is very important." Morris navigates her development of relationships in a way that is carefully built around credible and well-known organizations for support, which is markedly different from the majority of the other narratives. She transforms a situation in which she has no agency (the hospital stay) into a learning opportunity that results in her reclaiming agency of recovery. Morris' narrative seems to be one of the most forgiving of psychiatric hospitals, yet her criticism of the treatment of patients supports the website; the difference in tone between how the hospital helped her develop relationships and her disgust at the treatment of patients is jarring. She speaks well of her hospital stay because she begins to socialize, but she briefly mentions a

cruel nurse that would seem more out of place were that image not supportive of the website's argument against medical dependency and the implicit argument against psychiatry.

Each of the above narratives offer different iterations of the trope, but they all still support IGB's goals and still participate in the collection of narratives. They all operate under the same constraints of the discourse community IGB offers. By operating under these invisible constraints, they build a collection of stories rather than an interactive community. Additionally, even the narrative above that speaks positively about her hospital stay positions that experience as involuntary and mostly helpful as a place within which she could start to develop positive relationships (Morris). IGB's stance against psychiatry and the site's power to control which narratives get published puts into question the accuracy of these narratives; by necessity for publication, the narratives must participate within the discourse community. The narrators compromise some of their rhetorical agency to conform to the rather directive publication guidelines. While the narrators have the agency to represent many of the specific communities in which they participate, they do so with the understanding that once their narrative is published they also participate in the website's community and consequently participate in the creation of an alternative narrative to medical dependency, and this narrative is built by the website and the site's sponsors.

### *Journey Metaphor*

The journey metaphor follows a similar structure to the hero's journey: that though the journey itself may contain struggles, ultimately the hero succeeds. Success in this case is recovery. The narrators have the agency to portray their recovery how they see fit, but many of them follow the suggested format within the guidelines: illness and symptoms to recovery. The journey metaphor is a more descriptive approach to the structuring of these narratives, moving from pain and illness to health and recovery. However, by using the journey metaphor, the



narrators closely follow the guidelines set by IGB. Of the journey metaphor, many indicators of its presence include references to specific steps and goals to guide recovery. Often, but not always the case, the journey reveals itself through goal-making and future-oriented thinking. Dwelling in the past is equivalent to a lack of recovery. Agency and the journey metaphor coincide through these goals and through the narrators' "paths" to successful recovery. Many of them make goals and recover in spite of psychiatric pessimism (Crystal Choate outright states, "Well I tell you I can get better. Don't tell me there is no fixing this problem."). Although agency may be less apparent within the journey metaphor, the ability to make goals and achieve those goals is highly agentic. The journey metaphor itself does not necessarily indicate or suggest agency because a literal journey can be very dependent upon multiple outside factors; this translates somewhat into the metaphor because of the similar terminology and the comparisons between a literal journey and a metaphorical one as containing difficulties along the way. McGlone's discussion of the journey metaphor in terms of love is relevant also to recovery:

The conceptual metaphor LOVE IS A JOURNEY entails correspondences between lovers and travelers, the love relationship and a traveling vehicle, problems in the relationship and obstacles in the path of travel, and so forth. Expressions such as *We are at a crossroads in our relationship*, *Love is a two-way street*, and *We may have to go our separate ways* are consistent with these correspondences. (111)

A more commonplace phrasing for recovery as a journey is *road to recovery*. Recovery as journey contains many of these similar comparisons, including the path of travel as one that leads to the narrators identifying themselves as recovered, though like love, that journey does not necessarily end at successful recovery. Recovery and success are particularly difficult to define, since their uses change based on the narrator. Some define recovery as breaking away from medical dependency and finding strategies that resist psychiatric intervention while other may define recovery as a more socially accepted form of personal agency by choosing to participate

in medical treatment to control symptoms and allow for the resumption of normal activity (or even allow for the participation in normal activities).

One particular purpose for the journey metaphor as a trope rather than future-oriented thinking as a trope is the implicit assumptions within the metaphor. Another aspect of the journey is the time factor; journeys take time, as does recovery. Future-oriented thinking appears as part of the journey because of the continuous nature of recovery. While future-oriented thinking in terms of recovery contains a significantly more positive connotation, the metaphor somewhat ironically contains a more realistic approach to recovery. The irony of an abstraction of recovery as more realistic does not hold when additional factors are taken into consideration; rather than focusing solely on goals and the achievement of these goals, the journey metaphor allows for flexibility in the interpretation of recovery. Many of these narratives take into consideration and openly address the difficulties they had while recovering and the difficulties they know they face while maintaining their recovery. Charles Hughes' recovery narrative cited above (see page 44) contains this knowledge. He states that he still has symptoms, but he knows how to address those symptoms to maintain recovery. His journey does not end because he knows how to address these symptoms because the symptoms still occur; he continues on that journey of recovery. In some cases, the metaphorical language of journey is overt in its comparison while more commonly the language may be as small as phrases like "baby steps" or "little by little." These kinds of phrases indicate some form of direction and the goals that the narrators wish to accomplish; by doing so, they understand that recovery is difficult but do not portray it as such by working to break down the overall goal of recovery into small manageable tasks. The majority of the tasks they identify as manageable are common self-care techniques taught by many psychologists and other generalized health care workers, such as eating enough, exercising, and practicing good personal hygiene.

Goal-oriented thinking represents a plan for the future and the process it will take to accomplish that plan, which while not necessarily making an overt comparison to the journey metaphor does indicate the narrators' intentions toward the future and (pardon the pun) direction. The journey metaphor in these narratives poses the issue of falling into metaphorical analysis; I do not look at the construction of the metaphor or the implications of the metaphor itself. Instead, the metaphor is an encompassing term that classifies goal-oriented thinking alongside phrases like "baby steps" and "little by little" without straining to find a way to meld that phrasing under goal-oriented thinking. Rather, I analyze the strategies the narrators use to understand how they work towards recovery, how they define recovery, and how they view recovery. Accomplishing these little goals provides insight into how they define recovery. Their definition of recovery relates to agency in two ways: 1) they have the agency to define recovery however they view; 2) their definition of recovery often mimics IGB's goals that recovery occurs outside the mental healthcare system.

This trope, more so than the other two tropes, closely aligns with both the goals of the IGB site and the strategies found in a majority of the narratives. All fifteen narratives portray some form of recovery, which is not surprising since the main goal of the website is to collect recovery narratives; the narrators' fluid definitions of recovery appear in multiple ways from indicating a continuous struggle (Salminen) to fully recovered (Hartman). The journey metaphor does not extend to classify each and all of the definitions for recovery because not all of the narratives expand on how they achieved their recovery or how they maintain their recovery; the narrators who do not expand on how they achieved their recovery often portray it as a form of personal triumph, which has already been discussed. These narratives move from discussions of the past in which they suffer from mental illness (or from the diagnosis of the mental illness) into

a development of recovery through goals, often using some of the language associated with a journey metaphor.

Matti Salminen's narrative differs considerably from the other narratives because of its constant use of metaphors and idioms. The only personal information provided about any mental illness is presented in the first paragraph: "I was diagnosed with a serious mental illness."

Salminen offers no critique of the psychiatric system, nor any other system. The focus is instead an abstract representation of recovery as a journey:

I believe that when we take steps to go down the rocky road of trial and tribulations we do so out of a lack of self-esteem. I never believed I could achieve the things I knew in my heart I wanted. I thought that I had what it took to do great things but didn't believe it was my place in the world to make it happen. I thought I was a nobody. Thinking negatively causes you to act negatively. A lack of self-esteem causes you to live with a disregard for your future.

The narrative provides no specific advice on how to gain self-esteem, aside from a generalized view of lack of self-esteem as a cause of hardship and potentially a cause of mental illness. The narrator suggests that recovery comes from experiencing difficult life situations ("knocked down"). Salminen also places the onus of recovery and, to some extent, even the blame of being ill on the person suffering. The journeys are not just journey to recovery but also journey to illness that can be altered through self-esteem, personal confidence, and belief. While nearly all the narratives I analyze display hindsight as an opportunity to learn, this narrative seems to rely on it. Salminen's personal agency arises from the ability to reshape past experiences into learning opportunities. By manipulating the past, the narrative rewrites experience into part of a personal journey to recovery. As an agent, Salminen not only controls representations of the past but also the narrative's representations of how mental illnesses can develop. The lack of details regarding a personal story to recovery also indicates agency in the narrative's representation of self by choosing not to make the narrative about personal recovery but instead about the abstract

lessons learned during recovery; the advice also doubles as a report of those lessons. Yet Salminen's narrative still conforms to IGB's stated goals: this is a recovery narrative at its core and offers advice to people who may be suffering from mental illness, despite the unique means of packaging that advice.

While Salminen's narrative uses a journey metaphor, Kathleen Hartman orients her recovery through goal setting. By breaking down her recovery into manageable "baby steps," Hartman offers a brief explanation of how she went from mentally ill to a social participant:

I started very small, setting tiny goals like "take a shower every day." I started doing 15 minutes a day of cleaning my house. Within a few weeks, I began to see real changes in my environment and my attitude. I began to join the outside world again.

Much of Hartman's narrative separates recovery as steps and goals to be accomplished. The narrative transforms her personal recovery achievements into generalizable and replicable goals, even though Hartman has the freedom to set her own schedule (she works from home), which is not a widely shared freedom. All the goals the narrator accomplishes are daily tasks, and are not life goals or long-term plans; instead, the goals form a regular structure of her to follow. She has the agency to set these goals and represent these goals as manageable for others to try. Hartman creates an image of agency in which she maintains control of her recovery through self-guidance, even as her goals parallel common self-care practices suggested by psychologists. By setting goals, she reclaims agency through activity. Planning out twenty to thirty minutes of her day is enough to provide some stability. Her insight into what pushes her out of her mental distress indicates that she maintains agency through adapting personal experience into her recovery. By developing these goals in a setting without medical professional interference, Hartman is able to maintain control through setting her own goals; these goals have relevance to her own personal life and cannot necessarily be co-opted by another. Hartman works from home so she has considerably more personal control of her time. She creates an image of agency in which she

manages her time to fit her personal mental health needs. In creating this image, she personalizes her recovery and breaks it into small steps.

Jennifer Hill identifies the stagnant and regressive nature of her treatment as part of the reason she was ill:

I was told I could not complete college. I was not encouraged to have goals except medication compliance and symptom reduction or management. Goals were not discussed, only how to deal with illness or better manage stresses.

Though the management of stress does greatly improve a person's mental health, Hill's focus on the lack of goals refers to long-term personal goals. In that sense, her journey towards recovery does not occur because it is halted by psychiatric intervention. Her identified goal, to complete college, is not only not supported by the medical professionals she sees but outright rejected as a possibility. Psychiatric intervention implies that there is no possible journey because success begins and ends at compliance with the medical system. Hill's reclamation of agency, then, is the motivation to break away from the mental healthcare system. Her lack of agency stems from the stagnation for recovery that the psychiatric system insisted upon; though we do not know the circumstances under which she was told that she could not complete college, we sympathize with someone who is unable to accomplish a goal. Perhaps she threatened the safety of another student or was expelled for a number of other reasons. The lack of progressive recovery helps Hill create an image of a lack of agency that is only overcome once she starts to set and accomplish goals. Interestingly, Hill never says whether or not she completed college. Despite her agency to create and accomplish goals, her narrative still closely resembles the story arc that IGB specifies. Her "dark times" are when she believed that she should not develop personal long-term goals; her recovery begins when she rejects the psychiatric system and begins to "move forward."

The journey metaphor very closely resembles the submission guidelines described on the IGB website (see page 7). By narrowing down the journey metaphor to include fewer instances present in the narratives, I attempted to find more agency in the presentation of these narratives. The guidelines are very directive and the suggested structure appears in every narratives analyzed. The journey metaphor is more descriptive, offering the narratives more agency within their representation; however, they still adhere tightly to the structure in the guidelines. For example, Salminen's narrative, despite the unique metaphorical language, starts with describing possible outcomes because of a diagnosis with a mental illness (jail, etc.) before explain how recovery comes from personal insight. The agency Hartman and Salminen have while they map out their recovery is still limited by the regulation and oversight of *I Got Better*.

Each of these tropes reveals some of the ways in which the narrators represent themselves and reclaim agency for themselves. Though they each contain unique iterations of the tropes, the tropes themselves represent the ways in which the narrators recover: by recovering alone, by working with others, and/or by slowly accomplishing goals. Yet each of these narratives and the presence of the tropes are regulated through the *I Got Better* website.

## DISCUSSION

*I Got Better* presents their goal to build an alternate narrative as empowering; through the narratives hosted on the site, the implied dominant narrative is medical dependency for treatment rather than recovery. I revisit my research question to consolidate what this alternate narrative means for the site and for its participants, and how the site constructs that narrative. What does this mean for personal agency and for rhetorical agency?

*What does this mean for personal agency?*

As these narrators engage in retelling a piece of their life narratives, as they inscribe meaning to otherwise mundane occurrences, they wrote to offer a personal account of their recovery. In doing so, they revise the past and restructure their experiences with the medical system. They reclaim their recovery and their recovery narrative. Each narrator has a unique explanation and story for their recovery, a unique kind of recovery, but they all share similarities as well, from the basic (diagnosed as mentally ill) to the activist (participating in a discourse community with ties to an activist group). They write in similar fashion and rely on similar rhetorical moves, hence the existence of the tropes I analyze. The narrators shape the tropes to fit their purposes. For example, Johnny has no need for an epiphany to triumph over the medical system and his diagnosis, but Anna Leonide Brown's personal triumph hinges on her epiphany that the medications were harmful. Together, however, the similarities reveal perhaps how many recovery narratives re-present their diagnosis and their interactions with the medical system. As soon as someone is diagnosed, they become inextricably linked to the medical system; their diagnosis is part of the medical records and can affect the rest of their life. Yet these narratives work to extract (though perhaps not fully) their recovery from the medical model and reframe it to give them agency. Some narrators describe situations in which they risk their health to



recover, make dangerous decisions, and write in ways that could further dissuade reluctant people from seeking the assistance they might need. For the narrators, these decisions empower them to reclaim control (and even responsibility) of their recovery.

These narratives all contain story arcs that offer a “before and after” portrayal of recovery, or rather, of their agency over their recovery; the “before” is the presentation of their lack of recovery under the medical system and their lack of agency because of a cultural narrative for medical dependency while the “after” portrays the development of agency and the recovery that follows. Sometimes, the turning point is a sudden epiphany and sometimes, it is a slow realization that builds over years or over escalating circumstances. Some narratives focus on how they triumphed over medical dependency by developing their own accountability systems, or sometimes even the rejection of medical dependency leads directly to recovery (which is particularly apparent in the narratives that discuss quitting their medications). The narrators triumph by reclaiming and rewriting their illness narratives into recovery narratives. They do not just triumph over their illnesses; they also triumph over the medical system.

IGB, as a community, implies the expectation that these narratives reject the medical system. Particularly through the curation of specific relationships that offer support outside the medical system, some narratives represent that rejection through refusing to remain isolated in their treatment. Participation within the IGB community comes with the assumptions that the narratives will support the site’s argument. The medical system forms a kind of isolation between the patient and the provider (Adame and Knudson 160). Many narrators resist isolation, a couple narratives even identifying isolation as exacerbating their illness (Jennifer Morris). They find their own communities, form personal care teams that help them recover and maintain that recovery. This resistance to medical dependency restructures their recovery through agency to seek out communities and develop relationships that provide support. The support does not

cure them, but it does help them; they have other with likeminded goals to, in some cases, replace medical care. Here, the narrators reclaim the agency to interact with people who have had similar experiences outside a professionally facilitated meeting. They choose who to trust, who to talk to, and who to work with outside the constraints of a medical system.

As the journey metaphor expands and complicates the notion of getting from point A to point B so too do the narratives expand and complicate recovery. Many of the narratives describe how they struggled (and continue to struggle) with recovery. Some narrators state they do not consider themselves fully recovered (Salminen; Hughes), but they still work towards recovery. On multiple occasions, narrators equate medical dependency as lack of recovery; by allowing themselves to rely on the medical system, they would give up opportunities for success. One narrator says that medical professionals told her she would be on disability for the rest of her life (Marylou). Yet other narrators break down their recovery into manageable steps (exercising, showering, etc.), making mundane experiences more meaningful because they become part of their recovery. The narratives restructure recovery as something participatory. The narrators have agency to participate in the recovery by developing goals and by presenting their recovery as ongoing but still possible.

The narrators reclaim their representation by writing and sharing their narratives. They do not conform to medical dependency; they take agency over their recovery because they developed personal alternatives to the medical system. The narrators reshape their illness narratives into recover narratives. But the platform they publish their narratives on puts into question how much agency the narrators really have. IGB has oversight and editorial control over the narratives, and they can select which narratives are told publicly and which are not. So these narratives are still used as evidence. Instead of the narratives being structured as case studies, in which their diagnoses and recovery are documented for medical purposes as evidence

for or against specific forms of treatment, the narratives are evidence and support towards the site's develop of an alternative narrative that rejects medical intervention and dependency.

*What does this mean for rhetorical agency?*

IGB's sponsor, MindFreedom International, is well known as part of the antipsychiatry movement. The narrators, by agreeing to publish their narratives on this site, become associated with MindFreedom, regardless if they want that association. So why would they publish on this site? While this is only speculation, a few hypotheses provide potential insight: 1) they are already members of MindFreedom and willingly structure their narrative to support the site's argument; 2) the desire to be part of a community that share similar experiences to their own; 3) the dearth of available space to publish a recovery narrative, limiting where they can publish. Even those who support the site's goal restructure how they narrate their recovery, to portray that narrative as both personal and political. As mentioned briefly before, Marylou expressed concern that her narrative would not be published on the site, which begs the question: what narratives actually were not published? We do not know, but this question resituates IGB, instead of social stigma, as gatekeeper for which narratives are told. The narrators no longer have to conform to acceptable social narratives (that situate recovery as medically facilitated); they now conform to IGB's expectations and their narratives become representative evidence in support of the organization's argument and its association to the antipsychiatry movement.

Interestingly, while IGB hosts narratives that advocate potentially dangerous recovery methods, they have no language for disclaimers. The narratives themselves also do not contain disclaimers, though the ones that describe quitting medications might especially need a disclaimer. Quitting medications, particularly cold turkey, can lead to intense withdrawals and other serious issues. One thought for the lack of disclaimers is that they weaken the site's argument by referring people back to the medical system for assistance with their recovery. IGB

states on its website that part of the purpose for this site is to speak to people who may be struggling with mental health issues (“Written Story”); a disclaimer would both partially undermine their argument and build their credibility. They restrict that credibility by attempting to reject the medical system even in the face of dangerous suggestions.

The narratives that were perhaps published on this site because of the lack of alternatives questions the truthfulness of the narratives. While truthfulness in narratives is generally suspect, the truthfulness of these narratives is particularly important; some of the narratives offer advice and the sites itself recommends speaking directly to peers in similar situations. Truthfulness becomes vital the moment these narratives have extended consequences. By writing their narratives to conform to IGB, the narratives may be sacrificing or intentionally excluding bits of truth that might radically alter the reading of the narrative. Because of this, analyzing the narrators’ reclamation of agency and recovery only goes so far. We have no evidence of how these recoveries actually happened or a full explanation of personal difficulties along the way; what we do have are the edited, revised, and restructured narratives that no longer present an accurate portrayal of recovery and pose a potential danger.

Again, what does this say about the site and rhetorical agency? IGB’s argument, directive guidelines, and ties to an antipsychiatry organization limit the rhetorical agency of the narrator. The relationship between IGB’s argument and the narratives is somewhat complex because of personal agency’s appearance within the narrative; this relationship, however, is colored by the implicit demands by IGB for narrators to follow their directive guidelines and to write their narrative in such a way that the story supports IGB’s argument.

Another limit of rhetorical agency has relevance to half the narratives, which were written in question/answer format, guiding what the narrators discuss. One question even closely parallels a question a doctor might ask during a check-up:

How recovered do you consider yourself from any mental health or emotional problems? Please use your own definition of recovered. Indicate your level of recovery on a 10-point scale with 1 being “not recovered at all” to 10 being “fully recovered.” (Hartman)

A 10-point scale has many purposes, including the common pain intensity scale that doctors and patients use to rank pain, which 1 being “in no noticeable pain” to 10 being “I am likely actively dying” (see figure 3 below).

Comparative Pain Scale		
	<b>0</b>	No pain. Feeling perfectly normal.
<b>Minor</b> Does not interfere with most activities. Able to adapt to pain psychologically and with medication or devices such as cushions.	<b>1</b> Very Mild	Very light barely noticeable pain, like a mosquito bite or a poison ivy itch. Most of the time you never think about the pain.
	<b>2</b> Discomforting	Minor pain, like lightly pinching the fold of skin between the thumb and first finger with the other hand, using the fingernails. Note that people react differently to this self-test.
	<b>3</b> Tolerable	Very noticeable pain, like an accidental cut, a blow to the nose causing a bloody nose, or a doctor giving you an injection. The pain is not so strong that you cannot get used to it. Eventually, most of the time you don't notice the pain. You have <i>adapted</i> to it.
<b>Moderate</b> Interferes with many activities. Requires lifestyle changes but patient remains independent. Unable to adapt to pain.	<b>4</b> Distressing	Strong, deep pain, like an average toothache, the initial pain from a bee sting, or minor trauma to part of the body, such as stubbing your toe real hard. So strong you notice the pain all the time and <i>cannot completely adapt</i> . This pain level can be simulated by pinching the fold of skin between the thumb and first finger with the other hand, using the fingernails, and squeezing real hard. Note how the simulated pain is initially piercing but becomes dull after that.
	<b>5</b> Very Distressing	Strong, deep, piercing pain, such as a sprained ankle when you stand on it wrong or mild back pain. Not only do you notice the pain all the time, you are now so preoccupied with managing it that your normal lifestyle is curtailed. Temporary personality disorders are frequent.
	<b>6</b> Intense	Strong, deep, piercing pain so strong it seems to partially dominate your senses, causing you to think somewhat unclearly. At this point you begin to have trouble holding a job or maintaining normal social relationships. Comparable to a bad non-migraine headache combined with several bee stings, or a bad back pain.
<b>Severe</b> Unable to engage in normal activities. Patient is disabled and unable to function independently.	<b>7</b> Very Intense	Same as 6 except the pain completely dominates your senses, causing you to think unclearly about half the time. At this point you are effectively disabled and frequently cannot live alone. Comparable to an average migraine headache.
	<b>8</b> Utterly Horrible	Pain so intense you can no longer think clearly at all, and have often undergone severe personality change if the pain has been present for a long time. Suicide is frequently contemplated and sometimes tried. Comparable to childbirth or a real bad migraine headache.
	<b>9</b> Excruciating Unbearable	Pain so intense you cannot tolerate it and demand pain killers or surgery, no matter what the side effects or risk. If this doesn't work, suicide is frequent since there is no more joy in life whatsoever. Comparable to throat cancer.
	<b>10</b> Unimaginable Unspeakable	Pain so intense you will go unconscious shortly. Most people have never experienced this level of pain. Those who have suffered a severe accident, such as a crushed hand, and lost consciousness as a result of the pain and not blood loss, have experienced level 10.

0 – 10 Pain Scale

**Figure 3. Comparative pain scale (Rich)**

While not all narrators format their recovery in the question/answer format, the amount of people who do suggests that IGB had the questions available to further guide how these narratives are told and what the site suggests is told.

These narratives are written by people who already have experience with a lack of agency. This site continues to limit that agency by controlling which narratives are published and which narratives are not. They provide directive guidelines and even offer questions to further guide how people tell their stories. How these narratives would read were they published elsewhere is not the point, but rather how IGB directs the narratives that appear on their site is. IGB appears to be a space for people to write narratives about their recovery, yet the site possesses considerable control over what the narratives include.

This site poses the question: how much agency is someone actually able to claim? From these narratives, it depends. The narrators themselves, when comparing their agency from illness to recovery, portray themselves as building quite a bit of agency; however, when compared to the guidelines, these narratives answer the questions provided or follow the suggested format. From a critical viewpoint, these narrators do not actually possess much agency, but they believe they do. Perhaps agency is in the eye of the beholder.

*What does this mean for disability studies?*

The medical model of disability has already received considerable (and warranted) criticism for its impact on disabled people. The emphasis for diagnosis and individualized yet dependent treatment isolates people with disabilities. The pathologizing of these impairments ruptures communities in which disability can be a uniting factor. The American Disability Act was only passed in 1990, which marked an American shift towards accommodations, providing access to places that may otherwise have been inaccessible to certain disabled people (Emens 42). But this does not eliminate stigma, particularly for mentally ill people who were generally not considered or included in disability activism (Tomes 721).

The IGB site challenges the medical model by resisting dependence; but what does it add that is new? Heavy criticism for the medical model has been circulating since the 70's (Barnes

578). Perhaps, instead, IGB challenges not just the medical model but also the social model of disability. The narratives resist medical dependency, but they resist the need for social accommodations as well. The narrators do not need the construction of ramps to access buildings; they fight for and work for a shift in mentality. This shift in mentality is not merely towards an acceptance and destigmatization of mentally ill people, but towards a deeper understanding of the limitations and structures under which they have to work. Further, by questioning the medical model, they do not develop a resistance to the dominant social narrative; instead, they challenge the efficacy of doctors and professional health care workers. By also challenging the social model of disability's emphasis on deconstructing material social barriers, they re-imagine how disability operates. As many of the narrators attribute their recovery to personal triumph, the narrators re-imagine disability as self-imposed and socially and medically enabled. Additionally, through these narratives, they personalize and individualized how they were disabled, moving more individual than critical disability studies' focus on intersectionality. IGB's challenge to the medical model is important but somewhat derivative; the challenge to the social model and to critical disability studies, however, raises the necessity to give individual consideration to the effects of being disabled.

The political slant implied through IGB's association is vital because this individual consideration cannot exist solely within academic research. The social model and the medical model were borne from activism, and the individual should not be sequestered into existing for academia. Each experience within the medical system and the social sphere are influenced by and altered because of disabilities, and each disability is unique in its manifestation. Despite all the similarities within these narratives (and there are many), each one still portrays a uniquely constructed recovery, past, and future. IGB's criticisms of medical dependency do not necessarily even challenge the "dominant social narrative" ("About"); they challenge the medical

model of disability. The struggle to deconstruct stigma and resituate mental illness as “normal”<sup>5</sup> would truly begin to challenge the social narrative.

---

<sup>5</sup> Normal is a loaded word, particularly within the field of disability studies. However, its use here is not to say that mental health would be abnormal. Additionally, with the amount of people diagnosed with a mental illness, perhaps it is time to understand mental illness as normal and not just common (NMHI “Any Mental Illness”).



## CONCLUSION

Further research into how agency, rhetorical agency, and mental illness still must be conducted as this thesis is by no means encompassing and perhaps not necessarily generalizable. The implications of these narratives' interactions with the *I Got Better* site are generalizable in the sense that recovery narratives are still regulated and still used for the benefit of others. Testimonials for the effectiveness of medications are another example of how recovery narratives are co-opted and edited for another's benefit. While the narratives, or testimonials, may not be untrue, they do not encapsulate the full truth. In a consumer-mediated medical system, in which pharmaceutical companies can advertise directly to consumers, the authority of the medical system is questioned. In some ways, this is good; the monolithic (and potentially unethical) structure of the medical system is discriminatory and isolating. In other ways, however, it can undermine the expertise that medical professionals develop through years of training. The IGB narratives are used in attempted to undermine authority within the psychiatric system. The effectiveness of that attempt is difficult to engage.

Consumer, survivor, ex-patient (c/s/x) groups work to advocate for conscious decision-making while receiving treatment, whether that treatment is inside or outside the psychiatric system (Tomes 725). How c/s/x narratives differ from the narratives hosted on IGB remains to be seen. While many IGB narratives could be representative of some of the c/s/x groups, many do not advocate for conscious decision-making; they often attribute recovery to epiphany or finding alternatives to the medical system in ways that post risks for people who may consider replicating some of the strategies within the narratives. The IGB narratives, too often, portray impulsivity as their means of making decisions.

These narratives challenge the medicalization of mental distress. Some challenge their diagnoses (e.g., Marylou and Anna Leonide Brown) while others challenge the treatment they received (e.g., Johnny and Jennifer Hill). Together, the narratives identify medications, hospitalizations, and electroconvulsive therapy (also known as electroshock therapy) as treatments the psychiatric system has attempted to use to control both the narrator and the narrator's condition. The ethical use of each of these treatments has already received scrutiny; however, the connections these narratives make to cognitive behavioral therapy (CBT) are yet to be researched. The negative triad within CBT closely parallels the three tropes: personal triumph and the self, the curating of relationships and the surround, the journey metaphor and the future (Beck and Rush 11). This brings up the point that the pervasiveness of medical terminology and the medical system itself should be critically analyzed. An analysis of these narratives challenge many assumptions about the biomedical approach to diagnosing and treating mental illness, but the narratives are more than challenges. They reveal that even in a rejection of medical intervention, we must still rely upon medical terminology.

My analysis of these narratives asks more questions than I answer, and these questions delve further into our assumptions about mental illness and medical intervention. They delve further into our ideas of agency and how mental illness interacts with agency. They reveal an undercurrent of skepticism, distrust, and outright hatred for a system that has a history of abuse and cruelty; they explain in detail the negligence and abuse at the hands of the psychiatric system, yet we still rely upon this system for treatment of mental health concerns. The narratives on *I Got Better* do not cover the range of emotions and interactions that people have with the mental health care system. For some, perhaps the psychologists did more harm than any psychiatrist could. For others, perhaps the psychiatric abuse influenced them to become

psychologists. Interactions with the medical system are varied, and abuse and help may sometimes be difficult to gauge. But this does not mean that it cannot and should not be studied.

## WORKS CITED

- Adame, Alexandra L., and Roger M. Knudson. "Beyond the Counter-Narrative: Exploring Alternative Narratives of Recovery from the Psychiatric Survivor Movement." *Narrative Inquiry* 17.2 (2007): 157-178. *Academic Search Premier*. Web. 15 May 2016.
- American Psychiatric Association. "What is Psychiatry?" *American Psychiatric Association*. n.d. Web. 30 June 2016.
- "Any Mental Illness (AMI) Among US Adults." *National Institute of Mental Health*. National Institute of Health, 2014. Web. 16 May 2016.
- Arduser, Lora. "Agency in Illness Narratives: A Pluralistic Analysis." *Narrative Inquiry* 24.1 (2014): 1-27. *Academic Search Premier*. Web. 14 Nov. 2015.
- Barnes, Colin. "Disability Studies: New or Not so New Directions?" *Disability & Society* 14.4 (1999): 577-580. *Academic Search Premier*. Web. 4 Dec. 2015
- Beck, Aaron T., and A. John Rush, eds. *Cognitive Therapy of Depression*. New York: Guilford Press, 1979. Print.
- Beresford, Peter. "Psychiatric System Survivors: An Emerging Movement." *Routledge Handbook of Disability Studies*. Ed. Nick Watson, Alan Roulstone, and Carol Thomas. London: Routledge, 2012. Print. 30-41.
- Berkenkotter, Carol. *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry*. Columbia: U of South Carolina P, 2008. Print.
- Bernheim, Emmanuelle. "The "Rhetoric of Rights" in Mental Health: Between Equality, Responsibility, and Solidarity." *Power and the Psychiatric Apparatus: Repression, Transformation and Assistance*. Ed. Dave Holmes, Jean Daniel Jacob, and Amelie Perron. Burlington: Ashgate, 2014. 47-66. Print.

- Brown, Anna Leonide. "How to Survive Enough to Say, 'I AM Better.'" *I Got Better*. n.d. Web. 18 Nov. 2015.
- Brown, Kerry. "It Takes a Peer to Truly Help a Peer." *I Got Better*. n.d. Web. 14 May 2016.
- Bruner, Jerome. "The Narrative Construction of Reality." *Critical Inquiry* 18.1 (1991): 1-21. *JSTOR*. Web. 25 May 2016.
- Choate, Crystal D. "I Created an Environment I Love to Live in." *I Got Better*. n.d. Web. 14 May 2016.
- Cooper, Marilyn. "Rhetorical Agency as Emergent and Enacted." *College Composition and Communication* 62.3 (2011): 420-449. *JSTOR*. Web. 6 Sept. 2015.
- Costa, Anne. "Back from the Brink." *I Got Better*. n.d. Web. 14 May 2016.
- Cynthia. "Creator of My Life." *I Got Better*. n.d. Web. 14 May 2016.
- Elizabeth. "I'm the Architect and Builder." *I Got Better*. n.d. Web. 14 May 2016.
- Emens, Elizabeth. "Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act." *The Disability Studies Reader*. 4th ed. Lennard J. Davis, ed. New York: Routledge, 2013. Print. 42-57.
- Flower, Linda. "Going Public—In a Disabling Discourse." *The Public Work of Rhetoric: Citizen-Scholars and Civic Engagement*. Ed. John M. Ackerman and David J. Coogan. Columbia: U of South Carolina P, 2010. Print. 137-156.
- Frank, Arthur. "The Rhetoric of Self-Change: Illness Experience as Narrative." *The Sociological Quarterly* 34.1 (1993): 39-52. *JSTOR*. Web. 26 Apr. 2016.
- Fraser, Nancy. "Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy." *Social Text* 25/26 (1990): 56-80. *JSTOR*. Web. 29 June 2016.
- Goodley, Dan. "Dis/entangling Critical Disability Studies." *Disability & Society* 28.5 (2013): 631–644. *Academic Search Premier*. Web. 10 Mar. 2016.

- Hayes, Pat. "Taking Chances in Recovery." *I Got Better*. n.d. Web. 14 May 2016.
- Hartman, Kathleen. "Baby Steps are the Way to Feel Better." *I Got Better*. n.d. Web. 14 May 2016.
- Hill, Jennifer. "Part of the Human Condition." *I Got Better*. n.d. Web. 14 May 2016.
- Hubbard, Ruth. "Abortion and Disability: Who Should and Should Not Inhabit the World." *The Disability Studies Reader*. 4th ed. Lennard J. Davis, ed. New York: Routledge, 2013. Print. 74-86.
- Hughes, Charles. "Wilderness Hermit Charlie's Journey to Recovery." *I Got Better*. n.d. Web. 14 May 2016.
- James, Melinda. "I Got Better and Recovered From Psychiatric Abuse." *I Got Better*. n.d. Web. 14 May 2016.
- Johnny. "Try to Change Negligent or Abusive Mental Health Programs." *I Got Better*. n.d. Web. 14 May 2016.
- Jost, Walter. "Epiphany and Epideictic: The Low Modernist Lyric in Robert Frost." *A Companion to Rhetoric and Rhetorical Criticism*. Walter Jost and Wendy Olmstead, eds. Malden: Blackwell. Print. 311-324.
- Lewiecki-Wilson, Cynthia. "Rethinking Rhetoric Through Mental Disabilities." *Rhetoric Review* 22.2 (2003): 156. *Academic Search Premier*. Web. 25 Apr. 2015.
- Lewis, Bradley. "Mad Fight: Psychiatry and Disability Activism." *The Disability Studies Reader*. 4th ed. Ed. Lennard J. Davis. New York: Routledge, 2013. Print. 115-131.
- Linde, Carol. *Life Stories: The Creation of Coherence*. New York: Oxford UP, 1993. Print.
- Long, Elenore. *Community Literacy and the Rhetoric of Local Publics*. West Lafayette, Ind: Parlor Press, 2008. Print. Reference Guides to Rhetoric and Composition.
- Marylou. "Making New Sense of the World." *I Got Better*. n.d. Web. 18 Nov. 2015.

- McGlone, Matthew S. "What Is the Explanatory Value of a Conceptual Metaphor?" *Language & Communication* 27.2 (2007): 109–126. *Academic Search Premier*. Web.
- "Mental Health Medications." *National Institute of Mental Health*. National Institute of Health, 2016. Web. 16 May 2016.
- Miller, Carolyn R. "What Can Automation Tell Us About Agency?" *Rhetoric Society Quarterly* 37.2 (2007): 137–157. *JSTOR*. Web. 8 Apr. 2016.
- MindFreedom. "About." *I Got Better*. n.d. Web. 14 May 2016.
- MindFreedom. "Guidelines: How to Write and Send Us Your Written Story." *I Got Better*. n.d. Web. 14 May 2016.
- MindFreedom. "Home." *I Got Better*. n.d. Web. 14 May 2016.
- MindFreedom. "Learnings." *I Got Better*. n.d. Web. 14 May 2016.
- Morris, Jennifer. "Little By Little Things Will Change." *I Got Better*. n.d. Web. 14 May 2016.
- Porter, James E. "Intertextuality and the Discourse Community." *Rhetoric Review* 5.1 (1986): 34-47. *JSTOR*. Web. 26 May 2016.
- Price, Margaret. "The Bodymind Problem and the Possibilities of Pain." *Hypatia* 30.1 (2015): 268–284. Print.
- Rich, Alice. "0—10 pain scale." *Lucile Packard Children's Hospital*. Stanford. Web. 15 May 2016.
- Ritivoi, Andreea Deciu. "Explaining People: Narrative and the Study of Identity." *StoryWorlds: A Journal of Narrative Studies* 1 (2009): 25-41. *Project Muse*. Web. 12 Nov. 2015.
- Salminen, Matti. "Graduate of The School of Hard Knocks." *I Got Better*. n.d. Web. 14 May 2016.
- Saxton, Marsha. "Disability Rights and Selective Abortion." *The Disability Studies Reader*. 4th ed. Ed. Lennard J. Davis. New York: Routledge, 2013. Print. 87-99.

- Shakespeare, Tom. "The Social Model of Disability." *The Disability Studies Reader*. 4th ed. Ed. Lennard J. Davis. New York: Routledge, 2013. Print. 214-221.
- Shildrick, Margrit. "Critical Disability Studies: Rethinking the Conventions of the Age of Postmodernity." *Routledge Handbook of Disability Studies*. Ed. Nick Watson, Alan Roulstone, and Carol Thomas. London: Routledge, 2012. Print. 30-41.
- Szasz, Thomas. "Varieties of Psychiatric Criticism." *Power and the Psychiatric Apparatus: Repression, Transformation and Assistance*. Ed. Dave Holmes, Jean Daniel Jacob, and Amelie Perron. Burlington: Ashgate, 2014. 25-33. Print.
- Tomes, Nancy. "The Patient as a Policy Factor: A Historical Case Study of the Consumer/Survivor Movement in Mental Health." *Health Affairs* 25.3 (2006): 720-729. Print.
- Vázquez, Gustavo. "The Impact of Psychopharmacology on Contemporary Clinical Psychiatry." *Canadian Journal of Psychiatry* 59.8 (2014): 412-416. *Academic Search Premier*. Web. 29 June 2016.
- Wilson, Anne and Peter Beresford. "Madness, Distress and Postmodernity: Putting the Record Straight." *Disability/postmodernity: Embodying Disability Theory*. Ed. Mairian Corker and Tom Shakespeare. London; New York: Continuum, 2002. Print.