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RESEARCH

He's Mad! Stigma and the Changing Understanding of Mental Illness

LINDA SIROIS

Around 25 years ago, Julie's first born son, Neal, was diagnosed with autism. She and her husband had just returned from the Mayo Clinic with Neal where the doctors told them: "Don't expect too much from this child." Julie and her husband were devastated. A few days later, they were at a friend's house where another family was also visiting. This family had a daughter of about two who was lying on a blanket on the floor, unable to move around, and her mother was talking about how the little girl had just been diagnosed with a form of muscular dystrophy. Julie felt a sympathetic bond with this woman because of their recent diagnosis for Neal.

Approaching the mother, Julie introduced herself and expressed her condolences on the medical news the child's family had just received. They spoke for a minute, then Julie offered the news that her son, Neal, had just been diagnosed with autism.

"Autism!" the other mother exclaimed. "I'd rather my child could never, ever run or play again than have her diagnosed with something wrong with her *mind*!"

According to *Mental Health: A Report of the Surgeon General* (NIMH, 1999), the range of mental disorders suffered by nearly one in five Americans (including children and adolescents) is "spoken of in whispers and shame." Societal stigma, fear, and ignorance about mental disorders forms barriers between those who live with it and those who do not. While the corporeally disabled and the cognitively impaired most often bear visible signifiers, the mentally disordered (e.g. those with bipolar disorder, obsessive compulsive disorder, traumatic brain injury, autism, depression) live with disability that is largely hidden and not well understood. To the uninformed, mental disorders can look like negative personality traits, such as stubbornness, inattention, or indifference.

While some may disagree that these neurophysiological differences should be termed "illness" or "disorder," debating the semantics merely serves to delay those who suffer

from mental disorder from receiving the medical diagnosis and relief that might change their lives. I do prefer "disorder" to "illness" but, make no mistake, after raising a son with obsessive compulsive disorder (OCD) which was later exacerbated by a traumatic brain injury (TBI), and living with his partner who has bipolar disorder, "disorder" seems a reasonable, serviceable term.

Before and even after my son was diagnosed, people—especially at school—labeled him as oppositional due to lack of understanding about his OCD and TBI. In the *Surgeon General on Children's Mental Health Report* (2001), David Satcher discusses the need for education about mental health issues for all those who are involved with the care and education of children, especially those he terms "frontline providers—teachers, health care workers, school counselors and coaches" to be better able to recognize signifiers of mental disorder (p. 1). The term "disorder" is a clarifier, a reasonable explanation that sheds light on my son's neurological differences and offers some protections for him under the special education umbrella.

Medical doctors, mental health professionals, the mentally disordered, and their loved ones have long struggled with the language of mental illness. There is something alarming and yet satisfying about the brief, hard utterance of "Mad!" But that old term excludes the diversity that exists within the diagnosis of mental disorder. In semantical terms, some of the confusion may originate with the multitude of labels that exist: "psychiatric disorders," "serious psychological problems," "mental disorders," "mental illnesses," "anxiety disorders," "neurobiological disorders," "brain disorders," "psycho-neuro-physiological disorders," and "brain diseases" (Furnham, 2005, p. 1; Dess, 2000, p. 1; Adams, 2005, pp. 1, 2; Koplewicz, 2000, p. 103; Gravitz, 1998, p. 27). The language is nearly as confusing as the illnesses themselves. There is simplicity, if nothing else, in the old notion of a one-size-fits-all idea of madness. But as we grow in knowledge and, accordingly, in empathy, what seemed obvious and

self-explanatory (“He’s mad!”) becomes increasingly complex and individual.

As English instructors, we can use the narratives of people who have experienced mental disorder to expand our students’ acceptance and understanding of disabled individuals. In the same way that books and stories of racial trauma, gender differences, and cultural diversity have benefitted our students, so contemporary narratives written by people who have experience with mental illness allow students to enter the point of view of the author and connect with disabled people who may seem like “other.” Furthermore, as composition instructors, we are frequently presented with emotional disclosure in the classroom within the boundaries of assigned writing; when our students read narratives of mental disorder, they are able to feel less alone if they are struggling with their own or a loved one’s mental disorder.

Simi Linton, Rosemarie Garland-Thomson, David Mitchell, Sharon L. Snyder, and other activists and authors have done much to put a face and a voice to people who are confined to wheelchairs, people who have missing limbs, impaired vision or hearing, or reduced mobility. When we hear and read enough of the lived experience of physical disability, it becomes harder to hold those people at arm’s length or to imagine them as differing from ourselves. In the same way, narratives of the mentally disordered are crucial to expand understanding of life locked in one of these conditions. Mental disability that stems from cognitive impairment such as Down syndrome has physical markers to alert people to open their minds. We have time to arrange our background understanding and recall what we know about any deficits or challenges that those with Down syndrome face. In the same way, wheelchairs, canes, and missing limbs signal bystanders about the challenges faced by the apparently physically disabled.

With the non-apparent disabled, there are no obvious markers that allow people to summon a measure of compassion and good will. Without physical markers, people are free to misinterpret and assign their own meaning to someone with a mental disorder. Additionally, as educators we are often on the front lines of interaction with students who may be battling silently with hidden mental disorder—whether undisclosed, undiagnosed, or improperly treated—that impacts their work or presence in the classroom. When we teach using narratives of mental disorder, we consequently open our own minds to neurological differences that may masquerade as something else. We can move toward empathy within the classroom by engaging with texts that

deal with what it is like to live with mental disorder, then proceeding with student responses, working toward small group discussion, and then classroom discussion. Such open exchanges will broach the subject, lessen fear, and help to dispel the distance that fosters what many believe to be the greatest burden of mental disorder: stigma.

The Stigma of Madness

Despite this medical progress, mental illness remains stigmatized in modern society, just as it has long been. From Greco-Roman times, madness has been a hotly debated topic. In his book *Revels in Madness: Insanity in Medicine and Literature*, Thiher (1999) explores the historical origins of madness. Thiher explains that madness has been imagined to have originated as a “gift” from the gods; as a philosophical speed bump; as a theatrical device; as a result of “humors” and “melancholies.” Thiher states that the theories of ancient Greco-Roman physician and philosopher Galen are crucial as a connection between Greco-Roman thought and “later European civilization, and his views on insanity are central to any understanding of how the Western tradition came to construe madness.” Galen’s medical contribution to understanding mental disorder was the idea that “the body, construed as an alterity to self, is the main cause of madness,” and this belief was the platform upon which metaphysical, theological, and even political theory was informed for Christian thinkers throughout subsequent centuries (pp. 41-43).

In *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman writes: “The Greeks [. . .] originated the term *stigma* to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier.” Furthermore, Goffman notes that when we first meet someone, “evidence can arise of his possessing an attribute that makes him different from others” and “he is thus reduced in our minds from a whole and usual person to a tainted, discounted one.” He adds: “we believe the person with a stigma is not quite human” (pp.3-5).

In the Middle Ages, madness was thought to arise from spiritual maladies. As Thiher explains, “Madness could affect the body, or be an alteration of the body. It could also be a form of divine or, more usually, diabolical possession. And it could be the result of a diseased will” (p. 46). Insanity was thus a matter of sinfulness and retribution. Christianity attributed human instability of any kind to the fall from grace in the Garden of Eden and hence to original sin. Thiher writes that the theological view was that “all disease can be

interpreted in moralistic and teleological terms [. . . therefore] madness must ultimately be an expression of some divine purpose” (p. 47). It is not hard to trace how stigma became a permanent attachment to any form of mental disorder, with the nuances of divine retribution and sinfulness clinging to the diagnosis

Freud (1930) maintains that we humans must endure suffering from three directions: our own body, “which is doomed to decay”; from the external world, which “may rage against us with overwhelming and merciless forces of destruction”; and finally, from our relations to other people (p. 44). Freud notes: “The suffering which comes from this last source is perhaps more painful to us than any other (Freud, p. 44). Social stigma embodies the suffering that springs from our painful sense of separation and difference from other people. One way of combatting this separation and difference is through a scientific and medical approach to mental illness.

The Science of Mental Disorder

Fifty years ago, identified mental disorders such as obsessive compulsive disorder, Asperger syndrome, bipolar disorder, trichotillomania, and schizophrenia all lurked beneath the blanket term of “madness.” The science of neurology and psychiatry is, today, slowly teasing apart the physiological threads of madness. We know that maladies such as clinical depression, Tourette syndrome, and anxiety disorders have a physical cause—a source—of a chemical imbalance or a genetic predisposition, just as surely as diabetes or multiple sclerosis or heart disease is physiological. Neurologists with the enhanced tools of brain MRIs and PET (Positron Emission Tomography) scans allow medicine to encroach upon the formerly vast sweep of madness. Medical professionals are currently aware of over 200 diagnosable types of mental illnesses and disorders (Orr, 2001, p. 25).

The parameters of a mysterious generic “madness” are shrinking as science eliminates or explains away the mystery: this syndrome is a chemical imbalance, this disorder merely a genetic predisposition controllable by advances in pharmaceuticals. The National Institute of Mental Health tells us that of the people who experience mental disorder, some will recover completely, while many others will fluctuate between acute symptoms, manageable symptoms, and complete disability. Research has found that mental disorders are brain disorders; Steven Hyman, in his testimony to the White House Conference on Mental Health, stressed that mental

illnesses are “real illnesses of a real organ—the brain. Just like coronary artery disease is a disease of a real organ—the heart” (as cited in Clinton, 2000, p. 39). He explains that the treatment recommended for heart disease would include various stress and dietary counseling, as well as rehabilitation and medication. It is the same with mental illness. Medication, in conjunction with the appropriate psychotherapies are the accepted treatment (p. 39).

Medicine has made great strides within the last 20 years in the field of mental illness and brain disorder research, identification, and treatment. Medical research continues to tease out diverse subcategories and new disorders within the mental health field. Since the signing of the American with Disabilities Act (ADA) in 1990, the United States has also made progress against the stigma and discrimination associated with apparent physical disability. But in spite of the overwhelming evidence that these disorders also originate physiologically, the de-stigmatization of mental illness or mental disorder remains an enormous challenge.

The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* categorizes, describes, and classifies mental disorders. The development of the *DSM* began in part to collect statistics about mental illness in the United States. In the 1840 census, there was a category of “idiocy/insanity” on the form, and the numerous entries led to further categorizing. By the time the census was taken in 1880, seven categories of mental illness were listed: “mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy” (*DSM-IV*, p. xvii). Subsequent research and classification came about through collection of statistics from mental hospitals and from research brought about by returning World War II veterans, who were found to suffer from “psychophysiological, personality, and acute disorders” (*DSM-IV*, p. xvii). By 1952, the first edition of the *DSM* came out, heavily influenced by Adolf Meyer’s “psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors” (*DSM-IV*, p. xvii). Subsequent versions decided to remove the word “reaction” from the text.

The most recent edition of the *DSM* is *DSM-5*, published in 2013. When contrasted to the earlier version, there is a growth of subcategories, rearrangement of symptoms, and striking changes in the language used to label disorders. For example, the term “mental retardation,” which was used in *DSM-IV* has been softened to “intellectual disability” in the *DSM-5*; Obsessive-Compulsive Disorder now has its own chapter instead of being included among anxiety disorders,

and Post-Traumatic Stress Disorder (PTSD) is under a new category named “Trauma and Stressor-Related Disorders.” Traumatic Brain Injury (TBI) knowledge is further expanded with inclusion under the chapter entitled “Neurocognitive Disorders.” Changes in classification for disorders such as TBIs and PTSD reflect the elastic nature of identification and classification within the mental health field as research is progressing. Consider how the awareness of autism and Autism Spectrum Disorder has expanded within the education field in recent years. Only now, for the first time, does “Autism Spectrum Disorders” appear in the *DSM-5*. The science of identifying and diagnosing mental disorders is in a highly fluid state which *must* precede and pave the way for the ultimate goal of inclusion and acceptance of those with any kind of neurological difference (pp.809-811).

From the 1840 identifier of “idiocy/insanity,” medical knowledge about the nature and causes of mental disorders has exploded. The most important point to remember is that mental illness is not a choice. The National Institute of Mental Health (NIMH) (2014) asserts: “Through research, we know that mental disorders are brain disorders. Evidence shows that they can be related to changes in the anatomy, physiology, and chemistry of the nervous system. When the brain cannot effectively coordinate the billions of cells in the body, the results can affect many aspects of life.”

“Madness” in Life and Literature

There is something terrifying, yet compelling, about fellow humans with otherwise fully functioning faculties who flip over into the alternate reality of mental illness. We wonder: “Where is the line?” “Could it happen to me?” Those of us who are not afflicted with a mental disorder have a compulsion to look/don’t look when we are presented with what seems to be the ultimate human state of “otherness.” We as readers and audience thrill to, even as we shy away from, characters and plot driven by an altered state of perception. With mental unbalance, anything is possible—or so culture, film, and literature have implied.

We have been accustomed to madness as a grand literary device. Author and founding member of the MLA Committee on Disability Issues, David T. Mitchell (2002) writes in his essay, “Narrative Prosthesis,” that, historically, “Literary narratives support our appetites for the exotic by posing disability as an alien terrain that promises the revelation of a previously uncomprehended experience” (p. 23). He posits that “disability pervades literary narrative. . . as a stock feature of

characterization” which he terms “narrative prosthesis” (pp. 15-16). He asserts that “Disability lends a distinctive idiosyncrasy to any characters that differentiate themselves from the anonymous background of the norm” and writes “In literary narratives, disability serves as an interrupting force that confronts cultural truisms” (p. 16).

More and more, writers attempt to merge scientific reality with day-to-day experiences in literature that deals with mental illness. Contemporary literature is filled with memoirs and fictional accounts from the mentally disordered point of view. Madness has at different times been thought to have been given as a form of divine retribution, a “soul sickness;” there exists a lingering belief that mental disorder is caused or exacerbated by non-physical causes, along with a persistent sense that some sort of moral retribution is due the sufferer (and their family). This is being proven not to be the case as “hard science” has turned its eye upon the mental health field.

When mental illness narratives have been written by those who have no experience with the disability, lack of understanding can result in an altered lens on pain, motives, and the workings of the neurophysiologically altered mind. This lack of knowledge can be a breeding ground for misunderstanding which disseminates fear. Fear breeds distance, distance feeds stigma. Stigma is presently an inevitable secondary characteristic of mental disability—a resulting state of social judgment and of distancing. McDaniel (1969) states in *Physical Disability and Human Behavior*, “the study of attitudes toward the disabled may be expressed as the view that the typical attitudes held by the physically normal toward the disabled is that of a negative prejudgment concerning their personal traits, including what has been called ‘devaluation’” (p. 18).

Authors who write of their struggles with mental illness or disability are taking back the word “mad” in the same way that LGBT authors have conscripted the label “queer.” “Queer”—the word evokes the very essence of “otherness”—also announces and disarms. It’s hard to be stigmatized when one is proclaiming and dissecting, as well as accepting, one’s difference. Those who write of their experience with mental disorder are co-opting terms like “mad” and “insanity” in order to take back and claim what some are now terming their “neurodiversity.”

The parameters of a mysterious generic “madness” are shrinking as science eliminates or explains away the mystery: this syndrome is a chemical imbalance, this disorder merely a genetic predisposition controllable by advances in pharmaceuticals.

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As English instructors, we have the opportunity to incorporate the stories of people who have experienced neurodiversity, and therefore, stigma. “Even adding one essay or book to (see Appendix A for suggestions) expand students’ acceptance of disabled students is a good start. Stigma, ignorance, and fear about mental illness remain as major obstacles to diagnosis and treatment of these disorders. Encouraging students to share their responses to these narratives through journaling, reading responses, or reading logs will open communication about mental disorder/neurodiversity within classrooms. Research writing is another way to engage students and expand their knowledge; classroom presentations will allow more interaction. Reputable online resources abound and most disorders have informational websites with additional resources listed.

Building on existing background knowledge about mental disorder and stigma will be important within the English classroom as a pre-reading activity. Students can be introduced to an awareness of the feeling of being stigmatized by trying this activity in a high school or college classroom:

Pass out index cards to the class members. Then instruct them to write a 3 on the card if someone they know slightly (distant cousin, neighbor, a friend’s family member) has a mental disorder. Write a 2 if someone they know well (co-worker, friend) has a mental disorder. Now, write a 1 if someone they know very well, one of their intimate circle of family or friends—maybe even themselves—has a mental disorder. Then have them turn their cards over so the answers don’t show. Have the students write one sentence about how it felt to write those numbers while sitting there in class. Ask them: “Were you worried that someone might see what you wrote? Were you worried that I might ask about what you wrote down? Maybe you were concerned that someone might judge you or your loved one if they knew you had written a 1 or a 2. That’s because of the social stigma attached to any kind of mental disorder.” Spend a few minutes in class discussing the meaning of stigma and associated terms like “prejudice,” and “bias.”

The National Alliance on Mental Illness (NAMI) says: “We have every right to ask why this sort of prejudice still prevails and why, among many other serious illnesses, *mental* illness should be singled out for such a history of heartless social negligence. It is inconceivable that Americans stricken with heart disease, diabetes, arthritis, or cancer would tolerate this degree of discrimination against them when seeking help for their medical problems. Why should this deplorable

situation exist only for people with brain disorders?” (NAMI, Burland, 2011, p. 119).

Thanks to raised awareness and improved medical care, more neurodiverse people are now, more than ever, able to tell their own stories—and present in every one of those stories is the problem of stigma. There have always been stories *about* mad people, but there have never before been so many accounts written about mental disorder by those who are living with it. These story-tellers have authority and are willing, even eager, to tell us about how their lives look and feel. The end result can be that we all feel less alone.

The New Face of Literary Madness

In *The Place of Fiction in the Time of Science*, John Limon (1990) terms literature an “undisciplined discipline” and names literature “an upstart” when it comes to “truth-telling discourses” (as cited in Mitchell, p. 16). Mitchell takes this idea one step further: “Functioning without absolute standards or proof, literature can be said to behave like an unruly sister to the masculine domain of hard science” (p. 16).

With improved diagnoses and vastly improved medications and medical management, more and more persons with mental disorders are able to sustain clarity and achieve a more regulated level of cognitive function in society. With the politicizing of the disabled, and more scientific knowledge defusing some of the fear of those whom Thiher (1999) termed the “nonmad,” perhaps there is a sense that those who have not experienced mental illness are not qualified to write it. Certainly the mad experience should be written much differently by the nonmad than in the past. This could include the writing of mental disorder without a lived experience through which to view it—and this lived experience can include close proximity to mental illness through ties of love or profession.

Contemporary authors writing about madness or from the viewpoint of madness include: Wally Lamb, Lori Schiller and Amanda Bennett, Sylvia Plath, and Mark Vonnegut. In *The Quiet Room: A Journey Out of the Torment of Madness* Lori Schiller (1994) writes frankly about her battle with schizophrenia. Her doctor, Amanda Bennett, co-wrote Schiller’s 1994 memoir about life with this common mental illness. The connections in contemporary experience are intriguing, as when Schiller, in her teen years, journaled after reading Sylvia Plath’s *The Bell Jar* in English class: “I absolutely hate it! I have never been so emotionally upset about a book before. The symptoms of the crack-upped Sylvia Plath-

Esther Greenwood are me” (p. 17). This kind of honesty reaches across to those who, mercifully, have not lived the terror of Schiller’s hallucinations and screaming voices.

Schiller’s father admits that his own training as a practicing psychologist, made it “almost impossible” for him to come to terms with his daughter’s descent into mental illness. He writes: “Back when I studied psychology in the 1950s, there was only one cause for all mental illnesses, even the most severe: a faulty upbringing.” No matter which school of thought the professional mental treatment followed—either Freudian or Jungian—it was believed “that it was early life experiences that were behind mental disorders” (p. 45). So, for many, the “sins” of the parents were also attached to the stigma of mental illness.

The dangers of stigma clinging to any minority group include the idea that they must somehow fit into a preconceived notion of the limits of their perceived blueprint. Goffman (1963) tells us that the stigmatized person is usually obliquely warned against “normification” and the person is provided “not merely with a platform and a politics, and not merely with instruction as to how to treat others, but with recipes for an appropriate attitude regarding the self” (p. 111).

In the chapter of *The Quiet Room* written by Schiller’s father about her initial struggles in the late 1970s and early 1980s, he confesses that he thought “the most important help she [Schiller] needed was to make sure that nothing of this incident [a suicide attempt] ever came to light. . . I knew she could carry a psychiatric label for a long time—if not forever. I didn’t want my daughter to be stigmatized” (p. 41). In writing about their own lived experience with disabling mental disorder, these authors participate in Goffman’s “disclosure etiquette,” a formula whereby the individual admits his own failing in a matter of fact way, supporting the assumption that those present are above such concerns while preventing them from trapping themselves into showing that they are not” (p. 101).

He also discusses the idea of stepping out of concealment, “that if he accepts himself and respects himself he will feel no need to conceal his failing. After laboriously learning to conceal, then, the individual may go on to unlearn this concealment. . . It should be added that in the published autobiographies of stigmatized individuals, this phase in the moral career is typically described as the final, mature, well-adjusted one—a state of grace” (pp. 101-102).

According to the National Alliance on Mental Illness, taking action can be the best prescription for mental illness:

“Taking action [. . .] becomes the ultimate antidote to feelings of despair and powerlessness. It is a process where victims of social stereotyping take a decisive step to overcome their traumatic situation by refusing to remain silenced by the negative response to their life dilemma. Families and consumers refer to this as ‘coming out,’ ‘breaking the silence,’ and ‘speaking pain.’ It is a form of personal action which, because it confronts the forces that maintain ones suffering, can transform a shattering life experience into newfound pride, strength and determination” (p. 11.9).

Conclusion

Julie’s son, Neal, is currently in his final semester at a university where will complete his Bachelor of Science degree in writing. He is exploring options for graduate school. This is not to say, however, that there will be—or should be—rainbows or resolution at the end of the narratives of authors who write of their neurodiversity, or the living narratives of those with mental disorder. What, ultimately, pulls people through a narrative of pain? Is it the hope of a happy outcome or the expectation of the disappearance of the challenges? It can be deeply disrespectful to insist on resolution or solutions in a traumatic story. Quite often, there is no end; the story goes on and on. Of more value is the testimony, the telling and witnessing of events, no matter the outcome.

Insistence on any kind of happy ending can alienate people and diminish their experience of what is real to them and what is realistic to expect. More often, what readers would like to know is whether it is possible to survive chaos and heartache where there is no sign of a rainbow; they seek what scholar Kenneth Burke has termed “Literature as equipment for living.” Stories that acknowledge the ongoing and largely incurable nature of mental disorder can answer that question with: “Yes, you can survive. You can endure. Here’s what happened to me, to us; here is how we did it. Here is how we are doing it.”

While eloquent advocates for the physically disabled are increasing our awareness of those who are physically different, spokespersons for the mentally ill and developmentally disabled are few in proportion to the numbers affected. With the gains in scientific knowledge about the organic causes of brain disorder which results in mental illness, separation of the mentally disabled and the physically disabled should, by rights, no longer exist. The body and mind are all of a piece.

The Mad Scientist, the mad doctor, the Mad Hatter: the new medical model of mental disorder has squeezed the

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dramatic but dehumanizing notion of literary madness out of existence. King Lear's proclamation: "O, let me not be mad, not mad, sweet heaven!" is no more. Now we are likely to understand that he needs to consult with his psychiatrist, increase his dosage of his anti-psychotic and adjust his Prozac. Less romantic, perhaps, but infinitely more humanizing for those who live the experience of mental disorder, the new face of mental unbalance in literature serves to debunk the mythology of madness and sheds light on the stigmatized disability of mental illness.

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Appendix A. Mental Illness Resources

Contemporary writers are merging scientific reality with lived experience in present day literature that deals with mental illness. Recent literature is filled with memoirs and fictional accounts from the mentally disordered point of view. Some suggested titles are:

Memoir/Nonfiction

Head Cases by Michael Paul Mason (Brain injury)

The Quiet Room by Lori Schiller and Amanda Bennett (Schizophrenia)

Just Like Someone Without Mental Illness Only More So by Mark Vonnegut (Bipolar Disorder)

Louise: Amended by Louise Krug (Brain injury)

Passing for Normal by Amy S. Walensky (Tourette Syndrome)

The Center Cannot Hold: My Journey Through Madness by Elyn R. Saks (Schizophrenia)

Everything in its Place by Marc Summers (Obsessive Compulsive Disorder)

Madness: A Bipolar Life by Marya Hornbacher (Bipolar Disorder)

Wasted by Marya Hornbacher (Anorexia and Bulimia)

Look Me in the Eye: My Life with Asperger's by John Elder Robison (Asperger Syndrome)

Be Different: Adventures of a Free-Range Aspergian by John Elder Robison (Asperger Syndrome)

The Way I See It by Temple Grandin (Asperger Syndrome)

Different... Not Less by Temple Grandin (Asperger, Autism, ADHD)

Girl, Interrupted by Susanna Kaysen (Psychiatric hospitalization)

A Mind Apart: Travels in a Neurodiverse World by Susanne Antonetta (Manic-depressive Disorder)

Fiction and Young Adult

The Curious Incident of the Dog in the Night-Time by Mark Haddon (Autism)

I Know This Much is True by Wally Lamb (Schizophrenia)

She's Come Undone by Wally Lamb (Depression)

The Hour I First Believed by Wally Lamb (Depression and PTSD, after the Columbine shooting)

Kissing Doorknobs by Terry Spencer Hesser (Obsessive Compulsive Disorder)

Jerk, California by Jonathan Friesen (Tourette Syndrome)

The Bell Jar by Sylvia Plath (Depression)

Not as Crazy as I Seem by George Harrar (Obsessive Compulsive Disorder)

Damage by A. M. Jenkins (Depression)

Web Resources

Booksthathealkids.blogspot.com

A site for teachers of young children; multiple categories of books, including books about autism, anxiety, and depression; many posts by educators and school counselors.

Teachmentortexts.com

A site run by two reading teachers whose stated goal is "For students to interact with a text and use it to further their literary skills." Reading and writing strategies and writing prompts.

BrainLine.org

A newsletter with useful information about Traumatic Brain Injury (TBI).

Nami.org

National Alliance on Mental Illness site has educational programs that help school professionals identify early warning signs of mental illnesses in children and teens.