Mad Minds:

Theorizing the Intersection of Gender, Sexuality and Mental Illness

in Contemporary Media Discourse

by

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ABSTRACT

This project analyzes contemporary U.S. mental health discourse as an assemblage that constantly renegotiates the normative subject through the production and regulation of intersectional mentally ill subjects. It uses feminist disability and biopolitical theoretical frameworks to explore how media discourses of mental illness reveal the regulation of mentally ill subjects in relationship to intersections of gender, sexuality, and race. These discourses constitute a biopolitical technology that genders, racializes, and regulates mental illness. This regulation not only reveals the cultural boundaries around who is designated as "mentally ill" (and how they are designated as such), but it also demonstrates how mental illness is normalized when attached to certain bodies in specific contexts, yet perceived as a threat to the social body when attached to other bodies in other contexts.

In order to explore this assemblage, this project is organized around four foundational questions: How is mental illness produced, surveilled, and differentially regulated as a social formation within medicine and policy? How does media reproduce and renegotiate these medical and political mental health discourses? How do these mental health discourses intersect with gender, race, and sexuality? How does our assemblage of cultural, medical, and political discourse produce, observe, and regulate intersectional mentally ill subjects in relationship to shifting ideals of normative subjecthood?

This project answers these questions over the course of several case studies, each of which explores a set of thematically linked texts as a window into understanding how mental illness operates intersectionally and biopolitically in cultural discourses and social

institutions. The first section establishes a broad theoretical framework for articulating how discourses of gender and sexuality are central to the production of mental illness in the United States today. The second section explores how this intersection of gender, sexuality, and mental illness is observed and regulated through social institutions like the workplace, the nation-state, and the carceral system. The final section explores emergent discourses of mental illness that move us away from centering individual mentally healthy subjects as idealized entities and toward understanding mental and emotional well-being as a collective social enterprise.

TABLE OF CONTENTS

INTRODUCTION:

The Problem with the Problem: Theorizing Mental Health Discourse as Assemblage and Mental Illness as an Intersectional Social Formation

In July of 2016, the NPR podcast *Invisibilia* reported on communal models of mental health treatment in an episode provocatively titled "The Problem with the Solution." In the span of an hour, host Lulu Miller guided her audience through three case studies: the small town of Geel, Belgium, where residents have housed seriously mentally ill visitors for centuries; New York City's Broadway Housing Communities, founded by Ellen Mitchell in an attempt to bring the mission of Geel to the United States; and Miller's relationship with her older sister, whose experiences with mental illness often left her family feeling helpless. As the title implies, Miller used these three case studies to illustrate that exclusively medicalized approaches to mental health can do more harm than good -- and to explore the ways in which social, relational frameworks offer a more humane approach. In doing so, the podcast provides listeners with an accessible entry point into the basic tenets of critical disability theories of mental illness.

While the whole episode is compelling, its strongest moments explore the town of Geel's handling of mental health. The community does not disregard medical understandings of mental illness altogether, but rather takes steps to center the social dynamics of mental health. Visitors to Geel -- who are always called "visitors" or "boarders," never "patients" -- are guided through a central intake system. Here, psychiatrists diagnose their conditions, develop therapeutic and pharmaceutical treatment plans to help them manage their symptoms, and assign them to host families. Barring serious interpersonal conflicts, visitors are allowed to stay with their host families as long

as they would like -- and it seems that many do, as the average length of a Geel homestay is 28.5 years. Host families receive a small stipend that defrays the costs of expanding their households, and they are never told the diagnoses of their boarders. The community psychiatrists believe that this lack of disclosure is, in fact, what makes Geel work: not knowing a diagnosis removes any pressure on host families to treat or cure their visitors' mental health conditions. Instead, they are encouraged to focus solely on integrating boarders into their household routines and traditions without changing their behavioral patterns.

Miller, however, notes that there seems to be a major barrier to rejecting solution-based mental health frameworks: proximity. Miller draws on her own experiences with a mentally ill family member and those of Geel hosts who had greater difficulty with their own mentally ill family members than with their boarders to suggest that we are less capable of helping those close to us live with mental illness. An interview with Harvard psychologist Jill Hooley offers Miller some support for this theory. Intrigued by what Miller calls "the particularly cruel idea that closeness somehow makes you worse at healing," Hooley discusses a study which finds that others' criticism of, hostility toward, and emotional overinvestment in mentally ill people makes their symptoms more likely to recur and intensify -- and that the closer one is to a mentally ill person, the more likely one is to display these behaviors. In short, the closer we are to a mentally ill person, the more intense, and thus more harmful, our desire to help them may be.

At its core, the episode argues that an exclusively medicalized approach to mental health fails mentally ill subjects by centering notions of "healing," "cure," or "recovery" that may be unattainable due to brain chemistry, traumatic experiences, genetics, context,

or some combination thereof. Miller's reporting is grounded in the notion that mental illness is a relational social formation: while mental health impairments are lived, embodied experiences, we conceptualize mental illness as deviation from the normative expectations of behavior in a particular context. Our ideas of mental illness are thus oppositional to, yet inseparable from, our ideas of mental health as what is normative. In this cultural context, mental health is not simply an absence of diagnosed mental health impairments, but rather a state of being marked by productive participation in the social institutions of normative subjecthood, including the family, social networks, and the workplace. Medical treatment practices can reinforce this faulty equivalence between normative subjecthood and mental health by defining recovery as compliance with external behavioral norms, rather than internal stability.

This cultural production of mental illness as a deviant social formation is impossible to separate from individual subjects' lived experiences of mental health impairments[1]. Certainly, many mental health impairments present tangible barriers to full participation in social, familial, and labor institutions. At the same time, these institutions manage mental health impairments in a way that materially shapes the lives of mentally

[1] Throughout this project, I use the terms "conditions" and "impairments" to designate individuals' lived experiences with mental illness, and the umbrella term "mental illness" to designate the collective social formation that encompasses these many, often wildly varied, impairments. Critical theorists have long debated whether "mental illness" or "madness" is a more appropriate term (see Lewis, 2010; Martin, 2006). While I understand the contention that "mental illness" is more medicalized and thus can be more stigmatizing, I do not think abandoning the term altogether solves the problem of mental health stigma. As Anne Fausto-Sterling notes (2000), feminist theorists sometimes rely on a false distinction between medicine and culture, and in doing so, we often leave medicalized terms and frameworks unchecked by focusing too narrowly on social/cultural critique. Therefore, I use "mental illness" with the explicit intention of demonstrating that it is not an objective scientific category but a cultural concept that is as constructed, unstable, and porous as "madness."

ill subjects. Mental illness stigma reinforces the belief that mental health conditions are shameful, and potentially dangerous, individual problems that should be isolated, contained, and ideally eradicated. Stigma also makes it difficult for people to recognize and disclose their own mental health concerns -- a silence which both amplifies their own feelings of shame and allows damaging discourses about mental illness to continue to circulate. As such, stigma exists within a complex discursive and material flow. Harmful cultural beliefs about mentally ill subjects impact their quality of life and the material resources available to them.

However, the production and regulation of mental illness are not universal, stable phenomena. While normative subjecthood is the ideal which defines mental illness as an othered social formation, some mentally ill subjects are closer to this ideal than others. While all mental illness is regulated, the details of that regulation take shape in relationship to a subject's gender, race, class, and sexuality in a particular context. For example, emotional distress has been discursively feminized throughout U.S. history; mental health discourses and practices have assumed a white, middle-class patient and have thus excluded and harmed poor people and people of color; and non-normative genders and sexualities have been defined and treated as discrete mental health conditions. While it would be easy to suggest that these troubling approaches to mental health are dated or long deceased, the story of mental health in the U.S. is not a linear progress narrative. Many of these intersectional constructions of mental illness as a medical framework for understanding cultural deviance are alive and well, and the practices we rely upon to manage this deviance do not follow a teleological narrative of scientific progress.

This project analyzes contemporary U.S. mental health discourse as an assemblage that constantly renegotiates the racialized, gendered, normative subject through the production and regulation of intersectional mentally ill subjects within a matrix of recuperability and deviance. Mental illness is always already constructed as a form of deviance -- but both mental illness and deviance are broad, diverse umbrella concepts. Not all mentally ill subjects are produced as equally or similarly deviant, and not all forms of deviance are constructed through the prism of mental illness, even when mental health impairments may be at play, because such impairments are not as explicitly observable as other forms of disability. Our cultural discourses about mental illness -- and our consumption and internalization of those discourses -- are complex and fragmented, even at the level of discrete mental health impairments. For example, Emily Martin notes in *Bipolar Expeditions* (2007) that cultural representations of mania present it as both, and often simultaneously, a desirable state of hyper-productivity and a frightening loss of self-control. Furthermore, though mental illness is not necessarily marked on the body, it is visually observed and identified -- a process of surveillance that is influenced heavily by the intersection of mental illness with gendered, sexualized, and racialized social formations.

This assemblage emerges through multiple, sometimes fragmented social institutions; popular media, medicine, and public policy are three foundational and interwoven sites for the production of these discourses. Medicine has been established in both critical theory and popular discourse as the central site where cultural frameworks for understanding and managing mental illness are produced and reconfigured. However, it is impossible to separate medicine from its complicated relationship to social and

economic policy in the U.S. Such policy not only shapes material access to medicine, but it also often forces those without access into disciplinary institutions that isolate mentally ill subjects. Furthermore, public policy often reproduces social inequalities that make marginalized subjects more vulnerable to traumatic experiences that can produce or amplify mental health impairments. Though they do not carry the same material weight as medicine and policy, media discourses produce and normalize intersectional mentally ill subjectivities in specific contexts. Written and visual narratives reproduce and reconfigure consumers' perceptions of what mental illness means and looks like, as well as how mental health impairments should be managed both socially and institutionally.

In order to explore this complex assemblage of social institutions and mental health discourses, this project is organized around three foundational questions: How is mental illness produced, surveilled, and differentially regulated as a social formation? How does popular media both reproduce and renegotiate these regulatory and surveillance-based mental health discourses? How do these discourses interact with discourses of gender, race, and sexuality? Ultimately, these three questions can be encapsulated in one massive guiding question: How does our assemblage of cultural, medical, and political discourse produce, surveil, and regulate intersectional mentally ill subjects in relationship to shifting ideals of normative subjecthood?

Clearly, this is an expansive topic; cultural frameworks for understanding mental illness are massive and constantly changing. I could have picked a time, space, and medium out of a hat and likely found substantially different yet equally interesting patterns of mental health discourse and practice. However, this project focuses on contemporary U.S. medical and public policy, and English-language television

representations of mental illness that were first presented to U.S. audiences between 2009 and 2016. This is not only the time and place with which I am most familiar, but it is also a historically and culturally distinct site of analysis. The U.S. has a deeply marketized medical establishment; a geographically and politically fragmented policy structure; a massive, increasingly privatized carceral system; and a reliance on individualized explanations for broad cultural problems. These general trends were reshaped throughout the late 2000s and 2010s as a result of the Great Recession, the intensification of both neoliberal and neoconservative policy interventions, and demographic shifts in race and age (as well as the backlash against them). As a result of these developments, the parameters of normative subjecthood have simultaneously become more unstable and more heavily policed, and cultural discourses of mental health as an intersectional social formation have shifted as well.

While film and literature are fertile sites for the production of mental health discourse, I use television as my sole point of entry into the media analysis portion of this project. Given the way in which observational acts are key to the identification and regulation of mentally ill subjects, it makes sense that this project would use audiovisual rather than written media. However, I have limited my focus to television for two reasons: 1) U.S. audiences consume a lot of it[2], and 2) market and cultural factors have

[2] According to Nielsen's 2016 first quarter report, the average American watches five hours of television a day across live airings and digital video recorded shows. These numbers aggregate television consumption in general; access to specific television services is financially structured. Network television is more widely consumed than basic cable television, which is more widely consumed than premium cable.

Furthermore, this aggregated data does not account for streaming television, which has not only complicated the structure of traditional television tiers but also offered new avenues for television production. Streaming consumption data is tracked by streaming television companies, which rarely release ratings reports, although Nielsen

changed the medium significantly over the last decade, enabling a set of mental health narratives that are distinct in both volume and content from those displayed on film. For example, even limited-run series have far longer runtimes than films do, and this enables more complexity and nuance in narrativizing mental illness. In addition, not only do individual television series offer more content than films, but there are also a massive number of them: from 2009 to 2015, the number of scripted series airing in the U.S. jumped from 200 to 409 (Adalian and Fernandez, 2015). This explosion of narratives has enabled the micro-targeting of audiences: a show no longer has to cater to white men aged 18-35 in order to justify its production, but can appeal to and represent previously neglected subjects because there are simply too many television shows, networks, and mediums for any single one to dominate the market. To be clear, television is not immune to the racism, sexism, homophobia, and irresponsible representational habits of pop culture as a whole[3]. However, as a result of its simultaneous expansion and

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surveys indicate that viewers under age 25 watch far more streaming television than those over 25.

Access to online streaming media is also shaped by classed and geographic disparities in the availability and affordability of high-speed internet. However, as statistician Clare Malone notes (2018), it is difficult to make a comprehensive claims about inequalities in access to high-speed internet because much usage data is owned (and not shared) by the corporations that provide services, and some states and municipalities have policies in place that ensure greater access to affordable internet. (Disparities in high-speed internet access also presumably impact rates of digital television piracy, another means of accessing television for which comprehensive data is -- for obvious reasons -- scarce.)

[3] According to a 2015 report from USC's center for research on diversity in media, there are massive gender, race, and sexuality disparities in television representation. Women and girls had only 40% of speaking roles; people of color had about 25% of speaking roles; and only 2% of speaking characters were explicitly represented as LGBTQ.

These discrepancies are intersectional: the majority of women represented on screen were white; two-thirds of people of color represented were male (and black characters were represented twice as often as Latinx characters and four times as often as

fragmentation, television is better equipped than other media to provide a substantive, complicated, accessible volume of case studies for understanding the intersectional production and regulation of mental illness.

Obviously, contemporary television and its relationships with medicine and policy are not the only possible points of entry into theorizing how mental health discourse interacts with regulatory formations of gender, race, and sexuality. Mental health is neither a narrow nor modern discursive formation, nor is it specific to the U.S. Furthermore, there are so many contemporary U.S. television representations of mental illness that this project is not even exhaustive for the time and space it covers. As such, I do not present my analyses here as a universal, ahistorical framework for understanding mental illness as both a lived impairment and an intersectional social formation. Rather, I theorize how mental illness functions within a particular set of visual texts and social discourses produced within a highly specific time and space -- a time and space that I hope represents a turn toward more inclusive, complex, humane mental health discourse, not just within popular media but across the numerous, overlapping social institutions that produce and manage mentally ill subjects.

Historicizing the Regulation of Mental Illness in the U.S.

Asian characters); and 70-80% of LGBTQ characters were both white and male. On top of these representational discrepancies, women actors and actors of color are paid less than their male and white counterparts (Ahmed, 2016), and they are less likely to be recognized for professional awards.

The same issues persist behind the camera. The vast majority of writers, film directors, and television showrunners are white and male (Smith, et. al., 2015; Ryan, 2016). Annenberg researchers suggest that these on- and off-screen labor discrepancies are related, as they found that media with more inclusive production teams was more likely to represent a broader, more complex range of subjects (Smith, et. al., 2015).

The discursive production and regulation of intersectional mentally ill subjects is not a contemporary invention. As Michel Foucault's *Madness and Civilization* (1961) explicates, madness has been constructed throughout Western history as a broad category that encompasses any behavior that falls outside what is considered normative and rational in a given time and place. Changes to this categorization do not take shape in a linear timeline of medical progress but rather emerge alongside disciplinary notions of what normative subjects look like and how they should behave. Medical frameworks are built upon these disciplinary discourses, including practices that eradicate mentally ill subjects from the social body and practices that rehabilitate them into approximating normative behaviors. Both these types of practices have centered the normative subject as that which mental illness is defined in opposition to. As a result, mental illness has been disproportionately attributed to othered subjects.

One example of this construction of otherness as mental illness is that mental illness has been disproportionately attributed to women, especially those who defy the expectations of normative femininity (Gilbert and Gubar, 1979; Ussher, 1991; Goldhill, 2015). The medical and social strategies used to manage women's mental health have reinforced the longstanding discursive relationship between femininity, domesticity, and passivity. The most dramatic example of this is the late 19th-century "rest cure," which upheld the white, feminine, domestic ideal of the "Angel in the House." The regimen consisted of "six to eight weeks of absolute rest and isolation from family and friends, a closely monitored diet… and massage and electrotherapeutics to keep the muscles stimulated" (Blackie, 2004). Though the treatment has long fallen out of favor, its foundational assumptions about gender and madness live on: women are more likely to

be diagnosed with forms of madness considered "dependent," such as depression and anxiety – particularly when male practitioners diagnose them (Artis, 1997).

A similar phenomenon takes shape in the explicit categorization and management of queerness as a discrete mental health condition throughout Western medical history. As medical paradigms of social control replaced moral and criminal ones, non-normative sexual behavior -- though still criminalized and framed as immoral -- became a site of medical intervention (Lupton, 2003). This intervention took shape primarily through the labeling of certain sexualities and sexual behaviors as genetic conditions (Ordover, 2003) or as mental health conditions in the DSM (Goldhill, 2015). Though many mental health practitioners argued that the medicalization of sexuality was more humane than the criminalization of it, medicine nonetheless functioned as a mechanism for the social control of sexuality by treating non-normative sexualities as troubling conditions in need of cure. Events like the inclusion and subsequent removal of "homosexuality" from the DSM (see Bayer, 1981) reveal how medicine and culture work together to produce mentally ill subjects as a means of defining and managing sexualities.

Like gender and sexuality, race has been a foundational site for the medical regulation of difference. The U.S. has a long and troubling history of medicalized racism, from the total neglect of communities of color to the abuse of black and brown bodies in research (Briggs, 2002; Ordover, 2013; Bridges, 2011; Pollock, 2012; Roberts, 2014), and mental health has been no exception to this. As Martin Summers (2014) explains, mental health care in the U.S. has historically centered a white, European subject. Furthermore, people of color have been justifiably wary of the possibility that mental illness may be used to stigmatize racialized subjects and subsequently delegitimize their

claims to full subjecthood. This concern is certainly justified, given that the stigma attached to mental illness throughout U.S. history has not been equally distributed across mentally ill subjects. Rather, the label of "mentally ill" has carried more dramatic social consequences for those already positioned outside the boundaries of normative, rational subjecthood.

Intersections of Mental Health in the United States Today

Mental health conditions continue to be marked by shame and stigma in the U.S. despite the fact that they are staggeringly common. According to 2014 data from the Centers for Disease Control and National Institute for Mental Health, approximately 18% of adults and 20% of children experience a mental health impairment in a given year, and about half of all people will have such an impairment at some point in their life[4]. Not only are mental health conditions common, they can be chronic and debilitating. Mental health conditions rank among the top three conditions impacting Americans' quality of life in CDC analyses of both disability-adjusted life years (13.6 DALYs in 2014) and years lived with disability (27% of total YLDs in 2014). Despite the fact that mental health impairments impact the lives of most people in some capacity, the recognition and regulation of mental illness in the United States is shaped by a complex set of forces,

[4] This data is collated from several CDC studies, including surveys of practitioner diagnoses in both emergency and non-emergency settings and interview surveys of health among members of the general population. These interviews include explicit questions about mental health treatment/diagnosis as well as questions intended to screen for common mental illness symptoms. As such, while these statistics are by far the most comprehensive of what is available, they do not completely or perfectly capture mental illness rates in the U.S.

including the gendering, racialization, and marketization of healthcare; economic and legal policy; and cultural discourses of mental health.

Gender and Medicine: Women in the U.S. today are far more likely to be diagnosed with and treated for mental health conditions than men of the same race and class. While 22% of women were diagnosed with or treated for some form of mental illness in 2014, only 14% of men were (NIMH/CDC, 2014)[5]. This discrepancy does not necessarily indicate that women experience mental health conditions at a higher rate -- just that women's mental health conditions are more likely to be disclosed by patients and/or recognized by practitioners. Rates of diagnosis and treatment of severe mental illness -- defined as a mental health condition that constitutes a "serious functional impairment" -- are roughly equal between men and women (NIMH/CDC, 2014). Furthermore, men (especially those under age 35) commit suicide at dramatically higher rates than women, a concerning trend that many attribute to the under-reporting and under-recognition of men's distress.

Some critics contend that the continued cultural feminization of mental illness is the primary influence on these disparate rates of diagnosis and treatment. Psychiatrist Julie Holland (2015) argues that women are overdiagnosed and overmedicated for depression and anxiety because the pharmaceutical and medical workers have reframed mood fluctuations, hormonal inconsistencies, and gendered life stresses as abnormalities that must be fixed. In contrast, Andrea Nicki (2001) contends that women are not disproportionately diagnosed for mental health conditions, but that they experience them

[5] These discrepancies were only identified among people over age 18. Children and teenagers are diagnosed with mental health conditions at equal rates regardless of gender -- though interestingly, boys are twice as likely as girls to use mental health services (NIMH, 2014).

more frequently due to gendered experiences of trauma[6]. However, these two explanations do not necessarily disprove one another; higher rates of mental illness diagnosis in women could result from both cultural assumptions of women as normative mental health patients and gendered trauma.

The positioning of women as normative mental health patients does not just impact heightened diagnosis and treatment rates among women; it also impacts the under-diagnosis of men. Public health research indicates that men are reluctant to seek mental health services and hesitant to disclose symptoms of mental illness. Furthermore, general health practitioners often fail to identify these symptoms (NIMH/CDC, 2014). As a result of these multiple, overlapping factors, men are less likely than women to be diagnosed with a mental health condition or to be referred to specialized mental health services. Men's hesitancy to seek treatment and discuss symptoms are not exclusive to mental health, and many medical, psychiatric, and gender researchers argue that this emerges from cultural expectations of masculinity. As Julie Gast and Terry Peake (2011) note, men with "more traditional" conceptions of masculinity (as indicated by physical strength and toughness) are unlikely to seek out healthcare because it is a context "where one is expected to ask for help, reveal physical and emotional vulnerability, and forfeit control to others" (319) – all of which contradict traditional expectations of masculinity.

Furthermore, mental health and gender are not just intertwined via binary categories of masculinity and femininity. Transgender itself has long been classified as a

[6] Psychiatric research provides some support for Nicki's theory. Women who have experienced sexual and intimate partner violence are far more likely to experience PTSD and major depression than the general population (see Kilpatrick, 2000; Jones, et. al., 2001; Chivers-Wilson, 2006; Elklit and Christiansen, 2010). Their symptoms also persist for years longer than those who experience PTSD after other traumatic experiences (Kuwert, et. al., 2014).

distinct mental health condition within the DSM under the categories of both gender identity disorder (pre-2012) and gender dysphoria (post-2012). Such classifications have had a profound impact on the stigmatization of transgender as a form of psychological deviance and the medicalization of trans bodies. Fortunately, some mental health practitioners have taken strides to move the discussion on trans mental health away from treating transgender as a discrete mental health condition. These practitioners advocate for a more nuanced understanding of the way in which cultural structures and discourses of transphobia impact trans people's experiences of trauma, depression, and anxiety (see Wilson, et. al., 2015; Reisner, et. al., 2015; Thomas, 2016).

These research discussions reveal a number of ways in which gender impacts individual experiences of mental health. While we now understand that the biological materiality of mental illness is likely unrelated to sex, the social production of gender shapes the medicalization of mental health conditions. Gender expectations grant some subjects more ability to recognize their own symptoms of mental illness and to seek mental health services. Practitioners are more likely to recognize and validate these self-reported symptoms due to diagnostic paradigms that depend on patients' disclosure of emotional and mental distress. This produces a context in which women are more likely to be active consumers in the U.S. mental health care industry than men who share their race and class positionality. Furthermore, while people of all genders likely face mental health conditions at roughly comparable rates, gendered stress and trauma shape individual experiences of mental and emotional distress.

Race and Medicine: Though gender discrepancies in mental health are consistent within racial and ethnic groups, rates of reported and diagnosed mental health conditions

vary hugely by race and ethnicity. According to 2014 CDC/NIMH data, in a given year, professionals diagnose and treat mental health impairments in 27.1% of multiracial adults, 22.3% of Native Hawaiians/Pacific Islanders, 21.2% of Native Americans/Alaska Natives, 19.2% of whites, 16.3% of blacks, 15.6% of Hispanics, and 13.1% of Asians. These disparities have led medical and public health researchers -- including those at the CDC and NIMH -- to question whether these numbers capture differences in mental health incidence across racial/ethnic groups or reveal racialized disparities in access to mental health care services. Preliminary research indicates the latter: a 2015 NIMH study of mental health service use by race/ethnicity found that rates of diagnosis corresponded closely to rates of mental health service use.

However, differences in service use do not offer a full explanation for racial discrepancies in mental health care, as access to such services is shaped by material and cultural barriers that emerge from racist structures and discourses. Per Martin Summers (2014), mental health practitioners believe communities of color are unlikely to seek their services, but rarely question why this is. Summers contends that racial disparities in mental health service use reflect both 1) the limited availability of services within many communities of color, and 2) a skepticism within these communities about the limited services that are available. Summers attributes this skepticism to the history of racism in U.S. medicine, the (valid) assumption that psychiatry is Eurocentric, and a lack of practitioners of color. However, racism structures discrepancies in both resource availability and resource-seeking. Limited resources and low service usage rates feed into one another, as low rates of service use make it difficult for invested community

members and practitioners to justify an expansion of the limited services available to them.

Yet even the uneven availability of resources and justified mistrust in the healthcare system do not fully explain racial discrepancies in mental healthcare. According to Holden, et. al. (2014), black and Hispanic people are far more likely to be misdiagnosed or not diagnosed when they report symptoms of mental and emotional distress to practitioners, and far less likely to be referred to specialized mental health services. Like many medical researchers, Holden, et. al., attribute these racial disparities to structural forces in the medical industry, including patients' increasing reliance upon general health rather than specialized practitioners and a lack of cultural and mental health competency training for general practitioners, both in medical schools and continuing education curricula. However, as Khiara Bridges notes in *Reproducing Race* (2011), medicalized racism is not just structural; it is also perpetrated by individual practitioners who hold personal racist beliefs.

This combination of factors reveals that medicalized racism is not a historical artifact. People of color not only have fewer available resources, but they are hesitant to use those resources due to a mistrust in the medical industry's treatment of people of color, and their experiences within medical contexts often validate that mistrust. As such, improved rates of access alone will not resolve racial disparities in mental health care -- nor will isolated efforts to minimize mental health stigma in communities of color, to diversify the healthcare workforce, or to expand practitioners' cultural competencies. All of the above, developed within a paradigm that assumes mental health is part of general health, are necessary to rectify medicalized racism in the U.S. mental health industry.

Healthcare Marketization and Economic Policy: Gendered and racial discrepancies in mental health care also intersect with the market economy of health in the U.S., which structures access to healthcare through class, insurance status, and geography. Mental health care is a multibillion dollar industry; in 2014, $57.5 billion was spent on formal mental health care -- 6.2% of all health costs in that year (NIMH). The majority of that money went toward prescription medication and outpatient services (primarily talk therapy), followed by specialized inpatient programs and emergency outpatient care (NIMH, 2014). The cost of these formal treatments is quite high; mental illness has ranked in the top 5 costliest health conditions since the CDC began recording such data. Furthermore, individuals' total mental health spending is likely higher than these numbers indicate, as this data does not account for the numerous ways people spend money on mental health management outside formal medical contexts.

Though U.S. mental health care spending is high in aggregate, the personal financial burden on individuals varies based on their insurance status. According to NIMH, more than half of mental health care services are paid by public insurance (2003), and many researchers assume this indicates a correlation between mental illness and poverty. However, Rowan, et. al. (2013) point out that it more likely reflects the fact that public insurance offers more consistent, high-quality mental health coverage than private insurance. Drawing on data from 1999-2010, they found that rates of mental health care service use were consistently high among those with public insurance and low among the uninsured, but fluctuated wildly among the privately insured (2). In other words, publicly insured people likely do not experience mental health impairments at higher rates; they

are just diagnosed with and treated for them more frequently because their access to mental health care is more consistent.

Public policy interventions could potentially expand access to and minimize the personal financial burden of mental health care; however, many political representatives are unwilling to enact change and/or financially influenced by private medical and insurance industries. Rowan, et. al., (2013) believed that the implementation of the Affordable Care Act would expand public insurance and mental health coverage for the privately insured and prevent people from being denied coverage for preexisting mental health conditions. However, the ACA is still contested years after its passage, and individuals' access to care varies based on their state governments' implementation of it. There is hope for improved mental health care policy in the proposed Helping Families in Mental Health Crisis Senate bill (2016), which funds expanded public mental health care coverage, requires private insurance to expand coverage, and increases mental health training for general health practitioners. However, the bill continues to be placed on the backburner of the Senate's agenda despite bipartisan support, and it is hard to imagine how it might make a material difference when public insurance funding is at risk of being slashed and private insurance regulations may be rolled back.

While insurance status affects mental health care access for many, it has little impact in geographic contexts where resources are limited, such as rural areas, where the material needs of communities are seen as too minimal to justify serious economic or infrastructural investment. According to the American Psychological Association (2013), 60% of people living in rural areas of the U.S. have no specialized mental health services in their community, and many of those who have them are unaware of these services

and/or unable to afford them. This lack of services and lack of access is especially troubling given that people in rural communities are disproportionately likely to experience traumatic interpersonal violence -- one of the strongest risk factors for mental illness (APA, 2013).

Individuals' experiences with mental health are impacted by income, their insurance status, and geography -- all of which are embedded within a complex matrix of policies that support the healthcare industry as a profit-generating institution. Self-care practices, alternative care practitioners, online mental health communities, and digital counseling may provide much needed care to those for whom traditional clinical settings are inaccessible and/or unproductive. However, it would be flawed to assume that access to these practices is inherently more equitable; stigma, cost, and availability still present barriers to finding and using such resources. As long as mental healthcare remains embedded in late capitalist modes of profit generation, it will be marked by material inequality. These economic and social inequities are often obscured by regulatory discourses and practices of public health, which articulate care for one's own mental and emotional health as both an individual and social good, but fail to account for the fact that subjects are differentially positioned within the medicalized social body.

Social and Legal Policy: Policy interventions in the healthcare market are not the only way in which policy shapes mental health in the U.S. The federal government has invested in mental health awareness and advocacy programs, including online and traditional media initiatives, community-based workshops, and informational partnerships with public and private institutions such as schools and businesses. Under the Obama administration, these programs were organized around the concept that mental

illness impacts everyone in some capacity, and that it should therefore be a site of collective social investment, not of individual shame and stigma. In the same vein, the National Institute for Mental Health has paid increased research attention to the social dimensions of mental illness, as well as the biochemical and neurological materiality of it[7].

At the same time, however, policy rhetoric reproduces stigmatizing discourses of mental illness-as-criminality, which obfuscate the actual relationships between mental illness and the carceral system. For example, many policy-makers and pro-gun activists are quick to attribute mass shootings to a perpetrator's mental health, rather than lax gun regulations -- though few perpetrators have mental health impairments (Horwitz, et. al., 2015). This tendency to blame mental illness for mass violence is not applied equally to all shooters. The public is quicker to attribute the actions of white violent criminals to mental illness, whereas black and brown perpetrators are assumed to have motives that fit prevailing racist stereotypes (Metzl and MacLeish, 2015). This rhetoric is followed by policy proposals that fail to become law but succeed in reinforcing the mutual construction of mental illness and criminality -- including those that would lower thresholds for involuntary institutionalization and mandate practitioner reporting of patients who present "dangerous" symptoms of mental illness.

While mental illness is overdetermined in discussions about civilian violence, it is rarely mentioned in conversations about police violence. According to the *Washington*

[7] Biochemical and neurological models of understanding mental illness still take precedence over social models. In fact, as Nikolas Rose and Joelle Abi-Rached (2015) note, neurological paradigms are not just central to the medicalization of mentally ill subjects but also to conceptions of the self and one's social location -- including, as Rebecca Jordan-Young explores at length in *Brain Storm* (2010), gender.

Post's 2015 police violence database, a quarter of all people killed by police in the first half of that year were experiencing a severe mental health crisis (Lowery, et. al., 2015). The Post found that more than half of these cases involved concerned friends or family members calling not to report a crime, but for assistance with a person in distress. Many of these cases also involved police forces with little to no mental health training. As is the case with police shootings as a whole, the victims in these cases were disproportionately black. Though this data provides a staggering look at the consequences of escalation-based policing and mental illness stigma, mental health status remains at most a footnote in many conversations about state violence. The contrast between the intense focus on mental health in the wake of mass shootings and the erasure of it in discussions of police violence illustrates how mental illness is exaggerated where it is insignificant, and ignored where it is necessary. This dynamic is profoundly racialized: we struggle to conceptualize a violent white person without relying on discourses of mental illness-as-deviance; but cultural discourses that position black and brown people as always already criminal take precedence over any consideration of their mental health.

As Lisa Marie Cacho notes in *Social Death* (2012), the U.S. legal system entrenches discourses of deviance-as-criminality -- including the racialization and criminalization of mental illness -- through practices that place those who are marked as deviant as outside of full personhood and full belonging within the social body. Mentally ill people are incarcerated at increasingly high rates throughout the U.S. As Michael Rembis (2014) explains, this is primarily a consequence of the stripping of the social safety net, and it accelerated throughout the 1990s as state governments ceased funding public and community mental health services (Steinberg, et. al., 2015; Fuller, et. al.,

2010). As a result, anywhere from 25% to 40% of mentally ill people in the U.S. today will be incarcerated (NAMI, 2015) -- primarily for crimes of survival or drug possession offenses that are often related to attempts to self-medicate (Ford, 2015). Between one-half and two-thirds of all incarcerated persons have some kind of mental health condition at a given point in time (Kim, et. al., 2015) -- a rate at least twice as high as that of the general population. This intersects with racialized discourses of criminality and the regulatory practices that emerge from them; mentally ill black people are ten times more likely to be incarcerated than mentally ill people of other races (Hawthorne, et. al., 2012).

As a result of this dramatically high rate of incarceration of mentally ill people, jails and prisons are filled with people with profound mental health needs that often go unmet. While staff perform mental health and suicide risk screenings during intake (Chari, et. al., 2016), treatment offerings in jails and prisons are minimal but varied. Only one in three people in state prisons and one in six people in jails receives mental health care at some point in their confinement (Kim, et. al. 2015). Furthermore, many incarcerated people report that incarceration -- as well as the material and social barriers they face after their release -- intensifies their experience of mental illness (Ford, 2015). As such, though prisons and jails are now the primary apparatus for the confinement of mentally ill people, especially those who are poor and/or people of color, they do not function as sites of mental health care.

These multiple overlaps between carceral rhetorics and practices and cultural discourses of mental illness contribute to the cultural stigma surrounding mental illness by conflating it with violent, unpredictable criminality. Even in the face of heightened efforts to destigmatize mental illness, many still perceive mental illness as a dangerous

form of deviance that poses a threat to the health of the social body in general and to mentally healthy individuals in particular. Yet research on the topic fails to legitimize this assumption: mentally ill people are not only significantly more likely to be victimized by violent crime than to perpetrate it, but they are also ten times more likely to be victimized than those who are not mentally ill (Insel, 2011). Furthermore, the production of mental illness as a form of dangerous deviance that must be isolated from the social body is not evenly distributed across all mentally ill subjects. It disproportionately affects poor people of color, who are criminalized regardless of mental health status, while those who are white, middle-class, and mentally ill are treated rather than punished.

Mental Health as a Cultural Industry: The medical and political regulation of mentally ill subjects is reinforced and reconfigured by cultural discourses that normalize particular ideas about what mentally ill people look like and how their health should be managed. Though these discourses vary depending on the raced, gendered, and sexualized subjects to which they attach, they all emerge from the fundamental assumption that mental illness originates within the individual. Mentally ill people who are perceived as threatening or dangerous are marked for state and/or medical surveillance and intervention, while those whose mental illness is seen as troubling but not threatening to others are expected to find ways to self-manage[8]. Both these

[8] This is not limited to medicalized self-management. For example, much public discourse about mental illness operates on the assumption that it is "all in one's head." Proponents of this belief often argue that pulling one's self up by their emotional/mental bootstraps is the key to mental health, not therapeutic, community, and/or medical assistance. Certainly, many of the recommendations born of such arguments may mitigate some people's distress -- physical activity, volunteering, journaling, spending time in nature. However, the assumption that positive thinking and/or better self-care create mental health is not far off from the medicalized discourses such sentiments ostensibly critique. Both erase structural and social components of mental illness and

approaches identify mentally ill individuals as a problem to be fixed while erasing the social and material factors that create and amplify their distress.

An emergent representational regime has attempted to renegotiate these intersectional regulatory discourses of mental health. While mental illness was certainly not under-represented in written and visual media in the past, these representations typically contributed to negative ideas about mentally ill people as dangerous, erratic, and abnormal, and they often presented mental illness as a problem to be solved, and a cure as the desired endpoint within a linear narrative of trauma and tragedy (Mitchell and Snyder, 2000). This approach persists, but mental illness representation has also ventured into more nuanced, complex territory. Television shows like *You're the Worst* and *Orange is the New Black* and films like *Short Term 12* have taken strides to represent multiple characters of diverse genders, races, and sexualities whose mental illness is not depicted as tragic or shameful. Such texts have earned positive critical attention and major awards, and have generated massive volumes of paratextual discourse debating their merits. Mental health representation has expanded so dramatically within the past few years that critics declared 2011 the year of "Hollywood's (excellent) crazy lady boom" (Lambert, 2011) and 2015 "the year mental illness finally got some respect on TV" (Kliegman, 2015).

Fictional representations of mentally ill subjects are not the only site of mental health discourse in popular media. Self-help is one of few areas of publishing that continues to grow as overall book sales drop, and these books tend to be marketed to women, particularly middle-aged, educated, white women. Though not as popular as self-

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center an ideal of normativity; one simply rejects medicalized management while the other treats it as a silver bullet.

help books, memoirs of individual experiences of mental illness, such as Elizabeth Wurtzel's *Prozac Nation* and Suzanna Kaysen's *Girl, Interrupted,* have been quite popular, and magazines marketed to women frequently feature first-person essays about mental illness. This market for first-person narratives about mental health has trickled into online media as well. Podcasts like *Mental Illness Happy Hour* and *You Made it Weird* feature interviews explicitly intended to minimize the shame that attaches to mental illness and trauma. In the same vein, online publications have devoted increased attention to issues related to mental health, self-care, and stigma, such as Buzzfeed's annual Mental Health Week and Vulture's increased coverage about mental health representation.

While many of these efforts to make mentally illness visible promote empathy, consumers' desire to see others' experiences with mental illness can become voyeuristic and reproduce stigmatizing discourses of mental illness as threatening. When public figures are in distress, the gossip industry satiates consumers' curiosity with constant coverage and speculation -- an especially insidious choice given that, as Dave Chappelle noted in a conversation about his own mental health (Als, 2014), their lack of privacy often amplifies their distress. Reality television often occupies a similar voyeuristic space. Daytime self-help/counseling programming, cable shows focused on particular conditions like A&E's *Hoarders*, and docu-soaps all deploy participants' mental and emotional distress as an object of entertainment. Such programming does not necessarily undo the destigmatizing work performed by more nuanced, complex depictions of the mentally ill. Rather, these disparate strains of mental health representation work with one another, as well as with medical and policy discourses, to differentially regulate mentally

ill subjects by placing them within a matrix of deviance and recuperability that depends on disciplinary formations of gender, race, and sexuality.

Theoretical Framework

To make theoretical sense of mental health in the United States today, this project analyzes media, medicine, and policy as an assemblage of interlocking vectors for the discursive production and regulation of mentally ill subjects in the U.S. In particular, I focus on analyzing popular visual media representations of mental illness as texts that reveal the way in which the regulation of mentally ill subjects is differentially enacted in relationship to intersecting formations of gender, sexuality, and race. I argue that popular media discourses are a biopolitical technology that genders, racializes, and regulates mental illness by positioning mentally distressed subjects within a matrix of deviance and recuperability. This matrix reveals the cultural boundaries around who is designated as "mentally ill" (and how they are designated as such), and it demonstrates how mental illness is normalized when attached to certain bodies in specific contexts yet perceived as a threat to the social body when attached to other bodies in other contexts. This cultural economy of mental illness does not exist in an abstract discursive vacuum. By negotiating the continuum between the patient-consumer and the patient-threat, these media reproduce and reconfigure the existing medical and policy discourses that structure the material and lived experiences of mentally ill subjects.

Many narratives of mental illness continue to rely on dated, stigmatizing tropes that reinforce discourses that position mental illness as a shameful individual failing that must be resolved. I argue that mental illness stigma is the point where biopolitical

inclusions and exclusions of mentally ill subjects within the social body meet. Stigma is, at its core, an effort to create distance between the normative subjects of a given community or social body and those subjects who belong to it but undermine, destabilize, or threaten its norms. Though not all mentally ill subjects are held at the same distance, they are categorically not the normative subjects that a given community's biopolitical practices center and protect -- yet they can be recuperated into the social body when they either assimilate themselves into its mental health norms or are assimilated into those norms to serve a given community's desire to present an image of itself as inclusive or progressive.

Though we often imagine stigma as enacted on individual subjects, mental health stigma is always already situated within a broader network of social formations. Women, queer people, and people of color are generally positioned outside the boundaries of normative, rational subjecthood; this irrationality is tantamount to madness; this madness is inherently deviant; and this deviance can be constructed as a threat to public health and safety, especially when attributed to racialized subjects. At the same time, the stigma surrounding mental illness is increasingly counteracted by representations that demonstrate that mentally ill subjects are important members of their communities, that they deserve love and care and support, and that their distress originates in broader social problems we should be collectively invested in resolving.

In order to unpack the complexity of this discursive assemblage, I define mental illness through the lens of feminist disability studies and conceptualize subject production and regulation as biopolitical technologies. Feminist debates about mental illness and its feminization in the West have been, at times, far too dependent on entrenched

methodological positions. In the 1970s, Phyllis Chesler's *Women and Madness* (1972) and Sandra Gilbert and Susan Gubar's *The Madwoman in the Attic* (1979) advanced the foundational argument that mental illness is a discursive formation that is deployed to discipline the subversive or rebellious behavior of women. In response, postpositivist realist and standpoint feminists posited that mental illness is a lived, embodied experience (Caminero-Santangelo, 1998; Donaldson, 2002), and that women's mental distress often results from distinctly gendered, classed, and racialized experiences of trauma and violence (Nicki, 2001). While both bodies of literature offer compelling arguments, neither of these feminist paradigms for theorizing mental illness is sufficient on its own.

Feminist disability studies provides a means to bridge this gap by framing disability as both a material experience and a discursive subject formation. Susan Wendell (1989) and Rosemarie Garland Thomson (2002) argue that feminist disability studies enables us to think intersectionally about disability as a gendered social formation as well as an embodied experience of physical or mental impairment. While these impairments are embodied and material, they cannot be separated out from the social construction of disability as embodied and/or behavioral deviance. Disability is not a static medical fact, but a subject formation produced by the interactions between bodies, their physical environments, the normative expectations of their cultural context, and the collective anxiety that attaches to bodies that defy those expectations. This fluidity and complexity in the social production of disability intersects with discourses of race, class, gender, age, and sexuality that produce and regulate subjects as normative or othered based on their social location.

Drawing on these frameworks, I define mental illness as both an impairment marked by lived experiences of mental and emotional distress, and a social formation constructed in opposition to the normative, rational subject around which the social body is centered. This approach to theorizing mental illness draws heavily on feminist disability theorists who have worked to articulate mental illness as both a marginalized, intersectional social formation and an embodied, material experience (Donaldson, 2002; Hewitt, 2006; Martin, 2007; Cvetkovich, 2012), as well as mad studies, a subfield of critical disability studies that articulates mental illness as both material and social/cultural (Lewis, 2010). By working within both feminist disability theory and mad studies, this project advocates for an intersectional, multidisciplinary feminist mad studies -- one that not only analyzes how mentally ill subjects are regulated through discourses of deviance and normativity, but also centers methodological questions of how these discourses differentially attach to specific gendered, sexualized, and racialized subjects.

My approach to articulating the differential production and regulation of mentally ill subjects is informed by theories of biopolitics, originally defined by Michel Foucault as a means of governing over biological life in the service of maintaining and managing a population. Biopolitical governance, he argues, is not just the project of the nation-state; it is managed via numerous social institutions to regulate individual subjects into becoming normatively productive and reproductive members of the population. These applied norms are internalized by individuals, who then regulate themselves into normative subjecthood and manage the behavior of others. While Foucault's explanation of biopolitics as a concept has been foundational to critical theory, it is also limited by a lack of attention to how subjects are differentially regulated in relationship to their social

location. Giorgio Agamben's (1998) theory of *homo sacer* fleshes out the process by which individual subjects are produced as either inside or outside a given population. Achille Mbembe (2003) takes this line of insider-outsider interrogation further, arguing that governance is comprised not just of the biopolitical regulation of the productivity and reproduction of a given population but also of necropolitics, the capacity to violently eliminate any abnormal or outside force that may pose a threat to it.

Drawing on this body of work, contemporary critical theorists have developed detailed case studies of the relationships between specific marginalized populations and nation-states. Regulatory forces such as criminalized racialization (Cacho, 2012), the criminalization of poverty (Wacquant, 2009), and the transnational neoliberalization of productive (Ong, 2006) and reproductive (Cooper and Waldby, 2008) labor overlap with one another and produce a political and economic system wherein marginalized subjects exist within the social body but do not *belong* to it. This exclusion is a feature, not a bug; the processes that exclude, denigrate, and exploit marginalized subjects position full inclusion as a normative subject as aspirational, and also establish the boundaries of belonging within a given social body. Yet the parameters of belonging and exclusion are not static. Marginalized subjects are gradually incorporated into the social body, though this does not occur in a teleological timeline, nor does it necessarily change the ideal of the normative subject or the social institutions that reproduce it. As Jasbir Puar's *Terrorist Assemblages* (2007) explains, marginalized subjects who are closest to normativity are the first to be incorporated into the social body, and their inclusion is used to shore up rather than rearticulate the boundaries of normative subjecthood.

The state is not the only site where subjects are produced and biopolitically regulated as either within or outside normative subjecthood; as Khiara Bridges explicates at length in *Reproducing Race* (2011), medicine and public health in the U.S. are apparatuses for the surveillance of the bodies of women, people of color, and the poor, which are constructed as always already unruly and in need of disciplining. However, is not just unruly bodies that are disciplined by medicalization, but unruly minds as well. According to Miller and Rose (2008), mental health care is a discrete site of medical authority that identifies troubling behaviors and emotions as a problem to be solved by those with scientific expertise. The identification of said problems and solutions is, of course, closely linked to expectations of normative behavior, including what Jemima Repo (2016) describes as "sex and class-coded practices of respectability, obedience to the law, [and] deference to medical and political authority" (68). In other words, medicine is not just a site for disciplining behaviors and emotions into normative standards of mental health, but for ensuring that those standards reinforce normative ideas about other social formations, including gender and race.

These applied biopolitical analyses help theorize the production and regulation of subjects as a process that takes shape on a fluid, unstable spectrum between biopolitical and necropolitical forms of governance. In doing so, they reveal that belonging is not a process of designating subjects as always already either insiders or outsiders via normative standards of productivity and reproduction that serve the demands of the social body. Rather, belonging is the process by which intersectional subjects are produced and regulated differentially against the ideal of the normative subject -- an ideal that does not

necessarily exclude all mentally ill subjects, nor does it include them all equally or in the same manner.

Cultural narratives of mental health in the U.S. not only negotiate the context of differential, biopolitical inclusion and exclusion of intersectional mentally ill subjects; they operate as a biopolitical technology in their own right by reproducing and/or reconfiguring existing discourses of normative and deviant subjecthood. In *Narrative Care,* Arne de Boever (2013) argues that narratives are themselves biopolitical technologies not just in their representations of biopolitical governance, but also in the ethical and affective responses that circulate among consumers. Through this process of production and consumption, narratives become a site for not only articulating the parameters of humanity but also the manner in which human life should be managed. David Mitchell and Sharon Snyder (2015) expand upon this, articulating narratives of disability as biopolitical technologies of inclusion and exclusion that situate disabled people in varying degrees of deviance from the normative citizen-subject. As in Puar's discussion of homonationalism (2007), these inclusions of disability exist in relationship to the nation-state's desire to present itself as progressive without destabilizing its exclusionary foundation. These theories offer a framework for understanding cultural discourse as not only a product of other social institutions, but also as a discrete biopolitical institution that can help reinforce and redefine the boundaries of a given population.

While the consumption of mental health narratives is thus a biopolitical act, this is not to suggest that the discursive regime of mental illness narratives is a monolithic construction, or that all viewers interpret, internalize, or reproduce these discourses

universally. Mental illness is not visible in the way that physical disabilities and some other marginal subject formations are, yet the surveillance of one's behavior in relationship to the normative expectations of one's subject position is key to making mentally ill subjects legible. The consumption of cultural texts and images of mental illness echoes these biopolitical processes of observation, identification, and regulation. Unpacking how cultural narratives of mental illness are produced and consumed can help us understand how we justify the differential regulation of mentally ill subjects in relationship to their social location and their cultural context -- as well as how deviations from repeated narratives reveal shifts in our biopolitical context.

To conceptualize how the production and regulation of mental illness takes shape both discursively and materially without universalizing mentally ill subjects, I draw upon what Gilles Deleuze and Felix Guattari (1980) define as assemblage: a complex, unstable constellation of multiple, interrelated social institutions and the individuals who interact with them and with one another. The social body is not comprised of a fixed hierarchy of top-down power systems, but rather an expansive, interwoven set of discursive and material formations in which subjects are placed in constantly fluctuating relationships to one another. Though some theorists -- most notably, Puar (2007) -- have argued that assemblage and intersectionality are somewhat interchangeable concepts, I use "intersecting" or "intersectional" to designate the way in which social formations that have been conceptualized as separate entities interact with one another in constant and complex way that shape the lived experiences of individual subjects. In other words, intersectionality conceptualizes the multilayered nature of subjectivities, and assemblage conceptualizes the shifting processes by which those subjectivities are produced,

maintained, and reshaped; mental health is an intersectional subject formation, and the production and regulation of it emerges through an assemblage of medical, legal, and social discourses and practices.

Project Outline

To articulate the complex assemblage of mental health discourse that produces mental illness as an intersectional social formation, the first section of this project explores gender and sexuality as discrete vectors for the discursive production and regulation of mental illness. Expanding on previous feminist theorizations of madness as a means of disciplining women into the expectations of traditional femininity and the heteronormative nuclear family, Chapter One analyzes media that explicitly represent mental illness in relationship to gender non-conformity and queer sexualities, including Amazon's *Transparent*, the CW's *Jane the Virgin*, and ABC's *How to Get Away with Murder*. These texts work within cultural discourses of contact and contagion which present queer and trans subjects as always already mentally ill and thus a threat to the social body; they also explore the way in which the social production of deviance creates individual and collective trauma. Chapter Two explores the discursive formation of normative heterosexual commitment as a cure for young women's mental illness in comedy series that reinforce these discourses (HBO's *Girls*) and explicitly deconstruct them (FX's *You're the Worst*, the CW's *Crazy Ex-Girlfriend*). This representational regime both reproduces and undermines the notion that women's participation in normative gendered behaviors of sexual belonging are indicators of mental health. Chapter Three explores the way in which audiences' complex, varied responses to docu-

soap reality television reveals how we internalize regulatory discourses of gender, sexuality, and mental illness. Viewers' reactions to mental health crises depicted on ABC's *The Bachelor* and *Bachelor in Paradise* and Bravo's *Real Housewives* franchise reveal the affective dimensions of the differential regulation of mentally ill subjects.

Building upon this foundational argument about gender and sexuality as sites where regulatory discourses of mental health emerge, the second section of this project unpacks how mental illness is produced as an intersectional social formation in media that explicitly depict acts of observation. Though visual narratives represent numerous acts of seeing in their depictions of mental illness, here I broadly conceptualize surveillance as the means by which in which mentally ill subjects are identified and regulated. Chapter Four analyzes surveillance in series that depict mentally ill women as both subjects and objects of nation-state, workplace, and media surveillance (CBS's *The Good Wife*, and ABC's *Scandal*, and HBO's *Enlightened*). Chapter Five focuses on representations of women engaged in observing and attempting to contain violent men, including BBC's *The Fall*, Showtime's *Homeland,* and BBC's *Top of the Lake*. Such narratives use women's surveillance labor to negotiate cultural discourses that present mentally ill masculine subjects as dangerous, irrational, and unknowable/unpredictable.

The concluding chapter moves away from the visual experience of media consumption and into the temporal experience of it. As previously mentioned, the expanded screen time of television series enables longer, more detailed, and more complicated depictions of mentally ill subjects. Changes to the parameters of storytelling and how audiences consume television have destabilized traditional episodic and series-long storytelling frameworks, which in turn has opened up new pathways for representing

mental illness. This chapter analyzes *Orange is the New Black*, *Lady Dynamite,* and *Unbreakable Kimmy Schmidt*, three Netflix series which represent mentally ill women as subjects who exist outside linear time. Though the idea of streaming television as a revolutionary medium is arguably a bit overstated, I argue that streaming series are uniquely able to play with conventions of linear, rational time in order to tell stories that decenter recovery as the typical endpoint of mental health narratives.

These media depictions of mental illness exist within a massive cultural assemblage of mental health, wherein multiple institutions work within and against one another to produce and regulate mentally ill subjects. This regulation takes shape through the regulation of mentally ill subjects in relationship to shifting normative ideals of subjecthood that intersect with gender, sexuality, and race. Some subjects' experiences with mental distress are perceived as threats that must be separated out from the social body; others' are seen as temporary deviations from subjecthood that should be resolved as individual problems; some experiences are not recognized as mental distress at all. The texts included in this project (and the analyses that make sense of them in relationship to one another) are thus not a full picture of the cultural assemblage of mental health, but rather examples of the complexity, expansiveness, and slipperiness of the production and regulation of intersectional mentally ill subjects in the United States today.

CHAPTER ONE:

"You Gonna Pull Out the DSM and Diagnose Me?": Locating Mental Illness and Biopolitical Regulation in the Narrative Production of Queer and Trans Subjects

In medical, legal, and cultural discourses in the United States, gendered and/or sexual deviance and mental illness are often treated as mutually constituting entities, creating a discursive regime that justifies the treatment of queer and trans subjects as a threat to the social body that must be contained and/or removed, lest they disrupt the normalizing order of gender and sexuality. These practices feed back into the discourses that undergird them by reinforcing their validity, as well as by isolating and traumatizing those subjects who are produced by these discourses, thus enabling lived experiences of mental illness that are connected to marginality. As such, it is impossible to separate out the practices of biopolitical regulation by which deviant subjects are labeled and treated as "crazy" from the very real mental health impact of living as a marginalized subject within a traumatic context of biopolitical regulation and exclusion. Furthermore, these practices intersect and overlap with those that regulate other marginalized subjects by virtue of their classed and racialized subject positions. I do not mean to suggest here that marginalized subjects only experience mental illness as a discursive production. Rather, I want to unpack how our cultural assumptions about the relationships between marginality and mental illness are often not about marginalized subjects at all, but about our desire to shore up norms of gender, sexuality, and mental health that are in flux -- as well as our desire to shore up our belief in cultural progress and inclusion -- by examining narratives about the mental health experiences of queer and trans subjects that try to break this discursive mold.

Within this complicated context, such texts walk a delicate line: they seek to represent the trauma of life within a heteronormative, gender binary assemblage of mental health discourse and practice, but try to avoid reifying the norms that underpin this assemblage. In negotiating this tension, narratives of queer and trans mental illness often locate subjects' distress as a consequence of structural and institutional violence. This reframing of deviance as an interaction between a subject and their traumatic context echoes Rosemarie Garland-Thomson's theorization of physical disability as "misfitting" (2011), or:

> … an incongruent relationship between two things: a square peg in a round hole. The problem with a misfit, then, inheres not in either of the two things but rather in their juxtaposition, the awkward attempt to fit them together… The discrepancy between body and world, between that which is expected and that which is, produces fits and misfits. The utility of the concept of misfit is that it definitively lodges injustice and discrimination in the materiality of the world more than in social attitudes or representational practices, even while it recognizes their mutually constituting entanglement. (592-93)

Though Garland-Thomson is theorizing physical disability here, I argue that this framework is just as relevant for explaining how mental illness and marginality come to be mutually constituted: the problem to be solved is not the mentally ill subject, but the limiting context that labels particular non-compliant body-minds as deviant and/or mentally ill.

The television narratives analyzed within this chapter all grapple with how to reveal the production of mentally ill subjects in relationship to gender, race, and sexuality without reifying discourses that position women, transgender people, queer people, and/or people of color as inherently mentally ill due to their exclusion from normative subjecthood. At first glance, these texts may seem to share nothing but a cultural context:

ABC's *How to Get Away with Murder* (2014-present) is a network legal drama; the CW's *Jane the Virgin* (2014-present) is a surreal but sweet network dramedy; Amazon's *Transparent* (2014-present) is a dark family comedy that takes full advantage of streaming television's lack of representational boundaries. Yet the three series all reappropriate traditional soap opera storytelling conventions, and they all explore the relationship between gender, sexuality, and mental health at extensive length. Additionally, all three series offer substantially more inclusive representations than most popular culture in the U.S., and explicitly depict how particular subjects' lives are shaped by social structures of power and marginality. *HTGAWM* is part of Shonda Rhimes's network television empire, which prioritizes hiring performers, writers, and directors of color; *Transparent*[9] and *Jane the Virgin* offer detailed depictions of what it means to be Jewish and Latinx in the United States, respectively. These are not figures who "just happen to" represent a marginalized social formation; they have been carefully constructed to reflect the lived experiences that attach to various, often underrepresented subject positions.

As such, it makes sense that these series' depictions of mental health often echoes Garland-Thomson's theoretical framework, presenting mentally ill queer and trans subjects not as inherently mad, but as traumatized by cultural, medical, and legal

[9] During its first season, *Transparent* was justifiably critiqued for its lack of inclusive representation -- most notably, in the casting of cisgender actor Jeffrey Tambor as Maura and in the relative economic/social privilege of its central characters (Brodesser-Akner, 2014; Paskin, 2014). Tambor's presence on the series was called into question again when he was accused of sexual harassment in the winter of 2017; as of the time of writing, the future of the series/his participation in it was still unclear. However, from season two onward, the show expanded to represent a more inclusive range of trans characters, all played by trans performers, and presented its central characters' privileges with a much more cynical, critical gaze.

practices which degrade their bodies, minds, and lives. These traumatic contexts explicitly echo real-world events with which viewers will be familiar, and they attend carefully to the classed, gendered, and racialized social locations of the subjects they represent. At the same time, however, they occasionally reproduce cultural discourses that present mental illness as an individual threat to the social body that must be isolated and/or eradicated in presenting queer subjects' mental illness as a destabilizing (if not destructive) force. For example, mentally ill queer women of color on *How to Get Away with Murder* and *Jane the Virgin* threaten the nuclear family and other normalizing systems of order. In contrast, *Transparent* unveils an intergenerational narrative of misfit trauma that locates mental illness as a consequence not of its characters' genders, sexualities, or Jewish heritage, but of the social death (Cacho, 2012) forced upon them as a result of these intersecting subject formations across multiple historical/cultural contexts. This narrative offers a collective, relational understanding of mental illness that positions traumatic experiences and mental health impairments as collective yet not threatening to the community.

The Production and Regulation of Mental Illness as a Threat to Gender/Sexuality Norms

As Priscilla Wald (2007) explores at length, cultural narratives of contagion and immunity often reveal cultural anxieties about the porousness of the social body in shifting geopolitical and economic circumstances. Wald's argument hinges on the notion that our desire to contain and isolate particular bodies is not so much about those bodies, but about our desire to shore up the boundaries of the larger social body that we seek to protect from these "dangerous," deviant, contagious bodies; as such, it makes sense that

we obsess over stories of medical contagion at times when we see the social body in cultural flux. I would argue that our cultural narratives of mental illness are, at their core, narratives of contagion and containment. As in narratives of contagious disease, our broader cultural anxieties about other social formations -- including gender, sexuality, and race -- are intimately interwoven into our narratives of mental health. Our cultural fear of mentally ill subjects is not so much that their impairments will spread from mind to mind[10], but that they will behave in deviant ways that will cause mentally healthy subjects (as well as cultural norms of rational, productive behavior) to suffer. This assumption of mentally ill subjects as a danger to themselves and others has justified a wide range of practices intended to isolate them from the social body unless they can be brought back into the fold of normative subjecthood -- including institutionalization (Foucault, 2001; Lewis, 2006), incarceration (Torrey, 2010; Rembis, 2014), and coercive medicalization (Burstow, 2015; Davis, 2010). While some subjects who are regulated into these practices are enfolded back into the social body, others are expelled from it entirely. In so, the regulation of mental illness in the U.S. is very much a form of social death, which Lisa Marie Cacho describes as a process by which social and legal -- and, I would add, medical -- practices devalue marginalized subjects until they can no longer fit within the boundaries of full personhood.

Yet while some marginalized subjects become permanent misfits, others are deemed assimilable and thus differentially included in order to give credence to the

[10] There are a few exceptions, such as the concepts of suicide contagion (Gould et. al., 2003), intergenerational trauma (Danieli, 1998), and collective panic (Orr, 2006). However, these are not widely circulated and accepted, and one can buy into these concepts while still largely accepting a paradigm that treats mental illness as an individual problem.

notion that full subjecthood remains attainable if an individual subject works hard enough to be assimilated. These discrepancies and intersections reveal that self-other/insider-outsider are not static categories in which one group of individuals is always already within the social body and another is always already positioned outside its boundaries. Rather, the production of insiders and outsiders -- like the production of subjectivities in general -- emerges via a complex assemblage that not only shifts the boundaries of the social body but how individual subjects are positioned both within and outside that shifting boundary. Not all outsiders/insiders are similarly or equally excluded from/included in the social body, and a subject's relationship to a given community shifts across time and space. We cannot conceptualize the production and regulation of mental illness as a simple process by which subjects are either designated as mentally ill or healthy; we need to move toward more intersectional and complex understandings of how people are produced and regulated as mentally ill or mentally healthy subjects in various contexts in relationship to their social location as it relates to normative subjecthood within the social body.

The work of feminist theorists has made some inroads in interrogating the cultural and historical feminization of mental illness, as discussed in the previous introductory chapter. Yet these conversations often fail to articulate how race and sexuality are salient factors in the feminization of mental health, as well as the way in which subjects who do not adhere to binary, essentialized conceptions of gender are produced and regulated through the prism of mental health. While it is clear that mental illness is discursively feminized, we have failed to articulate the fact that not all women are produced as mentally ill subjects, nor are all mentally ill women produced and regulated in the same

way. Our articulation of the relationship between gender and mental illness is thus in desperate need of an intersectional lens. This will help us pivot away from the narrow question of whether women are either discursively or materially produced as mentally ill subjects, toward a more complicated interrogation of the ways in which discourses and practices of gender and sexuality function as animating forces in the cultural assemblage that produces and regulates mental illness as an intersectional social formation. Whether they comply with or resist them, cultural narratives can help us understand how discourses of mental health, gender, and sexuality underpin an assemblage of regulatory practices that produce queer and trans subjects -- especially those of color -- as misfits. This production of misfit subjects has justified social practices that regulate those subjects who deviate from norms of gender and sexuality -- often in the name of inoculating the social body from their destabilizing influence.

Such practices include the medicalization of queer and trans subjects, which as proven a central site for the assimilation and/or exclusion of those who do not fully fit within the heteronormative, gender binary social body. Though this medicalization sometimes centers the physical body, as in researchers' attempts to identify a "gay gene" (Ordover, 2003), it typically positions the mind as the site where queer and trans subjectivities are produced (Jordan-Young, 2010) and depends upon mental illness as a conceptual framework for articulating these subjectivities as abnormal/deviant. One obvious way in which this has taken shape is in the explicit framing of queer and trans subjectivities as discrete mental illnesses within the Diagnostic and Statistical Manual of Mental Disorders. Until 1973, "homosexuality" was listed in the DSM, and contentious debate led up to and followed its removal (Bayer, 1981); transgender was included in the

DSM as "gender identity disorder" up until 2012 and has since been re-articulated under the label of "gender dysphoria". This system of classification has justified psychiatric medicine as a means of regulating queer and trans subjects. Mental health professional organizations are now actively working to eradicate conversion therapy (SAMHSA, 2015), but it persists as a practice intended to "cure" queer and trans subjects. Furthermore, the formal psychiatric category of gender dysphoria structures the lived experiences of trans experiences. As Dean Spade (2003) notes, legal confirmation practices often require a diagnosis of dysphoria as a gatekeeping mechanism. This psychological management of trans subjects is not new, as Jemima Repo's (2016) analysis of the use of talk therapy as a "treatment" for trans subjects in the U.S. in the 1960s reveals. Via medicine, the bodies and minds of gender and sexuality misfits are either made to fit or expelled in order to encourage other marginalized subjects to internalize the biopolitical regulations that would allow them to fit.

Of course, medicine is not the only site in which queer and trans subjects have been excluded from and/or coercively assimilated into the social body. Heteronormativity and the binary conception of gender upon which it depends undergirds almost every social institution and practice, including the law, education, and the family. Cultural texts are not excluded from this assemblage of production and regulation; narratives about marginalized subjects in general and disabled subjects in particular often recenter the normative citizen-subject and the normalized order of the social body (Garland-Thomson, 1997; Davis, 1998; Mitchell and Snyder, 2000; Wilson and Beresford, 2002). In doing so, they validate the biopolitical practices that enforce and regulate marginality (deBoever, 2013), though they can also enable "mediated kinship" (Rapp and Ginsberg, 2001)

wherein cultural representations make consumers familiar with marginalized subjects they rarely encounter in the real world. The texts included in this chapter often strive for this mediated kinship by explicitly depicting the processes by which their subjects become misfits, but they sometimes fail to articulate mental illness as a collective social formation within the distinctions they draw between the individual and the contextual.

Queer Women of Color and Contagious Deviance/Mental Illness in Jane the Virgin *and* How to Get Away with Murder

How to Get Away with Murder and *Jane the Virgin* swing between empathetically depicting the trauma faced by queer and trans subjects and representing queer women of color as destructive figures whose instability is contagious. The erratic behaviors of *HTGAWM*'s antiheroine protagonist Annalise Keating and *Jane the Virgin*'s supporting character Luisa Alver produce narrative tension by driving other (usually straight, often white) characters into unpredictable, stressful, and even traumatic circumstances. Significantly, these difficult circumstances often hinge on some kind of disruption of the heteronormative nuclear family, and they present trauma and mental illness as contagious forces, even as these shows otherwise shed an empathetic light on the traumatic circumstances that destabilized these queer women of color in the first place. In positioning these subjects as Patient Zero in the spread of instability, these narratives reveal cultural fears that queer women of color threaten the heteronormative nuclear family by not only defying gendered, sexualized, and racialized expectations of normative, reproductive femininity but encouraging others to leave behind these expectations as well.

Part of ABC's Thursday night block of Shonda Rhimes-produced programming since 2014, *How to Get Away with Murder* seems at first like the standard hourlong Rhimes drama about diverse colleagues navigating professional stresses, interpersonal conflicts, and romantic relationships, anchored by a complex woman trying to balance the professional and personal. The series stars Viola Davis as Annalise Keating, a bisexual black defense attorney and criminal law professor. Annalise struggles to manage her philandering white husband Sam (Tom Verica), her black police detective boyfriend Nate (Billy Brown), her past love Eve (Famke Janssen), two assistants with mysterious personal histories (Liza Weil and Charlie Weber), five brand-new interns (Alfred Enoch, Jack Falahee, Aja Naomi King, Matt McGorry, and Karla Souza), and a revolving door of eccentric and/or troubled clients. Yet where other Rhimes programming balances single-episode professional procedural storylines with longer romantic and/or familial dramatic arcs, *HTGAWM*'s season-long arcs are about exactly what the title implies: murder, and how to get away with it. Each of the show's seasons revolves around Annalise and her employees participating in -- and attempting to extricate themselves from -- a series of increasingly dramatic and deadly crimes.

Another substantial divergence from the Shonda Rhimes formula is that the show is an ensemble program in name only. Annalise is very much the protagonist here, and her complex history and questionable morality place the show within a longstanding lineage of antihero narratives[11] such as *Breaking Bad* and *The Sopranos*, which trace the

[11] In television criticism, any protagonist who is a mentally ill woman will be described as an "antiheroine" by someone at some point, no matter how benign her behavior may be. However, *HTGAWM*'s production of an antihero narrative is distinct from this unchecked notion that a woman who is not typically likable must be a villain; the show self-consciously and often satirically re-appropriates and modifies the antihero genre that

downfall and destruction of villainous protagonists (Brown, 2015; Hope, 2014; Rosen, 2014; and Wallace, 2014). Like *The Sopranos*'s deep dive into its protagonist's psyche, mental illness is central to *HTGAWM*'s development of Annalise's character and the narrative structure of the series. Early episodes depict Annalise as a cold, manipulative person more concerned about professional achievement than relationships, ethics, or human life. As she describes herself, "I'm a bad person. Heartless. A sociopath. Is that about right?" This pathological behavior is intimately linked to her success in her profession: Annalise understands the law as a psychological battleground, and she teaches her students and interns how to manipulate judges, juries, opposing counsel, clients, and witnesses the way that she does, so that they can be as successful as she is. Even outside the psychological gameplay of the courtroom, Annalise engages in immoral strategies to win cases, teaches her interns and employees to do the same, and does not feel any guilt about anything that results in a legal victory. Other characters alternately fear, admire, and are disgusted by what she will do to succeed, but this does not diminish her achievements; her lack of conscience makes her a perfect fit for her law career even while she remains a misfit everywhere else.

While this professional amorality makes Annalise read, at times, like empowerment feminism taken to its most sociopathic point, the show gradually reveals that Annalise's personality has been hardened through a series of gendered traumas[12]. In the show's first two seasons, we learn that Annalise was sexually abused as a child, that

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typically features hyper-masculine, white, wealthy protagonists (Brown, 2015; Wallace, 2014).

[12] A significant departure from those hypermasculine antiheroes whose suffering is almost always self-inflicted.

she has severed ties with their family of origin as a result, that her husband is cheating on her, and that their marriage went cold after a stillbirth years prior. Exploring these traumas leads the show into empathetic, cathartic episodes that reveal the humanity and hurt beneath Annalise's cold exterior, including two standout episodes featuring Annalise reconnecting with her mother Ophelia[13] (Cicely Tyson). Yet outside these moments, the series relies on her lack of concern for others and her aggressive ambition to push the limits of every storyline, leaving the audience curious to see if there is anything Annalise will not do or anyone she will not betray in order to get ahead.

Furthermore, even when the show dives empathetically into Annalise's traumatic misfitting, it often continues to shore up the heteronormative nuclear family as an inherently positive and rewarding social institution, and thus inadvertently validates Annalise's failure to fit within it as a queer woman of color. For example, the show's depiction of Annalise's childhood trauma initially seems to critique the social privileging of the heteronormative family. Her family's knows she is being abused but does nothing, because the preservation of a normative family unit takes precedence over her individual health and safety. However, the continued consequence of that trauma is not that Annalise's biological family unit falls apart but that she, as an individual subject, must be expelled from it. It is not just this one particular family in which Annalise is a misfit; she later becomes incapable of belonging to any family structure, including nuclear family she tries to create with Sam and their late child. It is this second loss of a nuclear family structure that catalyzes Annalise's criminality, isolation, and instability; in this, the show suggests that the problem is that Annalise is a subject to be too mentally ill and

[13] A significant departure from those hypermasculine antiheroes whose mothers are either monstrous or nonexistent.

subsequently too deviant to belong to a nuclear family. This unwrites the show's earlier critique of the damage that excessive compliance with the heteronormative nuclear family can cause.

While the show explicitly positions Annalise's failure to become a mother as both cause and consequence of her sociopathy, her exclusion from normative maternity also continues a genealogy that pathologizes black women as incapable of heteronormative reproduction (Bridges, 2011; Roberts, 2014). The positioning of Annalise as a queer woman of color who is not just socially dead within the nuclear family but an active threat to it is further reinforced in the show's toxic depiction of Annalise's assistants and her interns as a pseudo-family. Within this community, Annalise is a monstrous perversion of a matriarch, a woman who can reproduce nothing but trauma and distress. When Annalise teaches her interns and employees how to emulate her amorality, they become traumatized and mentally unstable in direct proportion to their similarity and proximity to her.

In season one, after four of the five interns kill Sam in self-defense, the two interns who Annalise sees as her most promising proteges spiral into mental health crises. Connor (Jack Falahee), the only queer intern and the quickest to adopt Annalise's code of non-ethics, becomes increasingly manic and paranoid after the murder. His breakdown, however, is resolved quickly compared to that of Michaela (Aja Naomi King), a high-achieving young black woman raised in rural poverty. Like Annalise's instability, Michaela's breakdown is intimately linked to her fluctuating relationship to normative subjecthood. On the night of the murder, she loses her engagement ring, and her paranoia about its potential to connect her to the crime leads her to erratic behavior that culminates

in the disintegration of the engagement itself. Both Connor and Michaela explicitly blame Annalise for turning them into emotionally distressed misfits, and the series does not challenge the notion that Annalise's influence is so toxic and contagious that it can profoundly damage their mental health.

The mental distress of the two interns most demographically and morally similar to Annalise pales in comparison to the trauma faced by their fellow intern Wes (Alfred Enoch), a biracial young man who becomes a sort of surrogate son to Annalise. Their relationship predates his law school career[14], and the two are protective of each other, drawn to each other out in times of need, and willing to do horrifying things on one another's behalf. In season two, Wes tries to track down Annalise's client/his love interest Rebecca (Katie Findlay), as well as exact details of the circumstances surrounding his mother's suicide. These efforts are so distressing that he cannot sleep. He decides to visit campus health for a prescription for sleeping pills, where he is placed under an involuntary psychiatric hold due to his family history and his insistence that he will kill himself if he does not get a full night's sleep. While Wes's distress is linked to the loss of his biological mother, the show is careful to note that it is not catalyzed by biology but by Annalise's behavior. She has all the information he needs, but she withholds it because she fears he will become disloyal to her once he learns the truth. This storyline once again locates Annalise's deviance as the direct cause of another

[14] As season two reveals, when Annalise was pregnant, she was working on a case in which Wes's mother, an undocumented immigrant, was a fundamental witness but unwilling to take the stand in trial due to threats from her employer. Wes's mother committed suicide minutes before Annalise came to their apartment to make one final attempt to convince her to testify, and days before Annalise gave birth to her stillborn son.

character's mental distress, and it does so through the language and intimate structures of the idealized nuclear family.

Like Wes, Annalise's mental illness comes into contact with regulatory social institutions; unlike Wes, whose institutionalization is depicted as unjust, the series presents Annalise's social death via these institutions as a broader social good. Annalise is contained through both her choices to self-isolated and her detainment by the state; while her chosen isolation sometimes benefits her own well-being, all her various containments are presented as positive for her assistants and interns, because they are away from her damaging influence. When Annalise is away, Conor and Michaela return to emotional stasis; her assistant Bonnie and intern Laurel ascend to new heights of professional achievement; and Wes and Laurel find authentic intimacy with one another. But when she returns, the office returns to its usual state of manipulation, violence, and criminality. Even Annalise herself explicitly acknowledges that she is a destructive influence on her community, at one point encouraging her interns to turn her into the police by saying, "Lock me up. Then you can all finally be safe."

In repeatedly depicting Annalise as a mentally ill threat to the social body that must be contained, *How to Get Away With Murder* ultimately validates stigmatizing cultural, medical, and legal discourses of mentally ill subjects as dangerous, unstable, and pathological misfits. These discourses disproportionately attach to those subjects who are always already outside normative, rational subjecthood -- women, queer people, and people of color, of which Annalise is all three. At times, the show offers a productive look at the specific experiences of trauma that people who live within these outsider subject positions face, as in its exploration of Annalise's past trauma. Furthermore,

during incidents such as Wes's institutionalization and cases involving mentally ill clients, the show offers a searing critique of the way in which the law and medicine automatically treat people of color, queer people, and women as though they are mentally ill, even if they do not have mental health impairments.

However, this productive discussion of mental illness is often undone by the show's consistent characterization of Annalise as a danger to those around her, a mentally ill subject whose behavior makes trauma and instability contagious to those around her. The series validates the notion that certain mentally ill subjects -- in this case, a queer black woman -- are more "dangerous" than others, and that the threat they pose to the social body justifies their biopolitical regulation. While the criminal justice system is often the site of this regulation, the heteronormative nuclear family is the justification for it. Annalise is not just a threat to those around her, but to any family unit she comes across due to her multiple inabilities to fit within the norms of womanhood within the heteronormative family.

Though *Jane the Virgin*[15] is more upbeat and funny than *How to Get Away with Murder*, it also explores non-normative family structures and engages explicitly with mental illness. An hourlong CW dramedy based on a popular Venezuelan series, the show begins with the accidental artificial insemination of Jane Villanueva (Gina Rodriguez), an ambitious and responsible young Latina woman. Jane navigates pregnancy and motherhood with the help of her mother Xiomara (Andrea Novedo), her

[15] The title suggests otherwise, but the show critiques purity politics and the regulation of women's sexualities -- in fact, it is one of the most effective and nonjudgmental depictions of how women navigate these regulatory forces (see Zarum, 2016). As some critics have pointed out, this is particularly meaningful in a media landscape in which Latina women are stereotyped as hypersexual (Molina-Guzman, 2010; Mendible, 2007).

grandmother Alma (Ivonne Coll), her fiance Michael (Brett Dier), and the biological father of her child, Rafael (Justin Baldoni). The series borrows the storytelling conventions of the telenovela, including love triangles, conspiracies, supporting characters who are not who they claim to be, cliffhanger endings, and dramatic narration. Though these tropes can be a bit surreal, the show's tone is genuine, and it is often heartfelt in resisting cultural discourses that demonize non-normative families and mentally ill subjects[16].

However, not all characters' mental health is afforded equal empathy throughout the series. The show presents Rafael's half-sister Luisa (Yara Martinez), the OB-GYN who accidentally inseminates Jane, as unstable and destructive -- and therefore mentally ill. Though she is a recovering alcoholic, Luisa is never described as having any specific mental health impairment, though she has a family history of mental illness via her mother, who committed suicide. The rest of Luisa's family -- Rafael; their father, Emilio (Carlo Rota); their young stepmother/Luisa's lover, Rose (Bridget Regan); and Rafael's estranged wife Petra (Yael Grobglas) -- treats her with constant suspicion and uses her mother to justify this. Yet their perceptions of her as "crazy" seem less grounded in family history than how much she frustrates them as a result of her inability to fit within their normative expectations for her. As Rafael clarifies in one of several family debates about Luisa's mental health, she "doesn't actually seem crazy… idiotic, yes, but not clinically crazy." Yet outside of these occasional concessions from other characters, the

[16] In particular, many cultural critics praised the show's representation of Jane's nemesis and Rafael's estranged wife Petra (Yael Grobglas) experiencing postpartum depression as a realistic and empathetic take on a common impairment that is rarely reflected in popular media (Andrews, 2016; Hill, 2016; Zarum, 2016).

show's depiction of Luisa as an erratic and chaotic misfit figure typically justifies her family's suspicions that she is inherently mentally unstable.

The show often links this instability to Luisa's queer sexuality. Her storylines are invariably centered around her falling into and out of love with other women in a chaotic cycle that creates havoc for herself and those around her. These storylines are not only a rare default to repetitive storytelling in an otherwise inventive narrative -- *New York Magazine* television critic Kathryn VanArendonk (2016) has taken to calling the character "Mostly Useless Luisa" -- but they also link Luisa's unstable behavior to her desire for women. Luisa's accidental insemination of Jane only occurs because Luisa is so upset about finding her wife cheating on her that she cannot focus on her work and mistakes Jane's chart for that of a different patient. This breakup inspires Luisa to reignite her on-again, off-again affair with her stepmother, Rose -- a relationship that creates chaos not only for the very obvious reason that Rose is married to Luisa's father, but also because Rose is secretly running an international crime syndicate. It is not clear whether Rose's desire for Luisa is authentic or just a strategy to keep Luisa from piecing together her true identity, but Luisa's desire for Rose is so intensely real that it makes her an irrational accomplice to Rose's sociopathic behavior. Their relationship sparks a ripple effect that risks the Solanos' family business prospects, puts Michael's life in danger, and results in the murder of Emilio. Luisa is not intentionally complicit in this acts, but she is overwhelmed by her desire for Rose, and becomes increasingly erratic and irrational as a result of her inability to see Rose's underlying motives. This framing implies an inherent connection between Luisa's sexuality, her emotional instability, and the chaos it sparks. In doing so, the show relies upon discourses of women in general and queer women in

particular as prone to jumping into romantic commitments too quickly; this reinforces the notion that queer women, by virtue of both their sexuality and their gender, are too emotional to adhere to normative expectations for rational behavior in relationships (Gordon, 2006).

Luisa's destruction is not only a direct consequence of her desire for women, but it also disrupts the heteronormative relationships featured in the series. Jane's insemination causes Rafael and Petra's marriage to crumble, and it also creates instability in Jane's engagement to Michael. In a season two, Jane's newborn baby Mateo is briefly kidnapped, and Luisa's residual feelings for Rose (whom she now knows is a criminal mastermind and her father's murderer) are the most profound roadblock to locating Mateo. The only family unit immune to Luisa's chaos is the matriarchal community of Jane, Xiomara, and Alma -- the only family in the show that is built on a foundation of honesty, mutual support, and self-sacrifice. The show's centering of a multigenerational family unit reflects its commitment to accurately representing its characters' experiences as Latinx subjects[17]. Additionally, *Jane the Virgin*'s positive depiction of a multigenerational family of women expands cultural discourses of the ideal family beyond a heterosexual married couple and their biological children. This family unit is the heart of the series, per creator Jennie Snyder Urman: "I wanted it to be a multigenerational story between a daughter, her mother, and her grandmother, because those are the relationships I love" (Andrews, 2016). This centering of the Villanuevas gestures toward a critique of the centering of the heteronormative nuclear family.

[17] According to Pew Research Group, 25% of Latinx families in the United States live in multigenerational homes, compared to 15% of white families and 18% of the general population (Cohn and Passel, 2016), yet multigenerational households are rarely represented in media.

However, the show never develops this further, and any latent political stance is undermined by the fact that the series's only substantive queer characters are a mentally unstable woman and the sociopathic leader of an organized crime ring -- two figures who are inherently dangerous to the health and safety of those around them.

Like Annalise, Luisa is isolated from the rest of her community at several points in *Jane the Virgin;* unlike *How to Get Away with Murder,* the show does not present her containment positively. Instead, Luisa's absences -- which include voluntary departures from her everyday life (such as an ayahuasca retreat) and involuntary isolation (including a stint in a psychiatric hospital and a kidnapping -- simply amplify the chaos her presence creates. Like her disruptive presence, the show links Luisa's absences to her love life: she leaves for a retreat after a bad breakup; Rose has her institutionalized; and her kidnappers were hired by Rose. As such, the series does not so much suggest that Luisa should *not* be forced into these exclusionary and regulatory spaces but that her chaotic and destructive habits are so intense that her presence or absence is not required for other characters to feel the ripple effects of her instability.

Jane the Virgin and *How to Get Away with Murder* ultimately struggle to depict the relationship between queerness and mental health without reifying hegemonic discourses that produce queer, mentally ill subjects as a threat to the heteronormative nuclear family. Both shows depict queer women of color as mentally unstable subjects, and depict their instability as a contagious force that they spread through deviant behavior. Even when these narratives present empathetic depictions of the traumas marginalized people often face, the causes and the consequences of said trauma recenter the heteronormative nuclear family as the most vital unit of social belonging. These

representations thus fail to coherently negotiate the biopolitical regulation of sexuality, race, and mental illness that queer women of color fae. Instead, they produce these women as not just non-normative but as deviant threats who are always already far outside the boundaries of normative, rational subjecthood. In doing so, they produce a contagion narrative in which queer women of color threaten a social body that centers heteronormative nuclear families and the mentally healthy men and women who are seen as fit to reproduce them.

Reading Transparent *as a Queer Narrative of Collective Mental Illness*

One of Amazon's first streaming series, half-hour dark comedy/family drama *Transparent* loosely fictionalizes creator Jill Soloway's experiences with their own father coming out as a trans woman late in life. Using the story of Maura[18]'s (Jeffrey Tambor) coming out as a point of entry, the show tells an expansive story about the Pfeffermans, an economically secure but emotionally unstable Jewish family that includes Maura, her high-strung ex-wife Shelly (Judith Light), and their three children: Sarah (Amy Landecker), an overwhelmed and dissatisfied wife and mother; Josh (Jay Duplass), a womanizer who is obsessed with his public image; and Ali (Gaby Hoffman), an aimless twentysomething who adopts the interests and personalities of those around her. The show's first season explores the ripple effects of Maura's coming out among her three children. While Sarah runs into an ex-lover Tammy (Melora Hardin) and embraces her own queer sexuality wholeheartedly, Josh grows desperate to form a normative nuclear

[18] Following the show's lead, I use "Maura" to refer to present-day Maura/the character in a general, not-time-bound sense, and "Mort" to refer to the male-presenting character depicted in scenes prior to Maura's coming out.

family of his own -- and loses his job and his sense of self in the process. Ali meanders toward steady adulthood; as the child most similar to Maura, she feels both inspired by and wary of her "moppa" decisively claiming a misfit identity. In this, Maura's trans subjectivity seems to function as a contagious, disruptive force.

However, this is gradually deconstructed throughout the first season as flashbacks and conflicts in narrative perspective reveal that that the Pfeffermans have existed in a constant state of instability. This narrative concept is developed further in the show's second and third seasons, which explore the stories of multiple generations of Pfeffermans. This multigenerational narrative reveals formative experiences from Mort's childhood and young adulthood that contextualize Maura's experiences as a trans woman in the present day. It also depicts the family's experiences before and shortly after fleeing Nazi Germany, and this narrative thread reveals that Maura is not the first trans Pfefferman. In a devastating series of flashbacks, we learn that Maura's mother Rose (Emily Robinson) had a trans sister Gittel (Hari Nef), who lived in an queer community led by researcher Magnus Hirschfield[19] (Bradley Whitford) that was attacked by Nazis. Gittel would not have been present for the attack, but her mother Yetta (Michaela Watkins) could not secure a travel visa with her correct name and gender, and she refused to perform maleness in order to emigrate to the United States with the rest of her family.

[19] The show's portrayal of Hirschfield is based in real historical events and largely accurate. Hirschfield's research on sexuality and gender was politically progressive, perhaps because he was queer himself and saw his subjects as part of his community rather than case studies. His inclusion as a parental figure in a spiritual lineage that leads to Maura and Ali constructs an intellectual historical counter-narrative to the trans-exclusionary sentiments that pop up in traditional feminist/"women's" spaces throughout the show.

This multi-generational ensemble narrative relies upon a non-linear approach to narrative time which suggests that history -- both familial and cultural -- is constantly repeating. Significant family belongings are lost, recovered, and passed from character to character, including Josh, Ali, and Sarah's childhood home (and, in season three, their pet turtle) and a pearl ring that Gittel gave to Rose before she fled Germany. These objects seem insignificant as they are first introduced and gradually accrue more and more narrative significance as they are passed around by the show's present-day characters and traced back through flashbacks. The show also uses actors in multiple timelines: Gaby Hoffman plays young adult Ali as well as young adult Rose; Emily Robinson is both teen Ali and teen Rose; Bradley Whitford is both Hirschfield and Mark, Mort's cross-dressing friend from the 1970s; Michaela Watkins plays both Mort's grandmother and a woman Maura has a brief affair with at a cross-dressing camp. Along with these moments of visual repetition, the show also obsessively documents Jewish religious and cultural rituals to show how the family's participation in these practices repeats but shifts. These rituals often reveal details that track with the fitting and misfitting of each family member within the Pfefferman unit at that specific point in time -- and they also remind the viewer that the Pfeffermans' Jewish culture and spirituality has made and continues to make them misfits in their broader spatial and cultural context.

This repeating and interwoven intergenerational narrative often provides a broader context for the present-day Pfeffermans' relationships and behaviors, and in doing so, it sets the stage for characters' experiences with trauma and mental health. All five Pfeffermans struggle with mental illness throughout the series, and their experiences emerge from their distinct misfit positionalities in their familial, social, and cultural

contexts. Maura speaks of having "a depressive gene"; her depression manifests intermittently, peaking when her journey to medically confirm her gender reaches a dead end and her first romantic relationship post-coming out ends. This "depressive gene" is also implied as the root cause of Ali's inconsistent sense of self. Ali dissociates when she is under emotional stress -- an experience that the viewer witnesses through her perspective in the season one episodes "Symbolic Exemplar" and "Best New Girl," and later hears her partner Leslie (Cherry Jones) identify as a problem in their relationship. Though the audience knows Leslie's assessment is accurate and Ali has previously discussed these disruptions with her best friend and former partner Syd (Carrie Brownstein), Ali responds defensively: "You gonna pull out the DSM and diagnose me?" Yet she is not the only Pfefferman who is prone to dissociation. Sarah, who describes her typical state as "anxious exhaustion" and turns to medical marijuana to manage her anxiety, also dissociates during her wedding to Tammy in season two's premiere episode. While dissociation is profoundly individual and interior, the show manages to draw a collective connection between these separate incidents by positioning dissociation as an interior protection against exterior circumstances -- in this case, romantic/sexual relationships in which a subject cannot fully fit.

This emphasis on misfitting is reinforced in the show's production of Josh and Shelly as mentally ill straight subjects who do not quite cohere with heteronormativity. Both are quiet about their mental health impairments within their family, but the show carefully represents the struggles they keep private, and how this privacy emerges from their desire to appear as subjects who fit within their contexts perfectly. As a teenager, Josh was sexually abused by his babysitter Rita, and though he insists that this was "rad"

rather than "lecherous," the show makes clear that this experience (and the continued presence of Rita in his life) impaired Josh's ability to function in romantic relationships as an adult. Obsessed with image over substance, he either treats women he is interested in as disposable sex objects or rushes far too quickly into committing to them, and both scenarios reveal how he prioritizes a particular image of straight manhood over authentic trust and intimacy in relationships[20]. Shelly also experienced sexual abuse as a child, and she also struggles with intimacy: all her partners, including Maura, have secrets that keep them from being fully emotionally involved with her. She also has a complicated relationship to her physical body. As the viewer learns in season three's "If I Were a Bell," Shelly stopped eating after her abuse -- much to the horror of her Jewish immigrant parents, who "came here to get away from starving" -- and the show implies that she is not fully recovered as an adult. Though she talks about food constantly, she picks at her meals and always wears slightly oversized outfits that emphasize the thinness of her frame. Such moments reveal the ways that even those whose subjectivities are privileged face discomfort and trauma in the moments when they cannot conform themselves to the normative expectations of their subject position.

In the show's second and third seasons, Ali helps the audience tie together these disparate gendered and sexualized mental health narratives as she becomes obsessed with the notion of intergenerational trauma, eventually making it the subject of her graduate school research. This trajectory is catalyzed in season two when Josh off-handedly asks his sisters, "Are all Jews anxious?" In trying to find an answer, Ali comes to understand

[20] Josh's failures of intimacy border on sociopathy. At one point, Syd describes him as the romantic equivalent of a serial killer: instead of murdering as many people as possible, he tries to make them fall in unrequited love with him.

shared Jewish familial/cultural experiences of mental illness not as an impairment intrinsic to Jewishness but as a logical consequence of the many traumatic forms of social (and literal) death that Jewish people have faced. This is, of course, not exclusive to Jewish subjects: as the show illuminates at several occasions, queer and trans subjects face their own distinct, traumatic biopolitical regulation, both in the past and the present timelines, and this trauma often destabilizes those who are close to them as well. Gittel suffers tremendously as a result of how her trans subjectivity is positioned in her particular context, and the viewer later learns that her death left Rose in an unstable state. Yet Rose was a good mother despite her personal struggles, understanding and protective of Mort's childhood performances of femininity -- but ultimately incapable of fully protecting him from those who judged and shamed this behavior. These moments of shame and degradation cause Maura to hide her trans subjectivity into her adult life, and she continues to experience these interpersonal misfittings after her coming out. Moments such as Josh's discomfort around her, frequent misgendering from strangers, and aggressive mistreatment from security and medical forces echo Gittel's experiences and remind us that history is a cycle, not a linear teleology. The specific details of biopolitical regulation may change, but the purpose of these practices -- to isolate those subjects who are perceived as threats to the normative order of the social body -- remains consistent, and consistently traumatic, across time and space.

In these cycles and repetitions, the show continually reminds the viewer of its core argument that mental illness is not inherent to being a misfit but a logical consequence of misfitting and the trauma that comes with it. While each character's mental health impairments and traumas are an individual (and occasionally isolating)

lived experience, these impairments are shaped by social and cultural contexts that both enforce traumatic practices toward marginalized subjects and encourage shame and silence around its consequences. All five Pfeffermans experience mental health impairments, but the specific contours of how they experience these is shaped by their gender, sexuality, and cultural history. The Pfefferman family's relationship to mental illness thus functions as an intersectional assemblage: each individual family member's relationship to their own mental health is unstable and constantly in flux, but it also overlaps and comes into contact with that of other family members as well as the broader cultural and historical context in which they live and the social institutions with which they must interact, including but not limited to the nuclear family.

In situating mental illness within this complex representational structure, *Transparent* succeeds where other shows fail to articulate the ways that gender and sexuality animate our discourses and practices of mental health. The series depicts mental illness as inherently collective and intersects with other social formations, and it locates trauma in cultural and relational contexts -- including the nuclear family -- rather than in individual subjects. All the shows storylines emerge from deviant characters facing various forms of social death, in which they are either regulated into replicating normativity (such as Josh, Shelly, Mort in flashbacks, and occasionally Sarah) or excluded and isolated from normative subjecthood altogether (including Maura, her trans support group of Davina and Shay, Gittel, and Ali), depending on their positionality. In doing so, the show reveals how the regulation of one's various and shifting mental health impairments intersects with their social location and emerges as part of an assemblage of

bodies, communities, and cultural/historical contexts wherein gender and sexuality animate mental health discourse.

Conclusion

Discourses and practices of gender and sexuality have long been animating forces for the production of mentally ill subjects, and deviations from norms of gender and sexuality have long been constructed and regulated as mental illness. This mutual construction of deviance has been managed through medical, legal, and cultural practices that either assimilate or expel those subjects who destabilize the norms of the social body. Such practices often rely upon metaphors of immunity to justify the inoculation of the social body against those whose social location and/or deviant behavior calls into question the normalized order of things. Even well-meaning, ostensibly progressive narratives of queer mental health reify the notion that queer subjects are not just unstable individuals, but deviant subjects capable of spreading their instability throughout the social body in destructive ways. Annalise of *How to Get Away With Murder* and Luisa of *Jane the Virgin* are both queer, mentally ill women of color whose instability creates chaos and destruction in the lives of those around them -- and this chaos is often linked to their exclusion from heteronormative structures of reproduction and family, with little reflection on how that exclusion is a form of social death that can enable mental health impairments. Meanwhile, *Transparent* takes careful steps to represent traumatic conditions of exclusion, and in doing so, enables a collective narrative of mental illness that operates on the assumption that everyone experiences mental health impairments, but that these experiences are shaped by the misfitting dynamics between one's social

location and their context. Yet *Transparent*'s cultural focus is limited to one economically secure Jewish family, and though it is not realistic to expect otherwise, its narrative thus does not provide a complete depiction of the production and biopolitical regulation of gender, sexuality, and mental illness.

Taken as a whole, these texts reveal that not all mentally ill subjectivities are produced and regulated equally or in the same way (though they do not always problematize this differential regulation). Mental health discourse intersects with gender and sexuality, but the production of it is far more complex than a one-to-one correspondence between mental illness and gendered/sexual deviance; it depends upon a number of intersecting social formations, and how those intersections comprise a shifting, unstable social formation within an equally unstable context. As our obsession with immune discourse reveals, the boundary that designates insiders and outsiders within the is not a concrete wall, but a porous membrane. This chapter unpacks the process by which certain subjects are produced as beyond and outside normative, rational subjecthood and thus always already mentally ill. However, other subjects who are positioned outside but not entirely beyond normative subjecthood -- such as white women -- can nonetheless be included within the social body if they are willing to uphold certain conventions of the order of things, including heteronormativity, reproduction, and participation in the nation-state and/or the late capitalist economy. As the next chapter explores, the production of mentally healthy women subjects is connected to close adherence to norms of femininity and heteronormativity. This production of normativity, like the production of deviance, helps further reveal the complexity and instability of the cultural assemblage in which intersectional mentally ill subjectivities emerge.

CHAPTER TWO:

The Regulation of Heterosexuality as Mental Health in *Girls*, *You're the Worst*, and *Crazy Ex-Girlfriend*

Representations of culturally deviant genders and sexualities reveal the way in which the centrality of the normative subject -- white, straight, cisgender, male -- operationalizes discourses that produce queer and trans subjects as mentally ill. Yet the image of the normative, mentally healthy subject does not just produce and regulate deviance as deviance; it also regulates how and when subjects are produced as mentally healthy and thus enfolded into normative subjecthood. This production of mental health, like that of mental illness, intersects with multiple social formations and shifts across time and space. In *The Biopolitics of Disability* (2015), David Mitchell and Sharon Snyder use the term ablenationalism to understand how disabled subjects are differentially included in the social body in ways that seem progressive but in fact shore up the centrality of the normative subject. Drawing on this framework for understanding differential regulation and inclusion, I argue that mentally ill white women -- especially those who are heterosexual, middle-class, and otherwise able-bodied -- are discursively deployed to mark the boundary between the normative subject and the unstable, mentally ill deviant.

Heteronormativity -- which is, of course, inseparable from normative conceptions of masculinity and femininity -- is central to the production of the normative, mentally healthy subject as an intersectional social formation. Cultural discourses that produce particular white women subjects as alternately mentally ill and mentally healthy in direct proportion to romantic stability and heterosexual desirability invert but reinforce

discourses that present queer subjects as always already mentally ill. This production has historically reinforced, and continues to reinforce, the notion that a normatively white heterosexual woman is a mentally healthy woman, and vice versa -- yet these discourses often find little grounding in lived experiences of gender, heterosexual commitment, and mental health. Drawing on Robert McRuer's analysis of the mutual construction of able-bodiedness and heterosexuality as normative social formations (2003), this chapter analyzes how narratives of mental illness and heterosexual romance position compliance with heteronormativity as proof of white women's mental health. Such discourses further reinforce the mutual production of mental illness and non-normative sexualities by presenting heteronormative romance as a cure for women's mental health impairments. In this, romanticized heteronormativity does the cultural work of medicalizing mentally ill subjects, because heteronormativity itself has taken shape through a long, intersectional lineage of medicalized deviance that has centered intersectional formations of mental illness.

This heteronormative discourse depends on binary conceptions of gender, but it is disproportionately applied to women subjects. As writer Anne Theriault's discussion of the "sexy tragic muse" (2015) points out, the heteronormative romanticization of mental illness reveals the intersection of gender and mental illness *and* the intersection of heteronormativity and mental health. American popular culture is rife with narratives that position romantic rejection as the catalyst for a woman's mental health crisis, as well as representations of mentally ill women who enter into a relationship with a man and are suddenly cured of their mental health impairments. These depictions suggest that heterosexual romance functions as a gendered form of validation: it has the power to

abruptly restore a damaged or deviant woman's mental stability, and simultaneously brings her back into the fold of normative subjecthood. Of course, this normativity is not available to all women; on the whole, this representational regime overwhelmingly features white women. This unstable and differentially regulated discursive overlap between femininity, heteronormativity, and mental illness reveals how the normative subject and the mentally ill subject are produced as mutually exclusive (yet mutually constituting) intersectional social formations. Within this production and regulation, a white woman subject can be normatively loved or mentally ill at various points -- but she cannot be both at the same time. Like narratives of queer and trans mental illness negotiate the assumption that non-normative genders and sexualities are always already related to mental illness, contemporary narratives of mental health and heterosexuality work within and against the notion that participation in heteronormative practices is evidence of a white woman's mental health.

While these discourses undergird many pop culture romance narratives, few texts grapple with them in as much detail and complexity as HBO's *Girls*, FXX's *You're the Worst*, and the CW's *Crazy Ex-Girlfriend*. On the surface, these three texts are quite similar. They all blend traditional romantic comedy tropes with cringe-comedy sensibilities, drawing comedic moments from awkward characters placed in uncomfortable situations -- a discomfort that is often amplified by the viewer's identification with what is depicted on screen. In these texts, this uncomfortable identification is generational; both the uncomfortable personalities they depict and the audience they cater to are millennials (and millennial women in particular), whose engagement with the nuclear family is marked by a distinct set of economic and

sociocultural circumstances. Yet, while their protagonists are all mentally ill white women, these series differ in their negotiations of femininity, heteronormativity, and mental health. *Girls* reinforces the mutual construction of heteronormativity and mental health by presenting heterosexual romance as a cure for women's mental illness on multiple occasions, while *You're the Worst* and *Crazy Ex-Girlfriend* explicitly frame expectations to comply with heteronormativity as damaging to subjects' mental health, especially (but not exclusively) when those subjects are women.

Theorizing the Gendered Mutual Construction of Heterosexuality and Mental Health

As critical disability theorists explain, the social formation of physical and mental disability does not take shape along a single axis but intersects with many structures of privilege and marginality, including sexuality. Disabled people are constructed outside normative parameters of desire and attraction, as seen in both assumptions that they are asexual and assumptions that they are hypersexual (see McRuer and Mollow, 2012; Schildrick, 2009; Shakespeare, et. al., 1996). Though their content is diametrically opposed, both these constructions reveal how the cultural production and regulation of heteronormativity intersects with able-bodiedness/able-mindedness (Kafer, 2013; McRuer, 2003 and 2006). As Robert McRuer explains in "As Good As It Gets: Queer Theory and Critical Disability" (2003), able-bodiedness and heterosexuality are produced as mutually inclusive, invisible non-identities. When normative formations of ability and/or sexuality are destabilized, media narratives of recenter both able-bodiedness and heterosexuality by presenting heterosexual romance as a cure for disability. As McRuer writes of the 1997 film *As Good As It Gets*, "... heteronormative epiphanies are

repeatedly, and often necessarily, able-bodied ones" (82) -- a trope so common to narratives of romance and mental illness that even those that deconstruct it must acknowledge it.

Gender is also central to the intersectional production of heteronormativity and able-bodiedness/mindedness. Heteronormativity depends on binary constructions of masculinity and femininity, and, as Rosemarie Garland-Thompson notes in "Integrating Disability, Transforming Feminist Theory" (2003), binary constructions of gender are central to the normative ideals of embodiment and rationality that produce and regulate disability. Women and disabled people are constructed as passive, dependent, and in need of assistance from agentive, active, usually masculine subjects. This binary construction is central to those discourses which produce the heteronormative woman and the mentally ill woman as mutually exclusive subjects. As Sandra Gilbert and Susan Gubar note in *The Madwoman in the Attic* (1979), literary fiction has constructed women who did not fit within domesticated, heteronormative ideals as mentally ill. Jane Kromm (1994) points out a similar trend in theater, arguing that the mentally ill woman has served as "a sexually provocative" figure from early modern drama onward (507).

This construction of deviance from heteronormative femininities as mental illness is not a historical artifact. Per Theriault's "sexy tragic muse" theory (2015), ideals of heteronormative romance remain central to representations of women's mental illness in contemporary literature, screen media, and music. Theriault writes of this recurrent figure:

> She occupies the intersection of ableism and sexism, and her mental illness is portrayed in a way that makes it commendable, even necessary,

> for others to care for her. We feel gratitude to the men that step up and save her, because she obviously cannot save herself. We feel empathy to the men who break up with her, because we see that she is difficult and volatile.

Within this representational paradigm, breakups are framed as a traumatic catalyst for women's instability, and romantic commitments function conversely as cures. However, while Theriault's essay is useful in theorizing the overlap between madness and femininity, it fails to explicitly articulate the centrality of heteronormativity within assumptions about gender, madness, and romance. It is not just that a romantic relationship can "save" a woman from mental illness in these fictional narratives -- it is that a heteronormative relationship can. These parameters illustrate how cultural discourses of madness, gender, and sexuality are inextricable from one another, and how they locate individuals within and against the ideal of the normative subject.

While the heterosexual-romance-as-cure trope is consistent, its execution shifts in relationship to the temporal and cultural contexts that produce narratives that depend on it. As McRuer (2006) notes, these stories are a means of assuaging broader cultural anxieties about heterosexuality and the nuclear family. Heterosexual commitment is obviously not, in and of itself, a cure for mental illness; though marriage has positive mental health outcomes for straight men, women who are married to men have significantly higher rates of depression than single women, and other mental health outcomes vary widely based on the quality of said marriage (APA, 2017). Yet, while these narratives do not reflect the lived experiences of individuals, they do reflect the material anxieties of a given time and space -- in particular, anxieties around the

instability of the (hetero)normative subject, the nuclear family's role in the preservation of the social body, and the shifting role of women within the reproductive social body.

These anxieties have fluctuated and intensified as millennials in the United States reach adulthood. Compared to prior generations, millennials are more likely to postpone marriage, if not opt out of it entirely (Vespa, 2017) and birth rates in the United States have reached historic lows, especially among younger adults (Cha, 2017). These shifts have created a cottage industry of panicked discourse about millennials' rejection of the heteronormative nuclear family as a sign of broader social decline. Such discussions are about millennials but neither by or for them; they center older adults who are worried about the decline of heteronormativity as a social institution, and occasionally racists who are alarmed by the decline in white birth rates. However, this does not mean that millennials do not have their own distinct set of anxieties about dating, marriage, and family. Many young adults postpone or self-select out of traditional marriage and family because they cannot afford to participate in those institutions, and/or because many were raised by divorced or single parents and therefore harbor reservations about getting married themselves. Even for those who seek institutionalized monogamy, lengthened life expectancies, shifts in norms of sexuality, and online dating apps have changed the romantic landscape. *Girls*, *You're the Worst*, and *Crazy Ex-Girlfriend* situate their millennial characters within this distinct set of individual and cultural anxieties in their engagement with discourses of young white women's sexuality and mental health, and they each reflect how such discourses not only produce some gendered and sexualized subjectivities as deviant, but also produce the normative subject and the social body to which it belongs.

HBO's Girls*: Reifying the Boyfriend Cure*

A coming-of-age narrative about four young white women living in New York City in their 20s, HBO's *Girls* (2012-17) became a lightning rod for critical debates about the discrepancies between creator Lena Dunham's stated progressive feminist goals and the race- and class-obliviousness of the show itself. In the show's second season, another discrepancy between ideology and representation took shape in the show's depiction of protagonist Hannah Horvath's (Dunham) obsessive-compulsive disorder. While it begins as a complex depiction of a recurrent, nonlinear mental health impairment, this narrative arc concludes with a wholesale reification of the discursive construction of heterosexual romance as a space where women can validate their self-worth and thus cure their mental illness.

Where representations of obsessive-compulsive disorder often frame it as either a comedic quirk and/or an inborn trait marked by superhuman attention to detail[21], *Girls* offers a more complex, empathetic approach. Hannah's distress originates in clearly defined contextual stressors; her symptoms are thus not presented as an individual failure or pathological deviance. Throughout the season, the pressure of her best friend Jessa's (Jemima Kirke) absence, her new book contract, and her crumbling relationship with her

[21] Comedies like *Monk* (USA, 2002-2009), *Scrubs* (NBC, 2001-2008 and ABC, 2009-2010), *Glee* (2009-2015), *What About Bob?* (1991), and *As Good as It Gets* (1997) are the most notorious examples of this, but even the dramatic Howard Hughes biopic *The Aviator* (2004) played its protagonist's rituals for laughs. While mental illness can certainly be funny, framing a specific impairment as comedic above all else reinforces misconceptions that mental health conditions are neither serious nor real. This is particularly salient in depictions of and discussions around obsessive-compulsive behavior. Casual comments like "I'm so OCD" circulate as self-deprecating shorthand for being unusually organized, meticulous, or hygienic, which reinforces perceptions of the impairment as a personality quirk (see Ewens, 2016; Tipu, 2015).

on-again, off-again boyfriend Adam (Adam Driver) weigh on Hannah. Her building stress peaks when she learns that Adam has a new girlfriend, and she displays severe symptoms starting in the season's eighth episode, "It's Back." She goes through her daily routine doing everything in multiples of eight -- most strikingly, looking herself in the eye in the mirror and repeating her mantras "you are good and fine" and "you are fine and good."

The show's focus on these contextual stressors led both mental health professionals and cultural critics to praise its unusual level of accuracy in depicting Hannah's mental health crisis (Dotson, 2013; Lambert, 2013; Sepkowitz, 2013; Szymanski, 2013; VanDerWerff, 2013; Wortmann, 2013). This accuracy not only makes its depiction of Hannah relatable to viewers who live with similar impairments, but it also invites empathy from those who have not experienced obsessive-compulsive impairments but have their own stresses. Additionally, *Girls* not only reflects how people in general experience obsessive-compulsive disorders, but how young women in particular experience them: women are more likely than men to experience the impairment as a series of recurring episodes rather than a chronic condition (Lochner and Stein, 2003) and they are more likely to report a major life stress in the months preceding the onset of an episode (Bogetto, et. al., 1999).

The beginning of this storyline is not just accurate in its representations of symptoms and triggers; it also resists linear narratives of mental illness in which being cured is a teleological endpoint. As the title implies, "It's Back" is not the first time the

series acknowledges Hannah's neuroses are more than just personality quirks[22]. While some of these prior acknowledgments are implied, her condition is explicitly stated during a fight with her friend Marnie (Allison Williams) in the show's first season. While debating who is more selfish half of their friendship (it's a toss-up), Marnie dredges up Hannah's self-described "most shameful, painful, private secret" and yells, "You've been crazy since I met you! You've been crazy since middle school, when you had to masturbate eight times a night to stave off diseases of the mind and body!" This incident not only foreshadows Hannah's later experiences but also offers a window into understanding how Hannah herself experiences her condition as both emotional and embodied.

This embodied articulation of Hannah's mental illness contradicts recurrent cultural discourses of of mental illness as "all in one's head." Many of Hannah's rituals center around hygiene and cleanliness. Her distress peaks when she cleans her ears with such intense focus that she punctures an eardrum with a cotton swab and has to visit the emergency room. Though she does heed the doctor's order to leave her ears alone, she continues trying to manage her body in other ways. The following day, she decides to give herself a pixie cut after seeing Carey Mulligan on a magazine cover; the result is exactly as bad as you would expect. This intense focus on Hannah's body is not limited to the show's depiction of mental illness; as Lara Bradshaw notes (2014), the show

[22] A few critics argued that Hannah's OCD arc was out-of-left-field (see Hanna, 2013 and Phillips, 2013), but these are outliers in the overall critical response. In a more nuanced critique of the show's introduction of Hannah's mental health crisis, Willa Paskin (2013) contended that it fits within a larger trend, explained previously by Heather Havrilesky (2013): mental health impairments are used to engender sympathy for women characters whose behavior would otherwise be written off as irredeemably unlikable for reasons that male characters' would not. (Though this sympathy is clearly racialized, as the previous chapter of this project demonstrates.)

showcases Hannah's body -- which is average-sized by real-life standards but large by television's -- matter-of-factly. Throughout the series, she is depicted in realistic states of undress, her health is fallible, and she struggles against others' judgment of her body[23]. The show's intense focus on Hannah's mental health manifesting physically tracks with its overarching emphasis on Hannah's embodiment.

Yet while the show visually locates Hannah's mental illness in her body, it locates her recovery from it in heteronormative commitment[24]. While the development of long-term narrative arcs has never been a strong suit of the show, Hannah's recovery from her mental health crisis takes shape at a superhuman pace: within a few minutes in the season finale, she is simultaneously restored to mental health and committed heterosexuality. Emotionally distraught but unable to reach any of her friends, she reaches out to Adam via FaceTime and he asks, "Is that stuff going on? That stuff from high school? That OCDC shit?" When she admits that it is, he runs through the streets of Brooklyn, FaceTiming her to reassure her the whole way. When he reaches her apartment, she tearfully marvels, "you're here," and he replies, "I was always here"; they kiss and the season ends. The third season's premiere begins with Hannah's life quickly returned to

[23] This approach to the body would arguably not be as notable if Lena Dunham's body fit within the narrow paradigm of what is acceptably attractive in American pop culture. Yet these perceived abnormalities have been the center of much attention from critics -- including some who have gone so far as to challenge its representation of Hannah as someone to whom conventionally attractive, heterosexual men would be attracted (Bahr, 2015; Haglund and Engber, 2013; Martin, 2013).

[24] Every major storyline throughout the end of the season is focused on romance to an unusually intense degree, which further emphasizes the significance of it within Hannah's mental health crisis. Marnie forces her newly-rich ex-boyfriend Charlie (Christopher Abbott) to rekindle their college romance, and Shoshanna (Zosia Mamet) fears that she and Ray (Alex Karpovsky) are moving too quickly toward commitment.

stasis: she and Adam live together in cohabiting bliss, she is making progress on her book, and she takes medication and seeks out talk therapy.

The show fleshes out Adam and Hannah's relationship with some imperfections, such as Adam's lack of financial contribution to their partnership, but minor details do not contradict the show's overarching representation of their reunion as a positive development for Hannah's mental health. The show repeatedly reinforces the notion of Adam as a heroic figure who brings Hannah back into the fold of normative, mentally healthy subjecthood through the strength of romanticized, heteronormative commitment. As Hannah explains, "He takes care of me. He makes sure I take my medicine. He makes sure I eat protein. He does this very calming chant." In other words, her financial care for him is balanced out by his emotional care for her, despite the fact that Hannah is perpetually broke. The topic is broached again at the end of the premiere, when Shoshanna voices these concerns with Adam in the following monologue:

> What would she have done during this period of mental unrest of her boyfriend had been, like, a real human being existing in society? Like, what if you had a job or responsibilities or, like, places to be during the day like her best friend?

But Shoshanna's concerns are forgotten after Adam tells her, "She is my best friend," and she is as touched as the audience is supposed to be, her eyes welling up as she whispers, "Oh my god."

Once the show establishes that Adam is good for Hannah's mental health despite the material discrepancy in their relationship, her mental illness largely disappears from the series' consciousness. The fourth season episode "Triggered" opens with a close-up

shot of Hannah counting in the same cadence she used at the height of her instability -- but as the frame expands, we learn that she is counting linear feet to calculate how much larger her new Iowa apartment is than her Brooklyn one. In another callback, the opening scene of the season four finale depicts Hannah having a panic attack outside the school where she substitute teaches. However, in an echo of the conclusion of season two's "Together," she returns to stasis after her soon-to-be boyfriend Fran (Jake Lacy) reassures her that everything will be okay. That moment of reassurance marks the permanent end of Hannah's mental illness in the series[25]; once again, all it takes for Hannah to resolve any mental distress is a supportive male partner.

Season three's abrupt conclusion to Hannah's mental health narrative -- and the series's failure to acknowledge it as a source of concern after her reunion with Adam -- offers an inaccurate, troubling end to an otherwise nuanced storyline. Fletcher Wortmann (2013) writes:

> OCD flourishes in uncertainty; obsession thrives when you have some impossible situation to turn over and over in your head. So when someone tries to reassure you, to tell you that things are really okay after all, that might calm you down for a minute. But it doesn't permanently solve anything.

[25] The series' final season revisits Hannah's mental health crisis when Adam and Jessa make a movie that fictionalizes their relationship. Adam includes scenes in which he helps Hannah (depicted here as the "sexy tragic muse" Theriault describes) through her distress, and Jessa is jealous about this. It's clear that we are supposed to find Adam's heroic self-fashioning ridiculous, but Jessa's jealousy is presented as an appropriate, relatable reaction -- which re-validates the romanticization of heteronormative commitment as a cure for women's distress.

In other words: a supportive partner may mitigate the stressors that impact one's mental health, but they cannot provide the permanent, sudden cure depicted in *Girls.* Not only is this depiction inaccurate; it re-articulates an insidious set of discourses about lived experiences of mental illness. As Molly Lambert notes, it "romanticiz[es] mental illness with happy endings that pretend you will be magically fixed as soon as you find someone to love you" (2013). This romanticization reinforces the notion that mental illness as an unserious and/or unreal individual failure: if one pulls themselves up by their mental-illness bootstraps and makes themselves worthy of being part of a functional, normative relationship, mental health will magically follow.

This romanticized individualization of mental health impairments is neither abstract nor universal, however; it depends upon compulsory heterosexuality as a means of distinguishing normative subjects from deviant, mentally ill ones. It is not just troubling that *Girls* depicts finding a supportive partner as a magic cure for mental illness -- it is also significant that this savior figure comprises half of a heteronormative, committed relationship. This reinforces binary conceptions of gender and mental health: a mentally ill woman is not desirable or lovable, but when she enters into a normative and thus "healthy" partnership, her mental health is restored through the presence of a rational male partner -- regardless of whether anything else in her life has changed. As such, masculinity is reinforced as a stoic, stable subject position; femininity is reinforced as irrational and excessively emotional; and heteronormativity is reinforced in that the two are presented as necessary complements to one another.

Girls takes a complex, nonlinear, resonant story of a young woman's mental illness and twists it into depicting women's mental health impairments as problems that

can be resolved only by a male partner in a committed, heteronormative relationship. In doing so, it reifies the notion that a straight, white woman who enacts the normative expectations of her gendered subject position is automatically a mentally healthy one -- and that a mentally ill woman is always already outside the parameters and privileges of heteronormativity (and vice versa). While queer women and women of color are almost invariably positioned outside the social body in cultural discourses of mental health, *Girls* reveals how compliance with heteronormativity grants some mentally ill white women access to normative, mentally healthy subjecthood and membership within the social body, regardless of their actual well-being.

Heterosexuality as Madness: FXX's You're the Worst *and CW's* Crazy Ex-Girlfriend

Where *Girls* romanticizes heteronormativity as a cure for mental illness, *You're the Worst* and *Crazy Ex-Girlfriend* depicts romantic relationships -- and the sociocultural expectations that define them -- as actively maddening. The two series appear wildly different at first glance. *You're the Worst* is a dark thirty-minute cable sitcom about four aimless millennials living in Los Angeles; *Crazy Ex-Girlfriend* is an hour-long surreal musical comedy about the misadventures of successful but dissatisfied attorney Rebecca Bunch (Rachel Bloom). Yet both series use cringe comedy to deconstruct heteronormative romantic comedy tropes -- and both center mental illness in doing so. The shows subvert pop culture's tendency to use mental health impairments as a plot problem to be wrapped up into a satisfying resolution, instead focusing on the way such impairments shape our lived experiences both materially and emotionally.

Critics have alternately described *You're the Worst* as a deconstruction of the sitcom format (Goldstein, 2016; Herman, 2016), a distinctively millennial narrative of sex and love (Hoepfner, 2015), and a drama masquerading as a comedy (see Zoller Seitz, 2016, and VanDerWerff, 2015, for detailed analysis of this critique)[26]. The series traces public relations representative Gretchen Cutler (Aya Cash) and novelist Jimmy Shive-Overly (Chris Geere)'s relationship from a one-night stand to a committed partnership. Though Jimmy and Gretchen's first meeting sets the series in motion, it is an ensemble show that often dives into the particulars of their friends' lives, most notably Jimmy's roommate Edgar Quintero (Desmin Borges) and Gretchen's best friend Lindsay Jillian (Kether Donohue). In fact, I believe the protagonists of the series are not Gretchen and Jimmy but rather Gretchen and Edgar, who are the most fully developed characters, and whose respective conflicts consistently drive the plot forward from episode to episode. Jimmy and Lindsay's storylines, as well as those of more peripheral characters such as Lindsay's sister Becca (Janet Varney) and brother-in-law Vernon (Todd Roberts), often depend upon or are positioned as secondary to Gretchen and Edgar.

Though every character in the series is unstable in some way, both Gretchen and Edgar are presented as explicitly mentally ill: Gretchen has recurrent clinical depression, and Edgar, an Iraq war veteran, has post-traumatic stress disorder. Every episode of the

[26] This critique depends on a limited definition of humor, as Matt Zoller Seitz (2016) notes -- although, to be fair, most comedies do not feature major storylines about clinical depression or the VA's failure to serve the public. However, the way this debate clusters around comedies that feature mentally ill women reveals how cringe comedy hinges on a delicate balance between discomfort and comedy, and that it often only works for particular audiences. All three shows referenced in this chapter have raised this debate, and so have *Orange is the New Black*, *Unbreakable Kimmy Schmidt*, *Jane the Virgin, Transparent*, and *Enlightened*. HBO's *Veep* (2012-present) and Netflix's *BoJack Horseman* (2014-present), which are not discussed in this project but explicitly depict mental illness, have been swept up into this debate as well.

show is rife with small moments that reveal how Gretchen and Edgar's mental health impairments meet the cultural demands of normative adulthood. Edgar's flashbacks and anxiety about crowded spaces make it difficult for him to keep a traditional job or develop new interpersonal relationships, and Gretchen's depression makes small, everyday tasks, like opening her mail and emoting, a struggle she must constantly manage. As critic Todd VanDerWerff (2015) writes, *YTW* "does not suggest that depression can be defeated. It suggests, instead, that it can be lived with."

In treating mental illness as part of the fabric of everyday life rather than a catalyst for dramatic narrative arcs, the show treats mental health conditions as context-contingent impairments, rather than as diseases that can be eradicated. The show argues that mental health impairments can be managed but never fully healed, and takes on a virulently anti-pharmaceutical stance -- a rarity in a cultural environment in which pharmaceutical manufacturers pour millions of dollars into television ad buys each year[27]. This approach actively resists what Bonnie Burstow (2015) calls "the pharmacological revolution," wherein the medical diagnosis of impairments reproduces mentally ill subjects as capitalist consumers who can be "cured" by pharmacological products. This framework treats mentally ill subjects as faulty minds, devoid of context, and thus flattens the cultural contours of mental illness.

The show not only carefully contextualizes the labor of managing one's mental health but also reveals how mentally ill subjects are differentially disciplined in

[27] This is not to say that no television series has explicitly represented and critiqued the pharmacological narrative teleology of mental illness. However, those that have are largely concentrated on premium cable (e.g., *Veep, Enlightened, The Sopranos*) or streaming platforms (e.g., *Orange is the New Black*), which are not dependent on advertising money.

relationship to their intersectional social locations. Gretchen is resistant to seek out mental health care for a myriad of reasons, ranging from a belief that the medicalization of mental illness is often sexist to the fact that "being vulnerable makes [her] feel angry". However, she eventually commits to talk therapy, and her therapist Justina (Samira Wiley) helps her develop self-management strategies that mitigate the impact of her depression while also honoring her strong anti-antidepressant stance. Access to healthcare is not a material concern for her, an economically solvent white woman, but rather a political and personal one: her initial resistance to seeking out mental health care is grounded in both an awareness of the cultural contours of how medicalization differentially disciplines women, and a desire to continue compartmentalizing her depression.

Edgar, a Latino veteran whose post-traumatic stress disorder makes maintaining employment difficult, also wants a therapeutic rather than pharmaceutical approach. Unlike Gretchen, he actively wants and seeks out care, but he faces constant barriers within the bureaucratic structure of the Veterans' Administration. VA medical staff prescribe him antipsychotics that dull his sensory experiences, bar him from therapy programs because he has been labeled "non-compliant" for criticizing of their reliance on pharmaceuticals, and refuse to recognize medical marijuana -- which minimizes his flashbacks and anxiety -- as a valid treatment. Edgar and Gretchen's disparate narratives point out the inequalities in mental health care that disproportionately impact poor people and people of color. It is not difficult for Gretchen, a financially stable white woman, to find a mental health professional willing to recognize her depression and her anti-pharmaceutical stance; yet it is all but impossible for Edgar, a man of color with limited

capital, to get any useful healthcare out of the very system that produced his mental health impairment, despite years of effort.

The show's depiction of how Gretchen and Edgar's respective impairments shape their day-to-day lives in relationship to their respective social locations is one of its greatest strengths, but its narrative and affective core is how their mental health shapes their interpersonal relationships -- particularly their romantic ones. While Edgar's distress is in many ways interior and personal, it is impacts his romantic life and his friendships, especially his bond with Gretchen. In season one, we know that Edgar has PTSD and that he appreciates that Gretchen listens to his stories and does not attribute everything to his impairment. His trust of her makes him encourage (and, on occasion, manipulate) Jimmy to build a serious relationship with her. Later in the series, Edgar's mental health shapes his romantic relationship with Dorothy (Collette Wolfe) when he realizes his antipsychotic medication is limiting him emotionally and sexually. His desire to participate fully in their relationship inspires him to throw away the pills and pursue alternate means of managing his mental health. Though his subsequent neurochemical withdrawal and his engagement with VA bureaucracy amplify his distress, Gretchen introduces him to marijuana and later engages him in some very informal "immersion therapy," in which their friends set off a massive amount of fireworks to celebrate Edgar being able to experience loud noises without traumatic flashbacks.

It is not clear until the show's second season that Gretchen's bond with Edgar is grounded in empathy with a fellow mentally ill subject, as her depression recurs and shapes her emergent commitment to Jimmy. As Pilot Viruet (2015) notes, the show defies the typically melodramatic tropes of television depression: Gretchen is apathetic

and exhausted, and feels that she is a failure even as her work and her relationship with Jimmy are both going well. Jimmy interprets her emotional distance and her habit of sneaking out of their house in the middle of the night as signs of infidelity, but she is in fact leaving to cry in her car while playing Snake on her phone. Gretchen explains the reason behind the late-night sobbing sessions to Jimmy as follows:

> Okay, so. Here's an interesting thing you don't know about me. I am clinically depressed. It's been going on my whole life, so I'm actually pretty good at handling it. It strikes me whenever and I have no idea why, but it's fine… And who knows? With the right frame of mind, it could be a really fun adventure for everyone. And the only thing I need from you is to not make a big deal out of it, and to be okay with how I am and the fact that you can't fix me.

In this monologue, Gretchen acknowledges and contradicts the teleological narrative of mental illness as something that can be permanently resolved, as well as cultural discourses that romanticize mental illness and represent a normative, heterosexual relationship as a cure. Yet Jimmy is unable to resist these discourses, and his attempts to romance Gretchen back to mental health are so relentless that she pretends to be cured so that he leaves her alone. This act only lasts so long, however, and Gretchen eventually has to explain to him, "I'm scraped out… This is how I am now. And it's not okay with you, nor should it be." But Jimmy decides to stay with Gretchen; she cries because she is so touched and so shocked that he chose this, and the following episode concludes with the pair exchanging "I love you"s for the first time.

These romantic high notes, however, are couched within a broader presentation of the traditional nuclear family as a catalyst for madness. While the show offers a comprehensive argument about mental health as a relational social formation, its other main argument is best encapsulated in a throwaway line from Lindsay early in season one: "Marriage is dark." The series begins at the wedding of Becca and Vernon, whose commitment depends upon hiding the bulk of their inner lives so that they can maintain a perfect nuclear-family image. They are are the portrait of heteronormativity: they are attractive, fit, and white; he works outside the home, she does not; and they live in a bland, well-maintained McMansion -- and they are miserable. This misery is contagious: Drawing on her sister's misguided relationship advice, Lindsay engages in erratic and borderline sociopathic behavior trying to turn herself into an ideal traditional wife to Paul (Allan McLeod), with whom she has nothing in common. While all commitments, romantic or otherwise, require some kind of personal sacrifice, the series argues that young adult women re-mold their subjectivities in order to fit themselves into the normative expectations of marriage and family, and that this is deleterious to their well-being.

Despite being generally cynical having not a single example of a healthy long-term relationship in her life, Gretchen idealizes commitment even at the height of her depression. Her idealism is explored in season two's "LCD Soundsystem," often praised as the series's best episode (e.g., Herman, 2016; Kane, 2015; VanDerWerff, 2015) and compared to a short film (Murthi, 2015). This standalone episode represents the show's most extreme inversion of the romanticized teleological narrative of mental illness by not only representing depression as a profoundly lonely experience, but also demonstrating

how having a partner can amplify one's distress. Gretchen becomes obsessed with a neighbor family that appears to have her dream life: greenspace architect Lexi (Tara Summers) and film restorer Rob (Justin Kirk), who live in a hip, well-decorated home with their baby and dog. Gretchen admires that apparent emotional and material stability has not left them stagnant[28]. However, when Gretchen and Jimmy meet them for the first time, she quickly sees the dark reality beneath this exterior. Rob hits on her when they are alone, and then Jimmy spends their walk home listing all the ways in which he finds Lexi and Rob's shared life hopelessly uncool, a monologue he is so engrossed in that he doesn't notice Gretchen weeping next to him. This moment captures how Gretchen's depression takes shape in the gap between her ideals and her reality, and also suggests that this gap is impossible to bridge. The contented, monogamous-but-not-boring space she seeks might not exist; even if it does, the person she would like to be there with is uninterested in occupying it with her[29].

Gretchen is not alone in being distressed by the gulf between her ideal relationship and the reality of commitment; where other texts feminize the intersection of mental health and romance, *You're the Worst* makes it clear that men are not immune from these concerns. Edgar's relationship with Dorothy inspires him to challenge the pharmacological stance of the VA, but what ends their relationship is that Dorothy cannot handle the professional success he earns after he finds alternate means of managing his PTSD. She helps him when he's down, but she can *only* help him when he's down; Edgar realizes that this is not a relationship concession he can make, that he cannot feel guilty

[28] This fixation continues the theme of the season's premiere, "Sweater People," in which Jimmy and Gretchen fear that their newfound commitment will shrink the previously adventurous scope of their single lives into something mundane and routine.

[29] I swear this show is actually funny.

about his happiness after so many years of distress. Meanwhile, Jimmy seems convinced that he has resolved the discrepancy between relationship expectations and realities by reinventing himself as a "post-family" subject before proposing to Gretchen. This theory -- which comes with a dubious assessment of himself as "100% psychologically sound" -- is not so much a rejection of heteronormativity and a desire for an alternate structure of belonging, but a refusal to work through his own relationship to his nuclear family of origin (and, in particular, his father and their divergent masculinities). Unsurprisingly, this does not track well with his decision to marry Gretchen; rather, it leads him down a path of self-sabotage and repression that hurts Gretchen and jeopardizes their relationship.

Jimmy's tenuous emotional state drives home the notion that expectations of heteronormative commitment as a maddening force even for those who do not have explicitly defined mental health impairments -- a direct contradiction of those romanticized discourses that present love as a cure for instability and insecurity. Gretchen and Edgar's respective mental health impairments are not cured by their heteronormative commitments; not even the most well-intentioned partner can "cure" anything because the show approaches mental illness not as a personal problem to be solved, but as an intersectional subjectivity. *You're the Worst* thus defies both the romanticization and the medicalization of mental illness, and the heteronormative discourses that weave the two together. If anything, the closer a given character comes to achieving heteronormativity, the more unstable they become -- whether they have the self-awareness to recognize their instability (like Gretchen and Edgar do) or not (e.g., Becca, Vernon, Jimmy, and Lindsay). In depicting commitment as maddening, the show critiques heteronormativity

as a social structure that not not only limits human experiences of love, desire, and support, but also encourages people -- in particular, women -- to sacrifice their mental health to become part of the traditional nuclear family and thus a (hetero)normative citizen-subject.

Where *You're the Worst* presents heteronormative commitment as a form of cultural and individual madness, *Crazy Ex-Girlfriend* hones in how the pressure to achieve this heteronormativity is particularly maddening for young women. Where *Girls* and *You're the Worst* are marketed as romantic comedy series rather than meditations on mental health, the CW's *Crazy Ex-Girlfriend* is explicitly packaged a show about mental illness. Though several critics questioned the inclusion of a misogynistic cultural trope in the show's title (Feinberg, 2015; Sepinwall, 2015; Viruet, 2015), the choice is tongue-in-cheek and, like the rest of the show, intended to cause discomfort. As the absence of the "my" that usually precedes the term "crazy ex-girlfriend" implies, the show is not a reification of misogynist and ableist discourse but rather an exploration of the complex subjectivities that take shape within it. As Rebecca declares during the first season's theme song: "The situation is a lot more nuanced than that" and "Hey! That's a sexist term."[30]. However, the show does not explore the intersection of ableism and misogyny broadly, but how it overlaps specifically with heteronormative discourses of romance and family. This critique is couched within an understanding of mental illness as both a lived

[30] In general, the show's political and comedic sensibilities are unusual for network television, perhaps because it was originally created for Showtime. Per Bloom (Emami, 2015), the CW only requested that they limit their use of profanity as they switched networks. Not only does the series explore the intersection of heternormativity, misogyny, and mental health stigma, but it also critiques bisexual erasure, abortion stigma, the desexualization of Asian men and the hypersexualization of Latina women in media, and the role of organized religion in the production of heteronormativity.

experience and a discursive formation; as series co-creator Rachel Bloom explains (Emami, 2015), the series is ultimately about "how we come to be crazy, why love makes us crazy, what does the word 'crazy' even mean."

The pilot reaffirms the centrality of these themes, opening with attorney Rebecca Bunch (Bloom) in the midst of a crisis that undermines the assumption that one's productivity is evidence of one's mental health. She is on the verge of a promotion at her high-profile New York City law firm, but she struggles to manage her depression, anxiety, and insomnia. Though cultural discourses often center professional achievement as evidence that one is a normative, mentally healthy subject, it is clear that Rebecca's work is a significant source of distress. On the morning of her promotion, she lays in bed next to a nightstand overflowing with pill bottles and googles "how much sleep deprivation can you survive." Throughout the morning, she is followed by a vague -- but implicitly pharmacological -- advertisement that chipperly asks her "When was the last time you were truly happy?" The question haunts her until she has an anxiety attack during her promotion meeting and has to go outside for fresh air. There, she runs into Josh Chan (Vincent Rodriguez III), the charming and laid-back Filipino-American man she dated at the theater camp she attended as a teenager. Josh explains that he is currently living in his hometown of West Covina, California, where "everyone is happy," and then tells her, "If I'd known you'd turn out to be successful and hot -- I let a good one get away."

Inspired by this moment of romantic optimism, Rebecca quits her job and moves to West Covina; the show's first season follows her often-uncomfortable search for a fresh start on the West Coast, and it offers no easy answers or straightforward

interpretations of what is clearly a life crisis. At best, it is unrealistic for an adult to uproot her life and move across the country to chase down a man she barely dated as a teenager. At worst, it is an act of self-destructive delusion; as Bloom said in a 2015 interview with *Vulture*, "This is a profoundly disturbed person." Furthermore, the fact that Rebecca structures a drastic life choice around the possibility of dating a particular man complicates -- but, as Claire Fallon (2015) notes, does not necessarily undermine -- her feminist ideology. At the same time, one cannot declare that Rebecca's choice to move to California is totally bad; we know immediately that she needs a lifestyle change that minimizes the external stressors that amplify her depression and anxiety.

Of course, though her distress is in many ways relational and contextual, it is also grounded in a material, embodied reality, and so moving to West Covina does not magically cure Rebecca's mental health impairments. One of the first things she does is dump her antidepressants down her garbage disposal, swearing that she will go to talk therapy instead. However, it takes her a full seven episodes to follow through on this promise to herself -- and eight episodes after that to make a serious commitment to therapy (which turns out to be a sleeping pill-induced hallucination). Furthermore, we know from Rebecca's own admissions and her conversations with her mother (Tovah Feldshuh) that her depression and anxiety predate her promotion crisis. However, these material aspects of Rebecca's mental health are always connected to Rebecca's social location within particular contexts. In short, the series pays attention to the way in which mental health discourse operates as a gendered and sexualized site of subject formation without failing to represent the way that individual lives are shaped by the tangible, embodied experiences of specific mental health impairments.

It is within this context that Rebecca's obsession with Josh takes shape, but the series refuses to attribute this solely to her mental health impairments. Instead, it positions Rebecca as unusually susceptible to internalizing cultural narratives that are at best limiting and at worst damaging. Though she is at times self-aware enough to realize she has internalized cultural pressures, Rebecca often looks to external forces -- including popular culture, her social circle, and her mother -- to define what a successful adult life entails, how she should present herself as a woman who is both intelligent and desirable, and what a romantic relationship should look like. Musical numbers like "Sexy French Depression" -- essentially Theriault's "sexy tragic muse" essay set to music -- and "Put Yourself First (In a Sexy Way)" analyze how Rebecca has internalized postfeminist desirability-as-empowerment discourses.

Which is not to say that the show rearticulates such discourses; instead, it insists that Rebecca's obsession with Josh is not the product of a delusional mind but a consequence of forming one's subjectivity within a sexist, ableist, and heteronormative culture in which the most meaningful form of validation available to women is being desirable to and romantically pursued by men. This desirability is not afforded to mentally ill women so long as they remain mentally ill. Where other media forces women characters into the parameters of the normative subject in order to find romantic validation and thus resolve her mental health narrative, *Crazy Ex-Girlfriend* takes Rebecca further and further away from heteronormativity. Yet she is not the alienated "post-family" subject that Jimmy attempts to produce in *You're the Worst;* instead, she locates alternate forms of belonging that do not depend on heterosexual romance but nonetheless offer support and acceptance that can mitigate the isolation of mental illness.

The first season finale encapsulates this, ending with a wedding reception that does not culminate in Rachel running into the arms of either of her romantic interests, but into those of her best friend Paula instead. In such moments, the show builds a queer kinship community -- not the typical media assimilation of queer bodies and identities into the normative family of two parents and a child/ren in the name of representation (Walters 2012), but a collective structure of support and belonging whose parameters are entirely outside the heteronormative nuclear family.

Crazy Ex-Girlfriend's approach to mental health representation thus functions on multiple levels: Rebecca's depression and anxiety are lived, material experiences, structured by her sociocultural context -- a multilayered assemblage that includes both the non-heteronormative communities in which she ultimately finds a home, and a broader culture where misogyny and ableism overlap to produce tropes such as the crazy ex-girlfriend. While the show's musical numbers let its characters unpack their inner lives, they also present feminist critiques of mental health discourse and the notion of heterosexuality as a cure for feminized deviance. Ultimately, the show presents Rebecca as always already living with mental health impairments but depicts her "craziness" as a product of a distinct set of intersectional cultural discourses about love and gender. In doing so, the series articulates mental illness as a relational social formation whose identification and management is not only medicalized, but also interwoven with regulatory discourses of gender and sexuality. Adherence with heteronormativity thus cannot fix a mentally ill subject, because this "cure" recenters a normative subjectivity -- and while alternative, collective structures of belonging are not a cure either, they offer

relational support that is not contingent upon gendered and ableist discourses of heteronormative desirability.

Conclusion

The mutual construction of heteronormativity and able-mindedness is not a new invention -- nor is the gendered production of the "sexy tragic muse" whose mental illness magically disappears when a male savior chooses to love her, and reappears when he leaves her. Such narratives emerge logically in a culture that centers teleological narratives of mental illness wherein a permanent resolution to any mental health impairment is the idealized goal. That goal is inseparable from the gendered and sexualized expectations of normative subjecthood that shape the social production of mental illness as an othered subject formation that exists outside the parameters of normative gender and sexuality. Despite its ostensibly progressive sensibility, *Girls* contributes to this centuries-long discursive lineage in which mentally ill women are magically cured by the normalizing force of heterosexual romance.

At the same time, other millennial romantic comedy programs deconstruct the romanticization of mental illness, and explicitly critique it as a means of further regulating subjects into normative ideas about gender, sexuality, and ability. Because *You're the Worst* rejects teleological narratives of both mental health and romance, it defies the idea that one's mental health status is bound to one's relationship status. This enables more complicated depictions of what it means to be a mentally ill subject in the context of a romantic relationship (as well as what it means to be in a relationship with a mentally ill subject). This exploration of mental health and romance is couched within a

broader critique of heteronormativity as a maddening force in its own right, especially for women. Similarly, *Crazy Ex-Girlfriend* interrogates the production of romance as a cure for women's mental health as a collision of sexism, ableism, and heteronormativity. The series thoroughly depicts mental health impairments as lived experiences, but still critiques the cultural production of mental illness, presenting the label of "crazy" as a gendered, sexualized by-product of mental illness stigma. Its protagonist is demonstrably mentally unstable, but her impairments are amplified by a context in which the directives of normative subjecthood -- in her case, to be a woman who is both materially successful *and* heteronormatively desirable -- construct an idealized image of mental health that is impossible to comply with.

Collectively, these three series depict the intersectional production of gender, sexuality, and mental health and the regulation of the recuperable, non-threatening figure of the mentally ill, heterosexual, white woman. Where the previous chapter explores the discursive production of gendered and sexualized subjects who are presented as always already deviant and thus automatically mentally ill, this section reveals the way in which attaining the trappings of normative subjecthood is discursively constructed as a cure for those who are not automatically excluded from the parameters of mental health. Middle-class, able-bodied, heterosexual white women are not centered as normative, rational subjects, but they are nonetheless recuperable figures within the social body. While mental illness is discursively feminized, these women are not so far beyond normative subjecthood that they cannot be brought back into its fold -- in this case, through participation in a heteronormative relationship. As such, cultural discourses of women's mental illness typically produce heteronormative commitment and mental illness as

mutually exclusive entities: a mentally ill woman subject is neither lovable nor desirable; a respectably loved and desired woman subject is a normative and stable one, and thus a mentally healthy one. While this romanticized "cure" may read as cultural rather than explicitly medical, it nonetheless depends upon medicalized frameworks for understanding mental illness as an individual failure of productivity and/or reproduction that can -- and must -- be permanently cured, whether by enfolding the recuperable subject into normative subjecthood or by rejecting the always already deviant subject from the social body to which they pose a threat.

CHAPTER THREE:

"It's Hard to Watch, but it's Real Life": Fascination, Discomfort, and Empathy in Mental Health Representation on Unscripted Television

As the previous two chapters explore at length, regulatory discourses and practices of gender and sexuality heavily influence the content of contemporary mental health narratives; however, these discourses and practices also shape the affective dimensions of the production and consumption of these narratives. Mentally ill subjects incite a mix of empathy, concern, fascination, and fear -- sometimes all at the same time -- and these responses often hinge on viewers' perceptions of which particular subjects get to be mentally ill and how mental illness manifests in different subjects located in particular contexts. While these factors are at play in scripted narratives as well, this chapter uses unscripted narratives of mental illness as a case study for understanding the affective dynamics of particular mental health narratives. These dynamics reveal cultural perceptions of particularly located mentally ill subjects as worthy of fascination, empathy, and/or shame -- perceptions which take shape in relationship to normalized discourses of gender and sexuality. My analysis here is grounded in an assumption that unscripted television is both like and unlike scripted television; though viewers understand that "unscripted" television is in fact heavily produced, they also understand that the people on screen are not actors performing lines, but subjects behaving in exaggerated, but ostensibly authentic, ways. This real-but-not-real framing shapes viewers' affective responses as they consume unscripted television narratives. On the one hand, it is thrilling to watch real people act in those deviant ways viewers know they should not but sometimes wish they could behave. On the other, viewers soothe

themselves by believing that such behavior is heavily produced into an entertainment narrative and thus does not have real interpersonal or psychological stakes.

This balancing act, performed by both producers and consumers, incites a particular mix of fascination and horror in viewers that intensifies when unscripted narratives depict topics related to mental health, including nervous breakdowns, acts of traumatic violence, and even suicides. As in scripted television, these mental health events do not operate on assumptions of a universal mentally ill subject, but are embedded within a broad assemblage of forces that discursively produce and biopolitically regulate an intersectional formulation of normative, mentally healthy subjecthood. Moments like *Real Housewives of New York*'s Scary Island episode, *Real Housewives of Beverly Hills*'s second season, and Chad Johnson's appearance on *The Bachelorette/Bachelor in Paradise* sit within this complicated assemblage, and viewers' alternately fascinated, empathetic, and repulsed responses reveal the affective dimensions of the assemblage of complex biopolitical and discursive practices that differentially regulate and exclude mentally ill subjects based on intersectional formations of gender.

Theorizing the Production of Mentally Ill Subjects on Unscripted Television

Unscripted television series in the U.S. are built around cultural discourses of mental illness. Some unscripted shows, such as *Intervention*, *Hoarders* and its many knockoffs, and daytime self-help/counseling programming like *Dr. Phil*, make the mental health industry itself their subject. Despite this professional medical veneer, such shows ultimately depend upon and make a spectacle of their participants' mental illness -- just like unscripted shows that are not explicitly *about* mental illness but nonetheless center

cultural discourses of madness. These unscripted shows deliberately seek out participants whose erratic, unpredictable behavior will generate conflict and draw viewers' attention. In both these narrative approaches, unscripted television treats mental illness as both a plot device and a spectacle.

Yet not all mental illness on unscripted television is narrativized or spectacularized in the same way; the ways in which it is framed by producers and interpreted by viewers is shaped by broader social and cultural discourses. Like many scripted programs, unscripted television typically represents mental illness as a feminized formation. Men on unscripted television are not always presented as rational, normative subjects, but the spectacularization of women characters' distress is a hallmark of the genre. As in fictional narratives, women's instability is is often amplified by compulsory heterosexuality. Franchises like ABC's *The Bachelor* and Bravo's *Real Housewives* frame their most erratic characters as desperate for love from a male partner, whether that desperation takes shape in the context of a new relationship with a stranger who is dating twenty-plus other women on television, or within a troubled marriage. Unscripted television is not exempt from the racial politics of scripted television, and therefore it also represents mentally ill subjects as predominantly white because its casts are overwhelmingly white. Unscripted casting often reflects network assumptions about the racial demographics of the audiences. Competitive unscripted shows also try to mirror the assumed racial makeup of their audiences. Skills-based competitions[31] like Bravo/Lifetime's *Project Runway,* Bravo's *Top Chef*, and Logo's *RuPaul's Drag Race*

[31] While competition series feature representations of/discussions about mental health, these moments are often initiated by participants who are grappling with representing their own mental health experiences in their creative work, and they feel less extractive than unscripted television's usual approach to presenting instability as entertainment.

increasingly feature casts that actually look like the U.S. In contrast, the *Real Housewives* franchise is overwhelmingly white -- save for the Atlanta, Potomac, and canceled Miami franchises -- and dating competitions are notorious for casting a handful of competitors of color who are eliminated early and barely appear on screen[32].

Although unscripted and scripted series are grounded in the same set of discourses that produce mental health as both an intersectional social formation and a site of biopolitical regulation, one glaring difference exists between the two that impacts how audiences interpret their narratives: unscripted television features real people, ostensibly behaving in genuine ways (although often within unusual or extreme circumstances), where scripted television features performers playing fictionalized roles. Viewers do not, however, understand unscripted series as objective truth in the way that documentaries, non-fiction writing, and investigative journalism are. As John Corner (2002) notes, unscripted television is not field observation but a controlled experiment that "... build(s) its own social [world] precisely for the purpose of revealing the personal" (104). Audiences are cognizant of the means by which unscripted television production constructs its contexts (Sender, 2015), and producers know that viewers are in on the experiment. Programs satirize their own reliance on predictable narrative formulas, and characters provide meta-commentary about the surrealness of their filmed lives.

Yet this meta-framing coexists alongside the fascination and appeal viewers find in watching real people, not performers, on screen. Many theorists' attempts to

[32] Rachel Lindsay, a black attorney from Texas and the star of 2017's season of *The Bachelorette*, is a rare, recent exception to this decades-long rule. However, her season recorded some of the lowest ratings in the show's history, which creator Mike Fleiss described as a "disturbing" trend that "revealed something about our fans" (Angelo, 2018).

understand this appeal boil it down a "guilty pleasure" that comes from either engaging in simple nosiness about others' lives or mobilizing aesthetically-motivated class envy toward those on screen. But I believe something more complicated is at hand in the consumption of unscripted television. Certainly, an element of voyeurism undergirds this continued gawking at the chaotic, dramatic lives of other real people -- but to frame it as voyeurism alone undersells the extent to which narratives produce unscripted television characters' deviant, unstable behavior as something viewers wish they could do or say themselves but do not because internalized biopolitical regulation holds us back. As Anna Dorn (2017) writes in response to Lauren Collins's *Real Housewives* portrait exhibit, these "crazy" behaviors often express strong, conflicting emotions that women are usually shamed into keeping inside or making palatable. Viewers do not gawk at these characters as caged animals viewers gawk at, but see their outbursts as extreme, cathartic manifestations of impulses women normally repress. Witnessing these moments inspires a mix of empathy, repulsion, and fascination that intensifies when mental health events take shape on screen; analyzing these unscripted texts offers a more complicated understanding of the production and consumption of narratives of gender and mental illness today.

"You Need to Get Help": Participant Breakdowns on the Real Housewives and Bachelor Franchises

The surreality of Bravo's *Real Housewives* franchise has drawn in viewers for over a decade. Since the introduction of *Real Housewives of Orange County* in 2006, the show has expanded into nine U.S. cities, eight spin-off series, and a handful of

international installments. Every season of each franchise constructs a loosely-scripted narrative out of footage of characters' family and social lives and talking-head interviews that provide context and commentary. The season finale is a multi-part reunion episode, wherein performers look back on the major events of the season. The casting structure for each franchise's participants is also identical: find anywhere from five to eight ostentatiously wealthy women[33], the majority of whom operate outside any standards of socially acceptable behavior. (In fact, this is a more important casting requirement than being a housewife; many characters are not married and have jobs outside the home.) The selection and production of these characters deliberately incites conflicts, bizarre statements, and dramatic moments that are immortalized in marketing campaigns, fan discourse, reaction .gifs, and merchandise.

This handful of erratic characters is offset by one (sometimes two) level-headed character(s), who is a commentator and audience mediator -- as well as an embodiment of the neoliberal ideals of emotional and economic self-sufficiency and empowerment that underpin cultural images of mentally healthy women in media. In her engagement with other characters on screen and in her talking head narratives, she offers the viewer a point of entry into imagining what it would be like to be a participant in the series without acting as an instigator or counter-puncher in its conflicts and crises. Though this is not always the case, her social location is often closer to that of the assumed audience of her franchise -- she is often single and less wealthy than her classmates; though in some cases, she is older, wiser, and more materially secure. Regardless of differences in age,

[33] Despite the franchise's attention to wealth, several cast members have had financial/legal issues related to the conspicuous consumption that undergirds their televised image. (In particular, *Orange County*'s recession-era seasons are a dark look at the housing market crash.)

class, and marital status, she is invariably more educated, economically self-sufficient, and put-together than her castmates -- both aesthetically and emotionally -- and, as such, she is always already worthy of the audience's empathy.

She is also always already positioned as a foil to those characters deemed most "crazy," and one of the best examples of this is the conflict between Bethenny Frankel and Kelly Killoren Bensimon during *Real Housewives of New York City*'s third season. Bethenny, a fan favorite in her first stint on the show, perfectly fits the archetype of the audience proxy. Observant and self-sufficient, Bethenny is single but looking, and thus financially dependent on her cooking business rather than an inheritance, a wealthy partner, or alimony. In contrast, former model and present-day socialite Kelly, who seems to live off divorce settlement money, is one of the franchise's most notorious eccentrics. In her first scene, Kelly goes on a leisurely jog through Fifth Avenue traffic -- and this is one of the least bizarre things she does in her three seasons. Kelly offers a constant stream of entertaining and mystifying moments, from scrambled idioms, to announcements that she does not lend her name to charity event sponsorships, to explicit declarations that she is superior to Bethenny.

The conflict between the rational, self-sufficient Bethenny and the erratic, self-righteous Kelly reaches a boiling point during the cast's trip to St. John -- fondly known to fans as "Scary Island". Throughout the vacation, Kelly's behavior grows increasingly bizarre and unpredictable, crossing the line from standard *Real Housewives* eccentricity to the first (filmed and aired) mental health crisis on any *Real Housewives* series. Mental health representation is not unusual for the New York cast; more so than in any other city, characters regularly talk about mental health impairments and personal traumas, and

film scenes in their couples' counseling and individual therapy sessions[34]. However, this familiarity with mental health in general did not seem to equip the show to handle Kelly's breakdown: the series aired the footage but avoided acknowledging what happened despite viewers' concern about and critique of the treatment of a mental health crisis.

While the network shied away from assigning any sort of coherent narrative to what happened, the footage itself makes it hard to dispute that Kelly's behavior could be explained by anything but a mental health episode of some kind[35]. Throughout the Caribbean trip, Kelly blurts out phrases that have no relationship to the conversation at hand, insults her co-stars (more than usual), and becomes paranoid that they want to cause her physical harm. In "Sun, Sand, and Psychosis," she tells Bethenny, a professional chef, why she is not a chef ("chefs don't chop, but cooks do"); repeatedly shouts the phrase "satchels of gold"; and cries after interpreting Bethenny's conciliatory gift basket as an act of aggression. While others brush this off as typical dramatic behavior from Kelly, Sonja Morgan -- another rational audience-proxy character -- grows concerned that Kelly is having a mental health crisis. Sonja's theory is proven at that

[34] The ethics of this are murky. According to Leah Prinzivalli (2016), some therapists see their filmed therapy as a means to destigmatize mental health and encourage viewers to seek out talk therapy, while others are contracted by networks to fulfill very specific narrative purposes. Stephen Galloway (2013) also notes that not all television therapists ensure that their patients can access mental health care off-camera. Furthermore, it is impossible to measure the impact of a camera and production team's influence on participants' behavior, and thus difficult to gauge the efficacy of filmed therapy. I personally believe that therapy scenes included in the texts discussed throughout this chapter are semi-scripted; they often frame the narrative arcs of the season, much like talking head interviews.

[35] Other performers have offered a nervous breakdown, substance use, or prescription drug side-effects as possible explanations for her behavior. However, Kelly has alternately described it as "a breakthrough, not a breakdown" (Rosenblum, 2010); the consequence of bullying from her co-stars (Harnick 2015); and something she performed because "crazy sells" (Morissey, 2010).

night's formal dinner party, in which Kelly accuses Alex McCord of channeling vampires and the devil, and then claims that Bethenny is made of knives, that she has tried to kill her, and that she has slandered Kelly's young daughters in the press.

Bethenny initially interprets this accusation as part of a standard-issue *Housewives* feud and a new chapter in Kelly's year-long conflict with her, and thus tries to reason with Kelly and defend herself. However, she gradually realizes that Sonja's concerns about Kelly's mental health are legitimate. The final exchange of the night -- stretched out over twenty minutes -- reflects Kelly's paranoia and erratic behavior, Sonja's attempts to maintain some semblance of order, and Bethenny's gradual acceptance of Sonja's interpretation of Kelly's behavior:

> *Kelly, to Bethenny:* I just want to tell you what this truth is.
> *Bethenny:* What is the truth? I want to hear the truth. Be quiet. I want to hear the truth. "You can't handle the truth." I can handle the truth.
> *Kelly:* Oh my god! Al Sharpton! Al Sharpton! Put your hair up, it's Al Sharpton!
> *Sonja [in talking head interview]:* … It's getting really weird now.
> *[Cut to the dinner party with a shot of Ramona chugging a glass of white wine, wide-eyed, then cut to Kelly.]*
> *Kelly:* Why do you keep saying it? Over and over again. Just keep saying it. Like mantra. Go ahead. Keep saying it… You know what, this was a really lovely evening and I had a really lovely time. I'm gonna excuse myself like an adult and then I'm gonna come back and I'll have shots later… I am a woman and I have a prerogative.
> *Bethenny [in talking head]:* I think Kelly is incredibly paranoid, incredibly delusional…
> *[Cut back to Kelly at the dinner party.]*
> *Kelly, to Bethenny:* What about when you attacked Gwyneth, my friend Gwyneth?
> *Bethenny:* Who's Gwyneth?
> *Kelly:* Paltrow. And what about Rachel?
> *[Kelly abruptly leaves the table.]*
> *Sonja:* … She is damaged. Something has happened.
> *Bethenny:* What a nut bag.
> *Kelly, off screen:* Does anybody want a jellybean? Or a lollipop?

[Kelly returns to the table with a bag of jelly beans, continues to explain her theory that Alex and Bethenny are possessed by evil forces and out to kill her.]
Sonja: I feel sorry for Kelly now because something is clearly happening.
Bethenny, to Kelly: She feels sorry for you because she thinks you're crazy. Like she thinks something's wrong with you. Like you're absolutely crazy.
Kelly [eating jelly beans]: Okay. I'm crazy.
Bethenny: We all think you need to get help. There's something wrong with you.
Kelly: Yeah, because I don't like you.
Bethenny: That's not an illness.
Sonja: The four of us are actually sane, and she's crazy, and now we're picking on her, okay?
Kelly, to Bethenny: I feel like you're trying to kill me every night. And I threw up the night before I came, cause I don't want to be a part of this.
Bethenny: Go to sleep! Go to sleep! You're crazy. Go to sleep!
Sonja: No, don't be mean to her…
Kelly: I am so tired. I'm taking my lollipops and my gum berries --
Sonja: She has a chemical imbalance or something… [to Kelly:] You think she's going to kill you and you think she's a vampire. We need to protect you now, okay?
Bethenny: Kelly. I am not going to attack you. I am not after you.
Kelly: You've been after me since day one.

Bethenny grows calmer throughout this conversation as Kelly grows increasingly inconsistent and unclear, causing Bethenny to realize that she cannot take Kelly's behavior personally. The dinner party concludes with a heartfelt apology from Bethenny, which Kelly ignores. Production staff flies Kelly back to New York City in the middle of the night -- and quickly diverts focus from her breakdown with a surprise appearance from Jill Zarin, who was not invited on the trip -- and she only appears intermittently throughout the few remaining episodes of the season.

The decision to air so much footage of a woman in the throes of some kind of mental health crisis and then to pretend it never happened was disorienting. The episode drew a wide range of responses from viewers, most of who seemed to empathize with Kelly and feel that the spectacularization of her mental health was ethically wrong. Some

felt that producers should have removed Kelly from the situation sooner; others thought the lack of producer intervention proved that the breakdown was staged, while some felt her behavior proved that the series is entirely unscripted; and some were simply entertained whether the breakdown was authentic or not. The show itself offered little clarification or explanation to resolve the debate: In the season-finale reunion, host Andy Cohen asks Kelly only one question about the vacation, then abruptly moves on. While the series often relies on flashbacks to contextualize participants' relationships to one another, the show did not re-air footage of Scary Island until 2015.

However, the network came to reacknowledge Scary Island after viewers came to understand Kelly as a recuperable mentally ill subject whose material and social stability ultimately outweighed her moment of crisis and instability. Kelly's breakdown has had a long and vibrant afterlife among *RHONY* fans, and the debate around the episode has largely settled into acceptance, if not love, of it. Because Kelly has not publicly experienced any further mental health challenges, viewers now see her as a subject who only temporarily deviated from stability. Within the broader context of the series, Scary Island reads quite literally as an episode, with a clear beginning and ending. It is a small disruption within an otherwise financially and personally secure adult life, not an indicator of a deep, lifelong struggle to manage one's mental health, and thus, viewers can treat it as an object of fascination rather than a source of concern.

Furthermore, because Kelly was struggling with a breakup at the time of her meltdown, audiences expect at least a little bit of instability from a woman such a particular position. This shift speaks to how middle- and upper-class white women are centered in mental health discourse. Though the feminization of mental health is

troubling, it also enables the recuperation of those mentally ill women who are closest to normative subjecthood -- white, materially secure, heterosexual -- when they abide by the regulatory expectations of their social position. Yet viewers' shifted perceptions of Scary Island may have as much to do with Kelly as a subject than unscripted television as a context for the production of mental illness discourse. Kelly's breakdown is not only not a permanent state, but it also seems tame in comparison to later mental health events on other unscripted series. Whether it is a matter of subject, context, or some combination thereof, Scary Island lives on as an iconic *Housewives* vacation incident because, despite the name, it is ultimately not that scary when contextualized against the rest of the unscripted television landscape.

Like the *Real Housewives* docu-series, ABC's dating competition *The Bachelor* relies on character archetypes to familiarize the audience with the women vying for the prize of heteronormative monogamy -- and the most notorious of these is the Crazy One. In early seasons of *The Bachelor*, this archetype was marked by an uncomfortable desperation to be loved, but the show has reframed the role as a comedic one, grounded more in a lack of awareness of social norms than any distinct mental health impairment. Their oddball behavior provides a foil to the season's star as well as the competition's front-runners, who are relatable and level-headed. While it might be more accurate to label these characters as "weird" or "silly," it is telling of both the series and mental health discourse at large that the series relies on "crazy" as a descriptor. In recent seasons, designated "crazy ones" have referred to themselves exclusively in the third person, delivered impassioned monologues about onions, and blamed their inappropriate behavior on "thick ankles". They are eliminated in the middle of every season, when "the

bachelor's dislike for/fear of her becomes too painfully obvious for even the most optimistic of audience members and he is allowed to send her home" (Schechet, 2016). However, in the weeks leading up to their elimination, the Crazy One occupies a major share of screen time -- a priority for those contestants who want to gain public exposure in order to monetize their social media presence (see Jones, 2017 and Wakim, 2018 for an overview of the influencer economy). These multiple factors make it difficult to tell whether the women assigned the role are consciously performing inappropriate behavior, edited to seem erratic, or authentically bizarre.

Of course, this particular image of "craziness" hails broader cultural discourses that produce women who are not heteronormatively desirable as unstable subjects. Yet while this trope is often dependent upon feminized discourses of madness, the role of the Crazy One is not limited to women, as evidenced by Chad Johnson, a contestant on the 2016 season of *The Bachelorette*. Chad's narrative arc and viewers' responses to it track with broader discourses of white masculinity and mental illness. When his actions are eccentric but not unpredictable, he is automatically assumed to be a rational subject who is performing unspecified "crazy" behavior for strategic reasons; once he crosses a line into unstable harassment and violence, he is abruptly assumed to be a dangerous subject who poses a threat to his community and must thus be extricated from it. He transitions quickly from being an object of entertainment and fascination to being an object of fear, and both are dependent on his positionality as a straight, white man. As an object of entertainment, viewers assumed he was rationally self-presenting as "crazy"; as an object of fear, he validated broader cultural assumptions that white men act violently due to mental illness. Though the latter assumption is factually inaccurate (Horwitz, et. al.,

2015), it nonetheless reveals how designations of deviance depend on the social location of the subject in question -- as well as what subjects who are centered as rational, normative subjects must go to be recognized as such.

Chad's odd behaviors are clearly performative early in his time on the franchise. In one episode, he goes to town on a giant plate of cold cuts and eats a sweet potato like an apple during an elimination ceremony while making direct eye contact with the camera. In addition, some of Chad's behaviors are only deviant within the universe of the show. His co-stars malign him for saying that he will not declare his love for the bachelorette when he's only spent a few minutes alone with her and barely knows her. Though an act of defiance against the show's unstated rules, this is, by general societal standards, one of the most rational and level-headed sentiments spoken on this franchise. Similarly, Chad is socially ostracized for picking apart the insecurities of anyone who dares to confront him, such as Alex's height, Evan's physical weakness, and Jordan's failed football career. Yet even his most callous comments can't be written off as irrational. As Ali Barthwell (2016) notes, Chad's statements are neither incorrect nor unprovoked -- they're just inappropriate. Any viewer's reservations about whether Chad is performing a strategic role are resolved by the time he is eliminated from the show. In a scene accompanied by a horror-film score and a declaration from Chad that "life ain't all blueberries and paper planes," the show's tone turns so meta that viewers are clearly meant to understand that Chad and the production are working together to produce an entertainingly unpredictable character.

Capitalizing on audiences' entertained responses, producers decided to bring Chad onto that summer's season of *Bachelor in Paradise*, a limited series in which ex-

Bachelor/ette contestants pair off with one another while day-drinking at a beach resort. Though his reappearance on *Paradise* comprised the bulk of the show's marketing, Chad does not last long -- nor does the show's constructed narrative of his instability as a source of entertainment. Within hours of arriving at the resort, Chad drinks too much, slaps and body-slams co-star Lace while kissing her and calling her "a fucking bitch," tells co-star Sarah to "keep sucking on fame's dick" after she confronts him about his violence, and eventually passes out. The physical violence -- shown via security footage rather than a human-operated camera -- is unsettling, and his verbal attacks, unlike this call-outs during his *Bachelorette* season, offer no insight, just cruelty. The following morning, host Chris Harrison convenes a meeting about Chad's behavior, and the cast agrees that they feel unsafe around him and he is sent home. He continues to drink in the limo that takes him off-set, and this is the last viewers see of Chad.

While Chad's misogyny did not win him any admirers, it is ultimately his violent actions that incited discomfort and fear in his colleagues and the audience, forcing his elimination from the show. Every erratic behavior up to the line of physical violence is not just acceptable but desirable entertainment. However, thinking retroactively through his time on *Bachelor in Paradise* raises questions about whether producers and consumers preyed on his instability for entertainment; as culture writer Ben Lindbergh notes, "I still haven't decided whether [Chad] was exploiting TV's reality landscape or being exploited by it" (2016). The total lack of acknowledgment that followed his departure from *Paradise* reads as an effort to shy away from culpability -- both for the harm Chad enacted on his co-stars and the harm that appearing on the show may have

done to him. It is also a jarring contrast from the network's prior reliance upon his unpredictable actions as both a central narrative and a marketing tool.

The production's approach to managing Chad is echoed in viewers' responses: first he functions as an object of entertained fascination; then he is a source of fear whose deviance can only be disciplined by removing him from the social body. While Kelly's *RHONY* crisis is alarming, at no point does her behavior make the viewer fearful; this is the significant difference between her Caribbean breakdown and Chad's, and it is a profoundly gendered one. Chad's white masculinity grants him the assumption of self-awareness when he is acting as the Crazy One, but it also constructs how he is perceived as a threatening mentally ill subject. The deviant behavior of heterosexual white men is always already attributed to mental illness, regardless of whether they have mental health impairments (Metzl and MacLeish, 2015), and the possibility of unpredictable violence is the core of the discursive production of white, masculine mental illness. Mentally ill straight white men do not exist outside the gendered, sexualized, and racialized expectations of the normative subjecthood they are granted. Rather, they take the expectations of hegemonic masculinity -- impulsive/risk-taking behavior, physical strength, and domination over women and less stereotypically masculine men -- to such an extreme point that it counteracts the assumptions of stability and rationality that have been previously and otherwise granted to them by virtue of their social location.

"You and I probably have similar problems": Controversy, Empathy, and Discomfort in Real Housewives of Beverly Hills

One of the most uncomfortable examples of the gendered affective dimensions of madness on unscripted television is the second season of Bravo's *Real Housewives of Beverly Hills*. Russell Anderson, estranged husband of star Taylor, committed suicide just weeks before the show's second season premiere in 2011. Russell's death was preceded by financial and legal business issues, as well as domestic violence allegations from Taylor. Because Bravo filmed footage of the months leading up to his death, many viewers (and some of the show's participants) believed that the season should not air. Some argued that Anderson's suicide proved that unscripted television as a whole is toxic, attributing his death to the industry's unregulated, stressful filming conditions and/or its inadequate compensation of participants[36]. Others identified it as a consequence of the genre's reliance on unstable behavior, an event that marked "the extreme end of a business dependent on people with deep flaws, clinical phobias, and other psychological issues" (Galloway, 2013). Yet, despite these (valid) critiques, audiences still watched, and responded with a mix of empathy and discomfort that crystallizes how and why viewers come to see particular unstable subjects as worthy of recuperation into the social body.

Bravo edited certain events out of respect for Russell's family, and the season opened with a scene in which all the cast except Taylor discusses Russell's suicide and their reactions to it[37]. The network included mental health and partner violence public

[36] While principal characters are compensated for appearing on *Real Housewives* (and that compensation has increased over the franchise's tenure), details of whether the network also pays their partners, children, and other family members are murky.

[37] As of 2017, this discussion scene is not included on streaming platforms that host the show, so a first-time/unfamiliar viewer would have no knowledge of Russell's death until the season-finale reunion special.

service announcements during commercial breaks. While there is no account of all the revisions Bravo made, those who watched the original version of the season premiere report that editors removed a scene in which Taylor shops for lingerie while discussing her stagnant marriage. Julie Klausner argues that these edits were designed "to not make the entire series look like a ghoulish, *Memento*-like docu-soap about what happens when you can see something dissolving horrifically and know full well how it will end" (2011). Despite Bravo's best efforts, Klausner's description fully encapsulates the discomfort of watching the season; it is impossible to ignore Russell's suicide, and the network's attempts to assuage the viewer's discomfort about this in fact amplify it.

One key site of the production's obvious, uncomfortable reshaping of the narrative surrounding Russell's death emerges through its inconsistent handling of the materiality of class. In season one, the show focuses obsessively on the Andersons' wealth and consumption, and implies that Russell has to work the long hours that strain their marriage in order to support Taylor's spending habits. To be clear, the Andersons are not the only members of the Beverly Hills cast whose finances are spectacularized; class is, as most academic analyses of the franchise have noted (see Cox and Profitt, 2012; Wu and McKernan, 2013; Cox, 2014; Squires, 2014; Dominguez, 2015), the central theme. However, this consistent -- if not aggressive -- glamorizing of characters' wealth only makes the absence of any attention to the Andersons' finances all the more obvious in season two. There are no lingering shots of their expansive real estate, no scenes of Taylor shopping for designer clothes, and no references to Russell's work. This absence unwittingly draws attention to the circumstances surrounding Russell's death; he was in serious legal/monetary trouble, and his business partner committed suicide shortly

after he did. Even a viewer who lacks this context would notice the sudden shift -- especially in contrast to the show's continued attention to the wealth of Taylor's co-stars -- and find it uncomfortable.

On top of this sudden avoidance of the Andersons' finances, the series drastically changed its handling of mental health, acknowledging it openly where it previously avoided direct engagement. Much of season one dances around former child actress Kim Richards's struggles with mental health impairments and substance abuse, but in season two, Kim openly speaks about her health, and Taylor spends much of her screen time trying to handle her personal and marital struggles, participating in both individual and marital counseling sessions[38]. Taylor's approach to mental health reflects normalized discourses that hold affluent white women as their central subjects: she emphasizes self-care practices such as talk therapy, but validates self-care primarily by positioning it as a way she can better fulfill the gendered expectations of her social location. This self-positioning produces Taylor as empathetic: even though she is unstable and sometimes behaves deviantly, viewers can identify a clear source for her behavior, and she expresses an explicit wish to better adhere to the normative expectations of her social location.

Broader discourses of gender and mental illness are explicitly depicted in the season's inaugural dinner party fight, which takes on the validity of therapy and marital counseling after Taylor says, "I'm deep in so much psychotherapy that I'm sick of myself." In response, Ken Todd, self-described "old English man," announces that he

[38] As in the case of the talking head interviews that help frame the season's narrative arcs, it is possible that some of Taylor's individual counseling scenes were filmed after Russell's suicide and edited into the season. (In particular, there is one bizarre scene early in the season in which a completely different therapist visits Taylor for an in-home individual counseling session. This therapist is never seen before or again.)

would never go to therapy or marital counseling. Kyle tries to deflate the conflict by saying that it's normal for men to be wary of therapy -- a claim that contextual data reinforces (Kuehn, 2006; Gast and Peake, 2011; NIMH/CDC, 2014; Holland, 2015), especially for older adult men (Kuehn, 2006). Ken doubles down on his therapy-averse stance and says he wouldn't want his wife Lisa Vanderpump to go to therapy because it would make him "feel weak." While intended as a rebuke to Kyle, it reinforces her claim about men's wariness around therapy as grounded in a fear of seeming vulnerable and thus unmasculine. Taylor, however, interprets Ken's comments as a personal slight; in a talking head interview, she asks, "Did he just call me weak? For working on my mental health and trying to save my marriage for my child?"

This argument plainly illustrates cultural discourses of gendered mental health stigma, but it also hails a more subtle set of discourses about class and mental health. As Lauren Squires (2015) notes, material status is not the sole mechanism through which the franchise marks elite class status; the performance of effortless stability in one's health and one's family life is also key to appearing elite. Taylor's acknowledgment of the effort she puts into her familial and personal life defies this norm, but the season frames this in an empathetic light by emphasizing her stated goal to preserve her marriage and her family -- a purpose that upholds the nuclear family-centering cultural expectations of femininity and heteronormativity and the centrality of family stability to elite class norms.

Taylor's mental health concerns are rarely framed as a matter of individual health, but rather an effort to better uphold the heteronormative nuclear family and the gendered expectations that undergird it. One brief exception to this classed and gendered framing

of Taylor's mental health takes shape during the cast's trip to Aspen when Taylor has a few glasses of wine and experiences something she describes as both a "breakdown" and a "panic attack." She spends the evening alternating between bursting into tears, confessing her fears of being alone and financially unmoored, and shouting things like "I don't want to be the crazy fucking bitch." In their talking heads, her co-stars describe her as "broken" (Kyle), "disoriented" (Adrienne), and "irrational" (Lisa). While each of Taylor's co-stars attempts to stabilize Taylor, Kim is the only one who succeeds, gently reassuring Taylor that she does not have to fear being alone because she is capable of taking care of herself. Taylor acknowledges Kim's empathy, realizing, "You and I probably have similar problems." Kim replies that "Everyone has something inside that hurts them." This depiction of empathy on screen -- not bound at all to Taylor's position as a wife and a mother, but as a human person -- is not only the polar opposite of the prior judgmental conversation about therapy, but it also incites further empathy for Taylor (and by proxy, Kim).

At the same time that Taylor's mental health experiences are treated with respect and empathy, however, Russell is largely excised from the season, and his appearances are profoundly uncomfortable to watch. He does not appear until the ninth episode, and he never appears outside the contexts of a couples' counseling session or a party. In an echo of the season's silence around the Andersons' finances, the show's attempt to avoid the subject of Russell only draws attention to his absence and the reasons behind it, and the silence around his passing echoes a broader cultural erasure of and discomfort around men's mental health that ultimately reinforces the intersection of mental illness stigma and normalized masculinities.

The futility of this attempt to avoid making the audience uncomfortable is never more apparent than when the show skirts the topic of Russell's alleged physical abuse. The abuse allegations are a frequent subject of conversation among the rest of the cast, who vacillate between believing wholeheartedly that Russell is physically abusive to hedging on the topic because they've never witnessed his abuse themselves. It's unclear if these events were ambiguous at the time -- though it's entirely possible that they were -- or if the ambiguity was a constructed effort to avoid tarnishing the reputation of someone unable to defend himself against these allegations. Regardless of the reason, watching the cast dance around such a troubling topic makes for uncomfortable viewing of Russell, especially when paired with the way that the series amplifies viewers' empathetic response to Taylor's situation.

The best example of this discomfort takes shape during the season's largest and final fight, which begins during a lunch party conversation about the Andersons' marriage and Taylor's mental health. Camille -- another voice-of-reason figure -- breaks the unspoken rule of either avoiding or waffling on the subject of Russell's abuse, yelling, "We've all been protecting you because we don't want to say that he hits you! Because we don't say that he broke your jaw or that he beats you up and he hits you. We don't say that! But now we said it." This defiance of unspoken social norms is shocking from the typically serene Camille, and it sparks a chain of conflicts: Taylor is furious at Camille; other characters claim she only repeated things Taylor said; and Taylor characterizes the comments to Russell as "exaggeration" when he calls them "lies." Taylor's anger grows to such a point that she has to be physically restrained while screaming at Camille at a beach house party. Camille accepts Taylor's anger but does not

react to it, but this does little to diminish the conflict. Russell emails Camille threatening to sue her for "false and slanderous statements that could damage [his] business." Taylor decides to separate from Russell a few days later, and the season ends with her explaining this to her co-stars[39].

The emotional stakes of this trajectory of events is straightforward on paper: voice-of-reason Camille's comments are honest; Taylor is in a challenging, if not impossible, position; Russell is cruel to every main character at some point in this saga, especially his wife. Yet where *RHONY* marinates in presenting Bethenny as rational and Kelly as unstable, *RHOBH* presents the conflict between Camille, Russell, and Taylor with a gotta-see-all-sides approach. Much like the sudden silence around the Andersons' material lives, this attempt at distance from on-screen events again only serves to amplify the viewers' discomfort with the events unfolding. While Kim's empathetic reassurance of Taylor in Aspen seems to validate the argument that unscripted television's reliance on mental health can be a force for destigmatization, the season as a whole projects ambiguity and obfuscation onto a rather straightforward series of events. In doing so, it ultimately reinforces rather than subverts contextual cultural discourses of gender and mental health. Taylor (and, to a lesser extent, Kim) is presented as unstable in distinctly feminized ways, and her effort to manage it is validated because it is framed as a desire to recuperate herself into the normative subjectivity expected of an adult white woman of her socioeconomic status. Her desire for mental health is couched almost entirely in a desire to be a good wife and mother who provides her children with an emotionally and

[39] This explanation is validated by Taylor's therapist, a white man, who accompanies her to explain this to her colleagues. Even when we are willing to understand Taylor as a mentally ill subject, because we are generally willing to understand women as mentally ill, that perception evidently must be validated by someone we see as a rational subject.

economically stable home. At the same time, the show does not grapple fully with Russell's mental health, and leaves the viewer imagining him as a figure much like Chad: an unpredictable, unstable, hypermasculine force that disrupts not only the heteronormative nuclear family, but the social body at large.

Conclusion

Where little thematic difference distinguishes intersectional discursive constructions of mental illness on scripted and unscripted television, viewers' perceptions of unscripted television as a distinct site of narrative production and consumption enable a distinct set of affective dimensions within representations of mental illness. On the one hand, viewers can see the cracks in the "unscripted" and "reality" labels; they understand that shows are heavily edited, that field producers manipulate participants, and that some series' plotlines are semi-scripted. However, this knowledge is complicated by the fact that viewers understand the people they see on screen not as actors reading lines, but real people behaving in authentic (albeit exaggerated for the viewer) ways -- and this balancing act becomes even more precarious when they see participants' madness depicted on screen.

While viewers are happy to identify with the rational, self-sufficient unscripted characters who function as voices of reason on screen, their responses to unstable, irrational participants are far more complicated. On the one hand, they are fascinated to see people openly defying the unspoken rules of appropriate behavior, and occasionally envious that they feel free to behave however they wish (Dorn, 2017). However, when it becomes clear that these defiant behaviors reflect mental health needs, viewers are placed

in an uncomfortable position, and their fascination with so-called bad behavior turns into empathy, discomfort, or some tenuous combination of both. These differing affective responses reveal the limits of what kinds of deviant behavior viewers are willing to accept as not-quite-normative in particularly gendered subjects: eccentricity is entertaining; excessive emotion is intriguing, especially in women; but unpredictability is unsettling and violence is unacceptable, especially when it comes from those normative masculine figures from viewers expect rational, stable behavior.

As the long aftermath of the Scary Island reveals, viewers can treat mental health crises as objects of fascination -- if not of entertainment -- so long as producers reassure them that there are no serious consequences for the mentally ill subject or those around them, and so long as the subject in question seems always already predisposed to a certain degree of irrationality or eccentricity. At the same time, viewers are repulsed and unsettled by those whose distress manifests on screen like Chad's and Russell's -- those whose instability seems to pose a threat to others -- especially when such threatening behavior comes from those privileged subjects they are conditioned to trust as rational and normative. Of course, neither fascinated nor repulsed responses are grounded in empathy. Viewers only grant identification to those unstable subjects like Taylor, whom producers present not only as driven mad by tragedy or trauma, but actively working to assuage viewers' discomfort by rehabilitating herself into compliance with the normative expectations of her gendered, racialized, and classed social location.

CHAPTER FOUR:

"This Place is Sick": Observation, Productivity, and the Postfeminist Feminization of Mental Illness

Mental illness discourse depends on productivity as a means for defining mental health and identifying and regulating mentally ill subjects of all subject positions. As many critical disability theorists and activists note, communities implicitly conceptualize physical ability as a normatively embodied capacity to participate in the productive and reproductive economies of their particular time and place (Garland-Thomson, 1997; Snyder, et. al., 2002; Wendell, 2001). Conversely, any embodiment that limits a particular subject from achieving normative expectations of productivity becomes disabling. This holds true in conceptions of mental health as well. Diagnostic criteria list a lack of productivity as a symptom of certain mental health impairments, especially depressive ones. Furthermore, mental health professionals use a subject's productivity to determine levels of impairment among people with the same impairments. As Esme Weijun Wang notes in her essay on living with "high-functioning" schizophrenia, "Having a job, among scientific researchers, is considered one of the major characteristics of being a high-functioning person" (2016).

The conflation of productivity with mental health is not limited to medicalized spaces. It has also emerged through more subtle cultural discourses which produce productive mental health impairments as less stigmatized or dangerous. Impairments that are marked by excesses of energy are often produced as desirable or fascinating because they can enable increased productivity, as Emily Martin's 2007 analysis of the discursive construction of manic depression reveals. These discourses of productivity shape

subjects' lived experiences with mental health impairments. Laura Turner (2016) writes that the value placed on productivity puts pressure on those with anxiety impairments to mitigate their symptoms by funneling them into labor -- or "to spin an anxious yarn into productive fabric," as she describes it. This pressure is paradoxically anxiety-inducing; whenever Turner cannot meet her own productive expectations, she feels more nervous about failing to produce work. These examples reveal that the conflation of productivity and mental health goes beyond medicalized discourses, and that it does not take shape in a neat, one-to-one correspondence in which one's level of productivity indicates one's level of emotional well-being.

However, two substantive themes remain absent from the discussion about the relationship between productivity and mental health. Theorists generally agree that this conflation takes shape because monetized labor is the primary means of assigning human value under late capitalism (Snyder, et. al., 2002; Wendell, 1989), and that acts of observation -- theorized through the concept the gaze (Mollow and McRuer, 2012) and/or the stare (Garland-Thomson, 2002) -- are fundamental to the production of disabled subjects. However, theorists have not fully articulated the interplay between the regulation of normative productivity and the use of acts of observation as a means of producing disabled subjects. I would like to consider in this chapter the ways that productive labor enables particular mental health discourses because functions as a discrete, observable phenomenon, something that can be tracked and quantified. It provides an external, observable behavior that can (allegedly) illuminate impairments that have been produced as invisible, interior, and impossible to fully understand. Of course, the observation and regulation of productivity is, like the observation and regulation of

mental health, a complicated, multilayered, and multi-institutional biopolitical practice. Observation is not just a state enterprise wherein an invisible governmental entity surveils subjects; it includes a wide range of visual practices enacted and enforced through multiple social institutions, as well as what Sebastien Lefait (2013) calls the catopticon, an expansive collection of informal peer-to-peer observation and internalized self-surveillance.

The second missing piece of the productivity-as-health discussion is that expectations for a given subject's productivity reflect their complex location within their particular cultural and historical context. Toward this end, this chapter analyzes how the contemporary feminization of productivity shapes depictions of the social surveillance of women's mental health. Postfeminist cultural discourses claim women are equal, empowered subjects whose gendered social location no longer limits their professional or personal options (Gill, 2007). In spite of these claims of social progress, contemporary constructions of mentally ill women do not differ dramatically from the Victorian production of mentally ill women as failed feminine re/productive subjects (Gilbert and Gubar, 1979). Women subjects must adhere to a particular set of gendered rules to establish their proximity to normative, rational, mentally healthy subjecthood, and others constantly observe their compliance with these rules. Social institutions and individual subjects scrutinize women's behavior in the formal, productive economy as well as in the private sphere, and women face tremendous pressure to perform perfectly the gendered labor expected of them both in their public workplaces and in their private lives.

This constant observation and judgment of feminized expectations of productivity is a maddening force, and the three narratives depicted in this chapter -- CBS's *The Good*

Wife, ABC's *Scandal*, and HBO's *Enlightened* -- represent the mental health impacts of the constant patriarchal surveillance women face. All three shows differ in their approach to these themes and engage with different social institutions. However, they each depict a woman struggling to find mental health within a context in which her adherence to feminized expectations of productivity is under constant scrutiny. All three rely on the notion of the strong female character but do not reinforce it; instead, they use it to open up an exploration of the gulf between contextual discourses of women's postfeminist empowerment and the distressing lived experience of contemporary womanhood. While all three deconstruct the image of the strong, empowered woman, they do not do this in order to suggest women are inherently weak, passive, or fragile like prior narratives of women's mental illness tend to do. Rather, they treat gendered distress as a logical, yet disabling, consequence of the interaction between women subjects and misogynist contexts that constantly scrutinize them against impossible standards of normative, productive femininity while claiming to be equal and progressive.

Observing the Deconstruction of Postfeminist Empowerment on CBS's The Good Wife *and ABC's* Scandal

Network legal dramas *The Good Wife* (CBS, 2009-2016) and *Scandal* (ABC, 2012-2018) both deconstruct postfeminist discourses of empowerment in their depictions of women who gain monetary and institutional power but can never escape patriarchal surveillance and regulation -- or its impact on their mental health. The first of the two series, *The Good Wife* offered viewers a fictionalized peek into the life of Alicia Florrick (Julianna Margulies), a woman who stands by her politically powerful husband Peter

(Chris Noth) after his sexual infidelities and criminal activities are exposed. The series begins with Alicia Florrick (Julianna Margulies) -- a white[40], middle-aged wife and mother who functions like a composite of Hillary Clinton, Silda Wall Spitzer, Elizabeth Edwards, and myriad other disgraced political wives throughout American history -- returning to business law after Peter's incarceration. What at first seemed like a fairly straightforward postfeminist narrative of a woman becoming empowered by paid labor quickly revealed itself as a critical feminist interrogation of the observation and surveillance Alicia faces as a feminized public figure. Over the course of seven seasons, the show gradually exposed this constant observation and scrutiny as proof of the failures and limitations of postfeminist empowerment discourse -- as well as a social and cultural force that slowly drives the women who live within it mad.

The show's attention to surveillance-related topics intensified each season; by the middle of its run, critics argued that the series was more about life in the contemporary surveillance state than it was a legal or domestic drama. Many reviewers praised its depiction of surveillance technology as nuanced and realistic (Bosch, 2013; Kumari Upadhyaya, 2016; and Nussbaum, 2012 and 2016), and tech journalists became enthralled with the show as well (Brown, 2016; Letzter, 2016; Thompson, 2013). *Wired*'s Clive Thompson went so far as to describe the series as "the best force for digital literacy in pop culture right now" (2013). However, these discussions of the show's approach to

[40] The show depends heavily on whiteness. Others always see Alicia as an innocent bystander in Peter's unethical behavior because she is a white woman; Peter's career bounces back from his incarceration in a way a man of color's certainly would not. However, beyond a few episodes that handle cases related to racism in the technology industry, the show struggles to grapple explicitly with race. This is disappointing given its setting in present-day Chicago, which plays a very particular role in American discourses of race, the law, and criminality.

surveillance often limited their scope to the show's depiction of state or technological forms of observation[41]. In fact, *The Good Wife* presents surveillance not an omniscient, invisible, governmental eye, but a set of formal and informal practices that have the potential to be both productive and problematic because they are enacted by fallible, socially located human beings. The best example of this lies in the show's depiction of the NSA: it is not an insidious evil empire, but a workplace mired in tedious bureaucracy and staffed by aimless millennials who are more invested in the personal dramas of surveillance subjects than their potential criminal actions. This strategy does not make the NSA seem more benign or comfortable than depicting it as Big Brother would; instead, it implicates the viewer's own curiosity about others' private lives as another form of surveillance[42].

In short, the series presents technology as a formalization of informal human behaviors of observation and regulation and technological progress as simply a new, occasionally more effective vector for old practices. This cynicism about narratives of technological progress feeds into its overarching critique of postfeminist discourses of empowerment and social progress. The show consistently depicts family, domesticity,

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[41] In some cases, surprise that a woman-centered show tackles technological topics -- as though a contemporary narrative about business law could avoid them -- unwittingly reveals the writer's gendered perceptions of who gets to own debates around technological and state surveillance.

[42] The show's intention to implicate the viewer as one of many watcher-figures is further reinforced in the show's later seasons, in which Alicia, in the throes of grief, becomes overly invested in a hilarious fictional sendup of a prestige anti-hero drama. (This running joke also winks to the way in which critics suggested Alicia was becoming an anti-heroine late in the show's run, and points out that "anti-hero" usually refers in critical discourse to a male protagonist who is a literal murderer, while Alicia was deemed unlikable late in the show's run mostly because she was depressed and not wild about raising teenagers.)

and sexuality as gendered sites of surveillance and regulation, revealing a world that is far more retrograde than the image postfeminist progress narratives construct. When the vast assemblage of surveillance technology is exposed and interrogated in legal cases, male characters are unsettled by their new knowledge of being the object of observation. However, the women around them -- especially Alicia -- are unfazed. They are inured to being watched and, in some cases, have internalized and reproduced the gazes to which they are subject, no matter how much institutional and material power they wield.

Contextualized within a larger deconstruction of gendered narratives of social progress, Alicia's individual progress is also entirely nonlinear -- in fact, it is almost wholly circular, and this circularity reveals the maddening impacts of life under constant surveillance. The show's opening scene depicts Alicia standing by her husband's side at the press conference in which he admits to his wrongdoings. The camera cuts back and forth between the stage and the crowd, punctuating thes cuts flashbulbs and camcorders. Gradually, the shot focuses on Alicia's face and puts the viewer inside her mind, where she compulsively visualizes her husband's infidelity while maintaining a somber expression on stage. After they leave the stage, he asks if she is okay, and she slaps him. She then tries to leave the building but decides to stay, realizing she is blocked by a crush of reporters and cameras.

Relying on minimal dialogue, this moment clearly depicts the particular set of tensions in which Alicia lives: others see her as the very image of a particular kind of woman -- a good, loyal wife and mother -- but she has a dark, complex, contradictory inner life of her own, which she is physically and emotionally pressured to keep inside. She struggles throughout the season to bridge the gap between how others see her and

who she actually is, and this struggle not only makes her depressed and angry but totally ill-equipped to express her depression and anger. In a blatant defiance of postfeminist discourses of paid labor as empowerment, work only intensifies this struggle. Her colleagues constantly watch her for any signs of vulnerability or failure, and pressure her to perform a particular image of productive, working womanhood. Whether at home or at work, Alicia does not live in a world that offers any space for her to express that her adherence to others' gendered expectations has served her poorly, because her social capital and power lies in adhering to those expectations.

Toward the middle of the series, Alicia begins shedding others' expectations and expressing defiant thoughts and desires -- a change that takes shape alongside her efforts to find personally rewarding work and distance herself from the troubling men in her life. This rejection of docility, however, never makes a dent in the saintly, good-wife, good-mom, good-worker public image that follows Alicia wherever she goes. She becomes increasingly desperate for a way out of the trap of observed femininity and runs for public office, believing this will let her leverage her public image into the production of social progress. Yet this decision of course opens up her private life to even more scrutiny, and others use her image to try to maintain her subservience and compliance with the plans of men whose power supersedes hers. By the series' end, Alicia is somehow under *more* observation than she was at the beginning. The NSA surveils her; her boss monitors her for sufficient productivity; news media and gossip blogs study her every private-life move; and her new boyfriend (Jeffrey Dean Morgan) secretly investigates her. Once again, she becomes more observable image than complicated

person; she cannot locate space to assert herself beyond the gendered observations of others.

Alicia thus discovers that patriarchal surveillance is inescapable, and that being treated as a full, normative subject is impossible even for the most empowered women -- and this realization drives her back into depression and anger. No matter how much social and material capital she accrues, others will always judge her against her impossibly idealized feminine reproductive and productive image. The Alicia we meet in the beginning of the series and the Alicia we intimately know by the end of the series are nearly identical: depressed largely because she is dissatisfied with the gendered expectations in which she has been placed, unable to imagine a brighter future. As in the early seasons, late-season Alicia's depression is sketched out rather than explicitly stated. She drinks too much wine (and later starts drinking hard alcohol in the middle of the day), lays in bed for hours on end, withdraws from her interpersonal relationships, and proclaims disinterest in everything she previously cared about.

Halfway through the show's final season -- in an episode aptly titled "Judged" -- the show explicitly produces Alicia as a depressed subject in a tearful, rageful monologue she delivers to her friend Luca (Cush Jumbo) while standing in her laundry room. She declares:

> I'm sick to death of everything. This apartment, the laundry, the fact that things get dirty, the law, standing here. Sometimes I swear I just want to go into my bedroom, pull the covers over my head, and never do anything, ever again… Was it all about having two kids, who I don't even know if I like anymore? Seriously, was that the point?

This monologue checks the list of symptoms of depression, but more importantly, it situates Alicia's mental health in a particularly gendered context. Alicia's attention to the gendered demands of her life reflects the show's argument about contemporary womanhood. She resents the constant repetition of domestic labor; she feels defective because she has not found motherhood rewarding; she is dissatisfied by the workplace productivity that everyone believes empowers her. Presumably, she also hates the marriage she still performs in public, but Peter is so inconsequential to her daily existence by this point that she does not even mention him here.

But this moment of being seen as she is, not judged against her idealized feminine image, does not free Alicia from patriarchal surveillance. She is still dissatisfied with her life, still isolated from those around her, and still protecting a public image that has nothing to do with her lived subjectivity. The only measurable difference is this: where others previously saw her only as a loyal, subservient wife, they now idealize her as an empowered working mother. Whether she is a domestic icon or a high-achieving public worker, her image is used to shore up a heteropatriarchal system of power, with full subjecthood and the well-being she believes comes with it forever out of her reach. While some viewers found this conclusion reflective of a depressing lack of progress, I argue that this is the very point: the lack of progress American political and social culture has made on gender *is* depressing and *does* feel like a repetitive cycle. The fact that Alicia's emotional and psychological conclusion is identical to her beginning -- just with more social and material power this time around -- is a fitting conclusion to the show's consistent critique of a postfeminist social and political context in which all the power in the world cannot provide a way out of heteropatriarchy.

A similar deconstruction of the figure of the empowered woman, *Scandal* follows Olivia Pope (Kerry Washington), a high-achieving black attorney turned Washington D.C. political "fixer" and the on-again, off-again girlfriend of President Fitzgerald "Fitz" Grant (Tony Goldwyn). With the help of a motley crew of private investigators, hackers, and lapsed attorneys, Olivia serves clients in the D.C. political scene, helping them avoid civil suits, criminal charges, exposed scandals, and anything else that might end their careers. In these storylines, the show explores how private lives become sites of public fascination and observation -- and how power structures and social capital play into people's ability to manage their position within the public eye. Early in the series, Olivia believes that she is an agent of the public eye, but she slowly realizes that she is an object of the many forms of observation she believes she is the agentive subject of through a series of personal and political dramas. At times, Olivia's deconstruction reads as an exposure of a system of power that always already excludes women of color; at others, as in the show's repeated failure to engage meaningfully with her mental health, it feels as though the show punishes her for daring to believe she was a full, empowered subject.

Like *The Good Wife, Scandal* presents surveillance as a broad, complex technology enacted by numerous social institutions -- most frequently, the nation-state, state security, and the media -- and individual subjects who are also surveilled themselves. The series constantly argues that its characters -- and, by proxy, the viewers -- are always already both watching and being watched. The series marks cuts between scenes with the click of paparazzi flashbulbs; pivotal scenes play out in news footage[43]

[43] Olivia regularly watches other characters on live television, then calls them so that she can, without their awareness, observe their facial reactions to gauge whether they are lying to her.

and in grainy surveillance camera film. The show frames Olivia's labor as a matter of optics, and this terminology reminds the viewer that their observations of the world are mediated by a number of social institutions and systems of power. Olivia and her employees not only manipulate media optics, but also state surveillance systems, privacy laws, state and private surveillance footage, social media, private investigation, and pure and simple gossip[44] -- and they treat all these entities as parts of a whole observational apparatus.

But *Scandal* diverges wildly from *The Good Wife* because Olivia believes that she is the agent rather than object of this observational apparatus, fully in control not only of how she is seen but also how her clients, friends, and romantic partners are seen. Her professional success reinforces this belief (Olivia, more than any other character on television, holds on to productive achievement as proof of her normativity), as does her ability to conceal her personal life from public view and parts of her private life from people within it. This labor seems to require little effort; constructing and circulating a sanitized image of messier circumstances is natural for her. Even though she knows the scope of formal and informal surveillance, she truly believes that no one sees beyond the public images she carefully constructs for herself and others.

The series gradually deconstructs Olivia's belief in her own agency within this observational apparatus. First, much of Olivia's public success depends on her ability to leverage her private relationships with those who have more surveillance power than she does, such as Fitz, his chief of staff Cyrus (Jeff Perry), and his wife Mellie (Bellamy

[44] The show also questions whether there is any meaningful distinction between the items listed here. For example, Olivia argues that gossip, tabloids, and network journalism are indistinguishable because they all create the same consequences for her clients.

Young). Fitz often uses his power to coerce and manipulate Olivia -- behaviors many critics have labeled emotional abuse (Crosley, 2013; Holmes, 2013; Ntl-Asare, 2015), though Arit John (2014) correctly notes that every romantic relationship on the show is unhealthy on some level -- but the most insidious iteration of this is his use of state surveillance resources to track her. Yet Fitz is not alone in formally surveilling Olivia; her estranged parents are part of an espionage network[45] and they regularly use their professional resources to manipulate Olivia. Almost every single man she becomes romantically involved with (Fitz included) has worked for her father at some point. In some cases, this is coincidental; in others, her father explicitly tasked them with pursuing her to spy on her. These observational power dynamics harm Olivia not so much because they constitute an abusive violation of boundaries, but because they force her to question her sense of self, which is centered around her positionality within the observational apparatus in which she lives and works. This gulf between belief and reality is not presented as a delusion, but its exposure causes Olivia profound mental and emotional distress. Olivia never explicitly declares her distress, only going so far as to lament that she mistrusts her instincts; she throws herself into her work and hides her turmoil even from those closest to her so as not to appear vulnerable. Kerry Washington gracefully conveys this caginess, evasion, and self-isolation, slowly revealing the off-balance emotional state lurking under Olivia's competent, productive exterior.

[45] Much like the murder mysteries on *How to Get Away With Murder*, I do not fully understand the details of this plotline and cannot even begin to explain how it works. This inconsistency emerges from the fact that there is a bit of deus ex machina in the show's depiction of B-613: especially in the show's later seasons, it is used to explain every plot twist, every conspiracy, every major dramatic turn, regardless of plausibility. Not only is this shaky narrative ground, but it also raises fair questions about representational ethics when such storylines rely on, and thus validate, external conspiracy-theory discourses.

In season four, this dynamic intensifies after Olivia is kidnapped, held in isolation, and sold on the black market, which leaves her struggling with a severe and obvious case of PTSD. After returning home, Olivia functions at peak productivity but has regular flashbacks to and nightmares about her captivity. While the show's depiction of the physiology of traumatic flashbacks is accurate, the series fails to develop Olivia's experience (and the tensions between her mental health and her productivity) as a full, contextualized story. Initial episodes largely portion out her mental health from the rest of the narrative, and then Olivia's mental health drops off the radar almost entirely, aside from other characters' occasional suggestions that she seek therapy. This narrative erasure continues through season five, ending only when Olivia learns who perpetrated her kidnapping and gets the opportunity to confront him in a federal interrogation room. In an out-of-left-field fit of rage, she stops confronting him verbally and begins beating him to death with a metal chair. It is dark and difficult to watch, but it never pays off narratively: Olivia does not face any legal or social consequences for the murder, and her post-traumatic distress symptoms magically disappear from the show altogether.

This magical resolution to Olivia's PTSD is obviously unrealistic, and reinforces discourses of mentally ill people as unstable and unpredictably violent. It also marks a serious missed opportunity to explore and narrativize the intersection of mental health and black womanhood[46]. A long genealogy of racism in medicine has made many communities of color justifiably wary of seeking mental health care (see Holden, et. al.,

[46] This is surprising from a Shonda Rhimes series; as discussed in chapter one, Rhimes explored Annalise's mental health in relationship to her positionality as a queer woman of color on *How to Get Away With Murder*. She also produced a compelling storyline about Miranda Bailey's (Chandra Wilson) obsessive-compulsive disorder on *Grey's Anatomy*, which engages with discourses of mental health-as-productivity (but does not tackle the observation of normative femininity, which is why I do not discuss it here).

2014; Summers, 2014), and the notion that mental health treatment is for white people is reinforced by the overwhelming whiteness of media depictions of mental illness. For black women, this intersects with discourses that produce them as inherently strong. As Samantha Irby (2015) writes of her mental health as a teenager, "No one in my house was talking about depression. That's something that happened to white people on television, not a thing that could take down a Strong Black Woman." Olivia articulates similar beliefs early in the series; in the episode "Snake in the Garden," she says therapy is for rich white women who want to blame their unhappiness on their parents -- but these beliefs are never referenced again, not even when others encourage Olivia to seek therapy.

The show does not shy away from explicating how Olivia's ideas about strength, productivity, and achievement are shaped by her positionality as a black woman -- but it falters when this opportunity arises to explore her vulnerability through the same lens. Through its cases of the week, the show establishes a context in which powerful men manipulate optics in order to conceal their own amoral, abusive behavior, while women, queer people, and people of color manipulate optics to conceal trauma that is done to them -- often by powerful men. Through this pattern, the series reveals how normative rationality is observed and regulated differently for particular subjects based on their social locations and relationships to power. It is particularly deft at revealing that the boundary between belonging and deviance is far more forgiving for the powerful than it is for the marginalized, and that marginalized people are penalized at the slightest hint of vulnerability. Yet Olivia seems to exist outside of this system of power and vulnerability in which her clients and colleagues live; her strength is drawn out in explicit detail, but

her pain goes ignored. In a show that features so many supporting and single-episode characters trying to resolve their trauma within an observational and regulatory minefield of gendered, sexualized, and racialized mental health stigmas, it is a glaring omission to never see the protagonist engage deeply with her own trauma. This lack of attention to Olivia's mental health makes the show's embedded critique of empowerment discourse inconsistent and troubling.

Your Work is Your Life, Your Life is Your Work: Labor Surveillance and Collective Politics in HBO's Enlightened

At an initial glance, HBO's *Enlightened* (2011-2013[47]) seems like a dramatically different show from *The Good Wife* and *Scandal*. Though it is as workplace-focused as these texts, it is not a procedural legal drama but a dark workplace comedy, set in a large, Los Angeles-based corporation called Abadonn -- a name that hints at the insidious amorality running beneath this mundane, nondescript, sanitized office-job exterior. Though she is as complicated as the women protagonists discussed earlier, Amy Jellicoe (Laura Dern) is not a powerful public figure like Alicia or Olivia. Instead, she is an average middle-aged woman: working at a mid-level corporate data entry job that she hates, driving an unreliable Honda sedan, mired in tens of thousands of dollars in debt, living (and endlessly bickering) with her mom Helen (Diane Ladd), and struggling to

[47] Though the show was canceled after two seasons for low ratings, it became a cult favorite in the years following its cancellation. This is not unusual for an HBO show; since their series are permanently available on their streaming platform, many have a legacy that outlasts their live runs. However, I think part of this particular resurgence is that *Enlightened* is better suited to the current political climate than it was to its original viewing context; viewers in the U.S. are much more amenable to a narrative about overthrowing patriarchal, ableist late capitalism in 2017 than they were in 2012. (Also, pop culture Twitter was obsessed with Laura Dern in 2017.)

extricate herself from her aimless ex-husband Levi (Luke Wilson). Amy's averageness keeps her from the public eye from which Alicia and Olivia can never escape, but it does not exempt her from constant observation or its mental health consequences. If anything, of these three protagonists, she is the most complexly embedded in the observational apparatus that regulates gendered discourses of productivity. The series explores Amy's negotiation of this apparatus, and while it is a bit cynical in framing surveillance as so commonplace it is barely noticeable, it offers a hopeful argument that collective progress and individual well-being can resist and reshape our observational practices.

Fittingly, Amy is also the figure in this chapter most clearly represented as a mentally ill subject[48]. The series opens with her weeping in a bathroom stall at work, mascara running down her face as she eavesdrops on two other women gossiping about how she had an affair with her boss, Damon, and subsequently got fired. She walks out in a rage and confronts the two women, her assistant, and then Damon, who broke up with her and took over the department she used to run. Damon tries to escape Amy's rage by closing himself inside an elevator; she wrestles open its doors and threatens to kill him. This opener not only primes the viewer for the next seventeen episodes of cringe-worthy behavior, but it also subtly introduces all the show's major themes and establishes Amy as a madwoman figure. The viewer cannot tell if she is diagnosably mentally ill, but they recognize that those around her perceive her as crazy, and that this perception emerges from her failure to comply with the expectations of femininity. Amy is angry; she is

[48] Creator and producer Mike White has said in interviews that he based Amy's mental health crisis on his own (Syme, 2017) -- which he experienced after trying to create a different television series, a creative trajectory much like that of *Crazy Ex-Girlfriend*'s Rebecca Bloom.

ambitious; she acts on her sexual desires -- and does so in a way that violates the rule to keep one's private life separate from their professional life[49].

The show uses this intense opening scene as a tonal counterpoint to the calm, sunny, post-treatment Amy we meet immediately thereafter. She sits in a human resources meeting, explaining that she'd like her job back because, "I put all this energy into my healing, and now I have this energy built up to work." However, Amy does not buy fully into the notion that productivity is evidence of mental health; she requests a particular kind of productivity when she proposes a socially conscious environmental outreach job that does not exist. Her limited faith in the conflation of productivity and mental health dissipates when she is assigned a basement data entry job. Amy does not even understand what she is supposed to be doing, and she is offended that she is surrounded by the other employees Abadonn's HR department deemed "difficult to place". The idealism she found in treatment cannot stand up to the experience of returning to life as an anonymous part of a giant corporate apparatus, and she struggles to bring the therapeutic lessons of mindfulness and progress to her mindless, repetitive data entry.

Three-quarters of the way through season one, Amy realizes that her context is not something she can tweak until it becomes an appropriate fit for her subjectivity,

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[49] The enforcement of this rule is obviously and profoundly gendered: Amy is penalized for the affair; Damon gets a promotion. The show presents this as a consistent problem in Abadonn's workplace culture. Amy's new boss Dougie (Timm Sharp), a repeat sexual harasser, never faces a consequence more severe than an HR request to stop hitting on employees. More uncomfortably, her friend Tyler (Mike White) kisses Amy at a non-work gathering, and starts a retaliatory disagreement with her after she rejects this advance.The show later reveals a similar prior incident with a woman named Julie. (For an interesting, complicated reflection on re-watching the series during the workplace sexual violence reckoning of late 2017, see Rachel Syme's "*Enlightened* Dared Women to Speak Out.")

because the dehumanizing context of late capitalism is the most significant source of her distress. The show dives deeply into corporate immorality, using the basement project as a point of entry. In "Comrades Unite!," Amy passes a union protest during her morning commute and finds herself inspired to use collective action to fight against corporate exploitation. In the process of planning this collective activism, she finally learns what Cogentiva does: develops software that tracks employee productivity and identifies points where workplaces can be "streamlined" by laying off and underpaying employees. Amy is horrified to be complicit in a project that distills everything disgusting about corporate industry: the lack of moral compass, the exploitation of workers, the drive to maximize profit above all else. Of course, there is also something deeply personal in her anger and horror. Cogentiva formalizes the observation, regulation, and profit-maximization that led to Amy's breakdown, and she is disturbed that simple data entry made her a part of this enterprise without her knowledge or consent.

Cogentiva thus becomes Amy's gateway drug into radical political action. In the process of organizing against Cogentiva, Amy uncovers a massive web of bribery and fraud across the executive and managerial levels of Abadonn. After this discovery, she fully relinquishes her earlier belief that she might carve out a space in late capitalism in which productivity might serve her mental health, and decides that the healthiest thing she can do is to do her part to burn corporate late capitalism to the ground. She becomes a destructive rather than productive subject. Her activist methods are often infuriating: she alternately critiques and depends upon surveillance, using technology to spy on those in power; she manipulates vulnerable people into helping her without considering that they have more to lose than she does. Yet Amy is uncomfortable to watch regardless of her

methods, because her activism (and her insistence that is is good and worth recognizing) defies the fundamental notion that surveillance should not matter to a normative, well-behaved subject who should have nothing to hide from an observational gaze. Amy has access to invisible anonymity if she wants it, but sacrifices it willingly toward a collective good; she believes she is a normative subject but wants her deviance to be noticed. The viewer's discomfort around Amy's simultaneous desire for recognition and resistance to observation is grounded in gendered mental illness stigma as well: Amy does not behave the way a normal person should behave, nor does she behave the way a normal woman should. Amy becomes hypervisible through her refusal to be a compliant feminine subject or an anonymous cog in the late capitalist machine, and her success as an activist comes from embracing this visibility.

In the show's final episode, Amy blows the whistle on Abadonn CEO Charles Szidon, who calls a confrontational meeting in order to fire her personally. He tries to bait her into an outburst, but she resignedly tells him, "I'm just a woman who's over it" -- *it* being the drive to maximize profit by exploiting people and creating work environments hostile to marginalized people in general and women in particular. Charles replies that it's not her gender but her mental health that makes her a bad capitalist subject (though his description of her mental illness is profoundly feminized): "... you're a mental patient. You feel, but you don't think. You cry about the environment, you weep for the oceans… but you don't understand anything. You are an hysteric." Amy does not contradict his conflation of idealism and insanity or the undercurrent of misogyny that runs beneath it; she knows it is a little bit deranged to try to make a dent in late capitalism and its surveillance apparatus. But she also knows that trying to create radical change is

not any more or less insane than trying to find a space where she can exist in a full subject within the system that makes her crazy, that treats her as a deviation from normative subjecthood, that obsessively monitors her for signs of abnormality, that forces her to hide defiant thoughts and feelings.

Ambiguous events follow this climactic confrontation. The show does not tell the viewer what, if anything, will happen to Abadonn or any of the horrible people who hold power within it. Amy has added unemployment to the laundry list of interpersonal and financial problems with which her narrative began, but she is also free of corporate observation and demands of endless productivity, no longer complicit in the system she wants to dismantle. In the show's final scene, she walks to a busy coffee shop to buy a newspaper, whose headline lists the allegations against Abadonn. Though she is unemployed, in debt, and struggling interpersonally, the viewer finally sees restless, unstable Amy finally at peace in this moment, in which she is not being observed, judged, or quantified. She has done the meaningful labor she was searching for -- and found a sense of worth and purpose that does not depend on monetized, quantified productivity. The viewer knows enough of Amy's troubling context to recognize that their hope is, like Amy, a little bit irrational -- but the show suggests that powerful people will always produce the refusal of their dominant ideologies as irrationality as a way of individualizing mismatched interactions between subjects and contexts, and that collective action is the only way to work against this individual observation and regulation. In letting Amy find a little bit of peace, even if it's tenuous and incomplete, the show also offers a parallel argument about mental health, suggesting that individual

recovery is not as powerful as collective effort to dismantle current systems of stigma and shame and build a world that observes and responds to mental illness more humanely.

Conclusion

Cultural discourses and practices have long conflated mental health and productivity, and many theorists argue that this reveals the value placed on productive labor in a given time and place. I agree, but contend that productivity is also centered in mental health discourse because it provides an observable external phenomenon that can be observed as evidence of a person's invisible interior state. Furthermore, productivity is not a universal ideal; social expectations for a subject's quantity and kind of productive labor depend on their social location. As feminist theorists and historians have described at length, medical and social discourses have often produced women as mentally ill subjects when they fail to adhere to norms of feminine labor in a given time and place. Despite claims to empowerment and equality, contemporary social institutions and subjects constantly observe and regulate women's adherence to feminized expectations of productivity. Women who fail to adhere to (or openly critique) these expectations are often labeled mentally ill, while those who adhere are assumed to be not only mentally healthy, but empowered and invulnerable.

Yet this constant gendered observation and regulation is in itself maddening, as all three texts discussed in this chapter reveal. However, they reach two different conclusions about the mental health consequences of the observation of gendered productive labor. *The Good Wife* and *Scandal* argue that women, no matter how powerful, live under constant scrutiny in which they are constantly observed for any

misstep that might prove they are unworthy of the privileges of normative subjecthood. Both suggest that there is no way to escape this observational structure, not even the acquisition of economic, social, and/or cultural power; this inescapability adds gendered pain and loneliness to the isolating experiences of depression and post-traumatic stress. These series thus use women's mental illness as a means to deconstruct postfeminist discourses of empowerment -- but they do not stigmatize distress or suggest it disqualifies women from being strong or powerful; rather, they present the way that powerful women are discursively produced as subjects but observed and regulated as objects of white heteropatriarchy as a maddening force. *Enlightened* is equally obsessed with the observation and regulation of feminized labor, but it offers a much more hopeful perspective; it disempowers its woman protagonist by giving her a way out of the pressure to be empowered individually. While it presents surveillance as far more informal and thus more insidious, it also presents the capitalist institutions that practice it as fallible, an enterprise that can be toppled through collective organizing that resists its individualized logics -- and it suggests that, by extension, misogyny and ableism can be collectively dismantled as well.

While this chapter focuses on the observation of feminized productivity, men are subject to formal, informal, and internalized observation of their compliance with normalized subjecthood as well. In particular, observation marks marginalized and vulnerable men's compliance with gendered norms of productivity as evidence of either their mental health or their madness. In *Enlightened*, Tyler's quality of work conceals his depression and isolation; in *Transparent* and *You're the Worst*, respectively, others see Josh and Edgar's professional aimlessness as a mental health red flag, and their successes

at work as proof of recovery. However, the private, unpaid labor these men engage in is not scrutinized, while that of the women around them is. Furthermore, for normative male subjects, there exists a much higher ceiling for what constitutes deviant behavior. While this normativity is a privilege in many ways, it also means that men's mental health needs often go unrecognized if they are not severe -- and cultural discourses reinforce the invisibility of men's mild mental illness experiences by producing mentally ill men as threatening, violent, and criminal, a phenomenon explored at length in the following chapter.

CHAPTER FIVE:

"Is he keeping an eye on me, or am I keeping an eye on him?": Observation, Violence, and Hypermasculinity in the Crime Drama

In a 2018 Criterion collection essay on the 1990 film *The Silence of the Lambs*, critic Amy Taubin explicates a genealogy of gender in television and film investigative crime dramas that is not a linear progression of increasingly feminist narratives, but an inconsistent lineage in which production and consumption of gender-conscious crime narratives spikes at particular points in American cultural history. To explicate this timeline, Taubin traces the initial Reagan-era popularity of *The Silence of the Lambs* and David Lynch's *Twin Peaks* and the Trump-era resurgence of interest in both texts, as well as narratives like BBC/Sundance's *Top of the Lake*. She argues that viewers are drawn to these narratives at times when they are "finding themselves trapped in a wormhole… where the homicidal law of the father is forever unchecked and unchanged" (2). While some viewers find the on screen depiction of violent misogyny too troubling to consume, others find validation in seeing the contextual reality of gendered and sexualized physical violence made explicit, especially at moments when this reality feels especially salient for them.

The texts discussed in this chapter -- like their predecessors, *Silence of the Lambs* and *Twin Peaks* -- fit within this lineage, making explicit the reality of particular kinds of violence at a cultural moment when the realities of this violence are particularly obvious to viewers. They also situate this violence within a broader set of mental health discourses which typically produce women's mental illness as a matter of internalized vulnerability and men's mental illness as a matter of externalized violence. Showtime's

Homeland, BBC/Netflix's *The Fall*, and *Top of the Lake* put feminized vulnerability and masculinized violence in close proximity to one another in particular contexts of violence. While *Homeland* tackles state-sanctioned violence and *The Fall* and *Top of the Lake* deal with interpersonal violence, all three series depict characters who function as stand-ins for cultural ideas about gender, violence, and mental health.

American mental health discourse takes shape around a gender binary in which expectations of normative masculinity -- invulnerability, emotional control, rationality -- are discursively opposite the behaviors typically labeled "mentally ill". While social privileges attach to this gendered construction (especially for men who are straight, cisgendered, white, and economically privileged), it is also detrimental to the lived mental health experiences of many men, who often struggle to disclose and seek resolution for mental health impairments (see Gast and Peake, 2011; NIMH/CDC, 2014; Markowski and Smith, 2015). Furthermore, when men do seek out support, health care providers are more likely to fail to recognize or minimize their symptoms (see McCorker and Galupo, 2011; NIMH/CDC, 2014). This produces a system in which men are far less likely to be diagnosed with common mental health impairments than women of the same class and/or race, but equally likely to be diagnosed with a severe mental health impairment and substantially more likely to commit suicide (NIMH/CDC, 2014).

Cultural representations of men's mental illness do little to deconstruct the notion that mental health is antithetical to normative masculinity. Empathetic media depictions of mentally ill men are infrequent and often center around major geopolitical events. Such male characters are often straight and white, and they function as stand-ins for the nation-state or social body because their normativity renders their social position

invisible and thus "universal." Other, far more common texts about masculine madness depict mentally ill men as dangerous, violent threats to the social body and/or inhuman monsters[50]. This is especially true in crime dramas; as Erica Scharrer (2001) notes, the genre repeatedly links acts of sexualized brutality and violence to hypermasculinity and criminality, so that hypermasculinity, male madness, physical violence, and criminality become conflated with one another[51]. Russell Covey (2009) points out that the frequency of such representations produces a discursive regime wherein madness and criminality become interchangeable in the public imagination, which in turns justifies the carceral disciplining of mentally ill subjects. Network procedurals like NBC's *Law and Order* franchise and CBS's criminal psychology-obsessed *Criminal Minds*, rely heavily on this particular conflation of masculinity, violence, and mental illness in depicting violent male perpetrators. The increasingly popular antihero-protagonist genre (e.g., *Breaking Bad*, *The Sopranos*, *Mad Men*, etc.) also relies on this, and, with the exception of *The Sopranos*, few of these narratives explicitly critique and explore how that conflation functions in the world.

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[50] Academic research contributes to this discursive regime as well. Most research about masculinity and mental health focuses on the mental health impact of male violence against vulnerable subjects, especially women and children. While this is of course a valuable site of interrogation, focusing on it to the detriment of other topics -- such as the mental health consequences of hegemonic masculinity, or practitioners' failure to recognize men's mental health needs -- reproduces the discursive conflation of violence, masculinity, and mental illness.

[51] In these texts, victims are passive and feminized; they are often just maimed bodies. Law enforcement officers are usually masculine in these texts, but respectably so, and they thus represent a counterpoint to the objects of their investigation. The texts discussed in this chapter rewrite this gendered formula while still depicting violent, monstrous hypermasculinity and feminized trauma.

As such, the representational landscape around masculinity and mental illness leaves little room for depictions of masculine subjects trying to navigate everyday experiences of mental health with which the viewer might relate and identify, presenting men's mental illness either as a matter of grand historical/cultural significance or inhuman monstrosity. Paired with a cultural context in which men's mental health needs are under-recognized and under-discussed across race and class categories, this discursive regime normalizes (and, on occasion, glamorizes) the idea that men's mental illness manifests as extreme danger, violence, and sociopathy. Women-led crime dramas do not necessarily disentangle this troubling conflation of gender and mental illness; the mentally distressed men we see in the texts discussed in this chapter are a terrorist, a child molester, and a sexually violent serial killer. However, these texts reveal how discourses of hegemonic masculinity often shield men's violent acts of deviance -- even (if not especially) in particular moments that contest hegemonic masculinity, gendered/sexualized violence, feminized distress, and the social institutions that enable all three. As in the previous chapter, these narratives depend on depictions of in/formal observational practices that identify some subjects as threats to the social order based on how fully their behavior complies with the expectations of their subject position.

Yet these texts differ in that they represent men as objects of this regulatory gaze, and women as agents as well as subjects of it. This construction reveals how the normativity and deviance our institutions "see" is shaped by the individual positionality of who is being watched -- and also that of who is doing the observation. *Homeland* slowly reveals the deviance of a masculine subject who appears unquestionably normative, but ultimately retrenches the power of the nation-state and the social

institutions that produce him as normative. *The Fall* and *Top of the Lake* depict how hypermasculine violence is normalized up to a certain point, treated as deviant only at extremes. In all three series, the women who make masculine deviance visible are traumatized, and their positionality sheds a light on the role of gender in how communities and social institutions identify and discipline deviant, mentally ill subjects -- and beg the question of whether this process of observation and disciplining can actually protect the vulnerable when it is couched in social institutions such as the nation-state and the carceral system, which protect and reinforce heteropatriarchal systems of power.

Deconstructing and Reconstructing Normalized Violence in Homeland

In the first season of Showtime's *Homeland* (2011 - present), CIA agent Carrie Mathison (Claire Danes) becomes obsessed with Nick Brody (Damien Lewis), a U.S. Marine who recently returned home after eight years as a prisoner of war in Afghanistan. While others see Brody as a heroic figure and a potential intelligence resource, Carrie believes his captors have turned him, and she begins surveilling him. Throughout its first season, the show gradually intertwines Carrie and Brody's respective trauma and madness: Carrie has lived with bipolar disorder since college but hides it from her employer to maintain her security clearance; Brody struggles with post-traumatic stress that he refuses to discuss with his family, his military colleagues, or a mental health professional. The two begin as oppositional forces but gradually become interwoven mentally ill subjectivities, and in this interweaving, the show gestures toward a critique of the social institutions that produce and observe mentally ill subjects not for the sake of mental health, but for the sake of the order of the nation-state and its social institutions.

Yet the first season ends with Carrie in inpatient treatment, while Brody continues to maintain his visibility as a normative subject. This narrative choice walks back the show's earlier critiques of the nation-state, even as it productively reveals that the nation-state makes the madness of white, straight men legible only in its most extreme manifestations, while placing other subjects under constant suspicion of deviance and/or instability[52].

The show hails this gendered construction most explicitly in depicting Brody as a figure whose image is deployed to retrench normative citizen-subjecthood while his inner turmoil remains illegible. On the surface, Brody *is* the normative subject of the U.S. nation state in general and its imperialist military projects in particular. He is a white, heterosexual military veteran who is married to a white, heterosexual woman (Jessica, played by Morena Baccarin) with whom he has a son (Chris, played by Jackson Pace) and a daughter (Dana, played by Morgan Saylor). The Brody family's home and suburban neighborhood are distinctly recession-era middle-class; wood paneling, old appliances, and ugly wallpaper abound. The Brodys' social circle consists of other white, middle-class families, most of whom are also involved in the military. They are not overly pious but attend church services of an unspecified Christian denomination. These trappings of normalcy, combined with Brody's captivity, allow others to construct an image of him as a loyal patriot and loving family man. Characters often refer to him as a "poster boy" for the U.S. military (though not always as a compliment), and later in the season, politicians begin to groom him for public office.

[52] My analysis here focuses on the show's negotiation of Brody as a traumatized/deviant subject who appears normative; my article "Transgression, Embodiment, and Gendered Madness: Reading *Homeland* and *Enlightened* through Critical Disability Theory" (2016) provides a more detailed analysis of the show's approach to Carrie's madness.

This image provides a massive shield for Brody's involvement in terrorist activity. While the show uses this gap between appearance and reality as a force for dramatic irony and twisting plotlines, early episodes of the series embed this within a larger critique of the how and why the nation-state observes particular subjects as either deviant or normative based on particular social locations. In a midseason subplot that carries significant thematic weight, CIA agents nearly sabotage an investigation because they assume a Middle Eastern man (Omid Abtahi) is plotting an act of terrorism. The actual culprit is his white, American-born, wealthy wife (Marin Ireland) -- whom they assume is an oblivious bystander despite her decades of anti-U.S. political activity. The show also juxtaposes scenes in which "violent" criminals are apprehended in contrast with moments where Brody is valorized for his participation in state-sanctioned violence. Placed in contrast to one another, these images expose how "violence" is not a clear-cut concept, but a notion discursively circulated to serve the biopolitical needs of the state.

The nation-state is not the only institution that fails to recognize Brody's deviance; the nuclear family does as well. Brody's return to now-unfamiliar circumstances clearly disturbs and disorients him; though no one explicitly diagnoses him, his distress fits the profile of post-traumatic stress disorder (NIMH/CDC, 2016). He experiences flashbacks to his imprisonment and torture, which are depicted on screen as he experiences them. He also has sudden flashes of anger which often culminate in violence, such as when he punches a reporter who wanders onto his lawn. He startles easily, and the show is ambiguous in revealing whether this is a consequence of paranoia about his criminality being uncovered, or standard-issue hypervigilance. The show focuses particular attention on his sexual dysfunction, a common symptom among

combat veterans with post-traumatic distress (Tran, et. al., 2015) that also hails particular norms of masculinity -- norms that others see Brody as the embodiment of. While Brody's family recognizes these differences from the man they use to know[53], they stop short of articulating his mental health as a source of concern.

The intelligence community and the military are so determined to use Brody's image to shore up support for the U.S. nation-state and its imperialist projects that they never consider how eight years in captivity may have impacted him as a human being. His colleagues and friends assume he is stable because he gives television interviews, participates in military functions, and volunteers his assistance in intelligence efforts. Within the military/intelligence apparatus, Carrie is the only person who observes Brody as a person, not an image -- and the viewer sees Brody primarily through Carrie's observational perspective. She watches him through surveillance cameras as well as in their interpersonal interactions, and immediately notices a discrepancy between his public image and his private behavior. Carrie sees all of Brody's private habits and solitary behaviors (including, of course, his much-emphasized impotence). In particular, she obsesses over Brody's symptoms of distress; the only observation notes the viewer sees her jot down are symptoms like *nightmares* and *more paranoid hallucinations?*.

Yet these comments are not regulatory but empathetic, because Carrie is a mentally distressed subject herself. By positioning its two protagonists as connected mentally ill subjects, the show presents Carrie's observation of Brody as a distinct form of intimacy. The CIA accepts the idea that surveillance begets closeness; Carrie's mentor

[53] Save for Chris, who is not really a character. Many critics called attention to how poorly the writers handled the Brody children (Collins, 2012; Lawson, 2012) -- especially Dana, "TV's most hated character" (Romano, 2013), whom *Saturday Night Live* mocked in a sketch.

Saul (Mandy Patinkin) says that observers begin to miss their subjects after they are done surveilling them. However, the intimacy between Carrie and Brody is more intense than this because her observation is filtered through her own subjectivity as a mentally ill person, and she sees the inner distress driving his external behaviors. Through this recognition, Carrie is able to fully know Brody -- more than anyone else in the CIA, more than anyone in the military, and even more than anyone in his family. Those around Carrie, however, do not treat her mental health status as a privileged observational standpoint. Instead, her instability makes them suspicious of her, and they treat her as a liability to their nation-state project. Carrie's boss calls her a "loose canon," and asks her colleagues to "keep an eye on" her and report their observations back to him. Others' suspicions of Carrie intensify as she gains deeper knowledge of Brody. Even those who do not see Carrie as a liability to her workplace (and, by proxy, to the nation-state) begin to worry that she poses a threat to her well-being and potentially to the well-being of others.

In short, Carrie becomes overdetermined as a mentally ill subject while Brody remains illegible as one, and these two formulations depend on one another. The more others within the nation-state apparatus perceive Brody as a normative subject, the crazier Carrie appears to them -- even as she is the only person who sees the situation clearly. At first, Carrie and Brody understand each other due to their shared social location as mentally ill subjects, but they are driven apart by their differing positionality within the nation-state. On the surface, Brody -- a father, a husband, a soldier, a straight white man -- is an unquestionable hero; Carrie -- a single, emotionally unstable white woman -- is a liability. Yet this is a reality constructed to serve the needs of the heteropatriarchal

nation-state. In reality, Brody is the threat, and Carrie is the hero, saving the nation-state through her intimate knowledge of Brody's distress.

Some viewers might argue that this heroism does not take shape in spite of her mentally ill subject position, but because of it. Yet such a reading disregards the fact that Carrie could have all the empathy in the world for Brody's mental illness, but it would amount to nothing without her agentive position within the surveillance state. Alongside its form, the content of Carrie's heroic act also retrenches the heteropatriarchal order of the surveillance-based nation-state. She sways Brody away from his planned suicide bombing because she knows he cares more about his children than his terrorist affiliations; he has been driven to suicidal thought by madness rather than ideology and thus can still be recuperated into the nation-state and the nuclear family. Carrie gains nothing from her act of heroism -- she is now institutionalized and facing electroshock treatment -- but the institutions that treat her as deviant remain intact. In short, the show tries to valorize Carrie as a hero, but does so in a manner which validates the social institutions that produce her as a deviant threat. The series begins with a contextual critique of an unstable, imperialist, surveillance-based nation-state that treats straight white men as figures whose normativity is beyond questioning -- and ends with a retrenchment of that same nation-state as an entity ultimately worth saving[54].

Blurring the Lines between Acceptable and Pathological Observation in The Fall

[54] This retrenchment continues from the show's second season onward. In particular, these seasons validated the nation-state's imperialist imagining of all Middle Eastern subjects as terrorists or sympathizers -- a move that both culture writers (Al-Arian, 2012; Durkay, 2014; Ryzik, 2016; Gilbert, 2017) and graffiti artists (Mackay, 2016) criticized at length.

Where *Homeland* treats the intimacy of observation as a force for the protection of the nation-state, *The Fall* presents the intimacy between the surveiller and the surveilled as a traumatic nightmare of voyeuristic, gendered/sexualized violence that the carceral state cannot control or contain[55]. A horror film packaged as a crime procedural, the show follows two opposing protagonists. The first, English detective Stella Gibson (Gillian Anderson), travels to Belfast to solve a series of sexually violent murders and suspicious stalking reports. The second, local grief counselor Paul Spector (Jamie Dornan), commits said acts of stalking, assault, and murder. At the series's beginning, Stella functions as a distant outsider; her ostensibly objective position allows her to see connections and evidence that the predominantly male local investigators do not notice. Yet her objectivity and emotional distance disintegrate throughout the series. The investigation pulls Stella and Spector into increasingly claustrophobic proximity to one another, and the lines between watcher and watched become blurred as Stella surveils Spector and Spector begins surveilling her in response. At its core, *The Fall* is a show not so much about state-sanctioned surveillance but about voyeurism as it functions in both institutional and interpersonal contexts, and it forces the viewer to consider uncomfortable similarities between the two -- and their own behavior as a consumer of the televisual crime narrative.

The show's camera work echoes its narrative attention to voyeurism. When characters are in private -- and the show is filled with such scenes, depicting oblivious women in mundane private rituals like cleaning their bathroom or washing their face --

[55] There is underlying nation-state commentary throughout the show; however, the nation-state is not a narrative force here the way it is in *Homeland*. A familiar viewer might read geopolitical context into the narrative, but the show does not make these themes explicit in the way it makes gendered/sexualized violence explicit.

the camera mirrors the vantage point from which Spector watches his victims in their home. Such moments do nothing to advance the plot. Rather, they reinforce the show's presentation of surveillance as encompassing a broad spectrum of gendered behaviors: men watch, women are watched, and this pattern only becomes legible in its most extreme (e.g., Spector's stalking) or unusual (e.g., Stella's surveillance) forms. These scenes force the audience to observe women the way that Spector does, and thus to participate in his deviance. While this is intended to invoke an uncomfortable response in the viewer, it also calls into question why certain kinds of surveillance are uncomfortable while others are normal.

The show engenders viewer discomfort again in its framing of Spector's violent rituals, in which he preys on women with similar appearances and material lives, leaves their bodies identically positioned and groomed after every murder, and takes a lock of hair from each of his victims. The camera focuses in close detail on these scenes, and Spector's behavior belies his exhibitionism; the show mirror these scenes in moments in which Stella thoughtfully prepares for moments when she knows Spector will see her, such as press conferences or interrogations.

Drawing on investigative evidence, Stella deliberately modifies her appearance and demeanor to fit the pattern of Spector's victims, even going so far as to paint her nails with the same red polish Spector uses on his deceased victims. Spector notices this and tells her, "You spend a lot of time observing herself." Yet this is not a pleasurable activity in a psychoanalytic sense, it is a pragmatic choice -- not just a good investigative strategy, but a good survival strategy for a world in which women are constantly watched. In contrast, Spector could (and does) easily make his way through the world

unseen and illegible, but he is pathologically motivated by a sort of Lacanian scopic drive.

While Spector is deeply disturbing, the show pulls back from treating him as a monstrous, inhuman entity of pure deviance not only by forcing the viewer into visual affiliation with him but also by couching his behavior in a broader critique of hegemonic masculinity. Like Brody, others see Spector as a normative subject: a straight white man, a loyal husband, a caring father, and a productive employee. The show draws out the contrast between Spector's normativity and deviance unsubtly, following each scene of Spector's violence with a scene of him parenting his daughter or comforting his grieving patients. Like Brody, only one particularly located woman sees the deviant behavior lurking beneath this idealized masculine image. Yet Stella is nothing like Carrie: not only is she repressed and strategic where Carrie is erratic and impulsive, but she also sees that the normative subjectivities of *all* the men who surround her are constructed fictions. Her male colleagues scramble for an explanation for Spector's behavior that distinguishes him from their rational masculinity, whether it be childhood trauma or inborn monstrosity, but Stella settles on the most fundamental explanation: Spector is the product of masculinity gone awry. His problem is not that he is deviant, but that his violence is all too normative -- that it is not outside the norm but a norm taken to its most dramatic conclusion.

To Stella and thus to the viewer, Spector is not terrifying because he is a monster; he is terrifying because male deviance like his is everywhere, and because cultural discourses of normativity have rendered it invisible as a threat to the social body. In a season two scene, Stella makes this continuum of behavior obvious after her supervisor

and former lover Jim Burns (John Lynch) drunkenly stumbles into her hotel room, bemoans his personal and professional problems, and then tries to kiss her. She tells him no repeatedly but he persists, and she has to hit him in the face to make him stop. While she cleans Burns's injuries in the bathroom, Spector breaks into her hotel room, reads her journal, changes her computer screensaver, and leaves a menacing note. Burns's predatory behavior gets lost in the shuffle of Spector's actions over the next few episodes, but Stella later reminds him of it in the following conversation:

> Burns: He's not a human being. He's a monster.
>
> Stella: You can see it that way if you want. You know it makes no sense to me. Men like Spector are all too human… He's not a monster; he's just a man.
>
> Burns: I'm a man, and I'm nothing like him.
>
> Stella: No, you're not. But you still came to my hotel room uninvited… I was saying no quite clearly. You ignored me.

While this exchange is a bit on-the-nose, Burns is stunned by Stella's account of his actions -- not because he was intoxicated at the time, but because he truly believes he is a normative, rational subject while Spector is a monstrosity. In this and several other moments, male detectives are determined to find proof that Spector is "crazy" and therefore unlike them. While this repeated motif exposes real, damaging cultural discourses, the series misses an opportunity to further deconstruct of the conflation of violent hypermasculinity and madness by depicting mentally ill men who are not violent or deviant.

However, the similarity between Spector and his investigators is not bound by masculinity alone. Early in season one, the show suggests that Stella and Spector both

gain power and control by observing and tracking a subject they want to regulate. Stella tracks and watches Spector in socially sanctioned ways: he is a deviant threat to the social body, and she is qualified to identify, observe, and intervene into his behavior in order to protect the community. She sets up surveillance cameras within his home, tracks his movements, documents all his behavior, and supervises all interrogations of him via video. Her emotional distance and ability to watch acts of violent horror without flinching make the viewer wonder, at times, whether she is as sociopathic as the man she observes. Spector's voyeuristic actions and motivations are not far from Stella's, after all: though he is not an agent of the carceral state, he genuinely believes that he protects the social body by killing professionally successful, sexually active women who defy his ideas of normative femininity. Gradually, Spector turns his voyeuristic gaze toward Stella, trying to determine what parts of him she does and does not see so that he can continue his violent pursuits. This motivation -- to know and defeat an oppositional force that puts him in danger -- is again not dissimilar from Stella's.

Toward the end of the first season and into the second season, the show draws out an important distinction: while both protagonists are obsessive observers, Spector is also an exhibitionist, while Stella does not want to be seen. Spector's hotel room break-in traumatizes Stella not because her living space has been invaded, but because he steals and reads her journal. The journal presents a record of a tumultuous inner life that belies her composed exterior; her entries reveal grief over her father, what Spector calls "her compulsions," and an implied history of childhood sexual abuse. As the note Spector leaves in the hotel room tells her, she is now "exposed" -- and the moment she reads this note is the first time in the series that the viewer sees her cry. After this, Stella stops

trying to understand Spector through observation and begins to build relationships with other women who have survived their encounters with him. Through these connections, Stella gives up her previous observational distance. She becomes more emotionally invested in and thus traumatized by her work, but she also becomes more passionate about finding justice for those Spector has harmed.

In a less incisive show, the relationships Stella forges with Spector's victims would provide information that solves the case. In *The Fall*, the carceral state -- a mechanism upheld by the same voyeuristic practices and biopolitical beliefs as the subjects it attempts to regulate -- becomes increasingly futile and unproductive, and formal justice remains always out of reach. Instead, Stella finds herself becoming less of an investigator and more of a leader of a community of women traumatized by Spector -- a sort of miniature social-body island within a nation-state that heavily polices women's so-called deviance while eliding a wide swath of dangerous masculine behavior. Her interactions with her fellow traumatized women do not pave the path to formal justice; instead, they reveal how hypermasculine deviance and women's trauma co-constitute one another, making explicit a hegemonic system in which trauma is treated as a fact of women's marginalized experience, but only the most extreme hypermasculine deviance is a legible threat.

Institutionalizing Gendered/Sexualized Violence in Top of the Lake

Like *The Fall*, the first season of *Top of the Lake* situates hypermasculine violence within a continuum of normalized and deviant masculinities, and presents social institutions like the carceral state as mechanisms for the surveillance and regulation of

said violence. The shows have similar premises: its detective protagonist, Robin Griffin (Elisabeth Moss), provides outside expertise to the Laketop police force as they try to locate Tui Mitcham (Jacqueline Joe), a pregnant twelve-year-old girl who runs away from home, and identify her rapist. However, where *The Fall* points out uncomfortable similarities between the actions of carceral state and those it hopes to regulate, *Top of the Lake* presents the carceral state -- and the heteropatriarchal social system it protects -- as criminal and violent in itself. In the series, the law is a deviant, destructive institution that not only protects power rather than people; it also conceals, enables, and enacts violence against vulnerable subjects, driving them toward madness. If *The Fall* is a gender-conscious horror film pretending to be a police procedural, *Top of the Lake* is a feminist treatise on gender violence presented in a surreal, endless loop of "the call is coming from inside the house" jump scenes.

The show's setting lays the foundation for its claustrophobic narrative. Laketop is a small New Zealand town, and the social and familial lives of its residents are intertwined across class and race lines. However, three distinctly gendered incidents disrupt this tightly-knit community: the disappearance of Tui; the return of Robin; and the creation of the Paradise settlement. Paradise is a collection of shipping containers where "a lot of women in a lot of pain" live in community and adhere to the anti-medicalized self-care/spiritual guidance of G.J. (Holly Hunter), whom one follower describes as "in a different mental state". Though they are not explicitly diagnosed as mentally ill, the residents of Paradise are clearly troubled. The show traces their instability back to their relationships with men. One obsessively cares for an ex-husband who left her for a younger woman; another seeks out compulsive, seven-minute sexual

encounters with strange men. Throughout the season, Tui and Robin find their way to the compound as well. Their integration into the community ties together the show's disparate narrative threads by allowing a feminized, traumatized community to disrupt and replace the violent heteropatriarchal structures of the nuclear family and the carceral state.

Paradise doesn't simply disrupt the heteropatriarchal nuclear family in an abstract sense; it disrupts the Mitcham family specifically and directly. The commune and the family engage in a complicated battle over land rights and insider/outsider politics, as patriarch Matt Mitcham (Peter Mullen) swears the property Paradise is built on rightfully belongs to him. This conflict illustrates a very particular set of gender dynamics; openly traumatized and vulnerable women making their experiences legible in a space to which the Mitcham men feel entitled unsettles Matt and his aggressive, hypermasculine sons. They actively surveil, harass, and abuse the women to try to force them off the property. Matt begins a sexual relationship with one of the residents and turns on her when he finds her asleep in Tui's bed. He flies into a fit of abusive rage that culminates in an attempt to hit her with his car. "Look what you made me do," he yells at her, before turning to shout at the other Paradise residents that they are "unfuckable" -- evidently the harshest thing he can imagine saying to a woman. The moment exposes how easily masculine entitlement can turn erratic and violent, a contradiction of the false discursive equivalence between masculinity and stoic rationality[56].

[56] The show's indictment of harmful norms of masculinity is reinforced in its treatment of vulnerable and marginalized men -- most notably, Tui's teenage friend Jamie (Luke Buchanan), who brings food to her in hiding and ultimately dies to protect her from her father. This is obviously a profound moment of heroism, but both before and after his death, Jamie is shamed by men throughout the community for his inadequate masculinity

This gendered conflict provides the backdrop for Robin's investigation into Tui Mitcham's disappearance -- an investigation Robin alone is passionate about pursuing. Initially, Robin's colleagues seem to not take Tui's case seriously because she is a young girl of color with a history of shoplifting; however, the show gradually reveals that they are, in fact, tiptoeing around the possibility of upsetting her family. The Mitchams exert tremendous influence in Lakewood, though they are not wealthy and frequently engage in deviant behavior. Matt has a wide range of questionable "business" connections, as well as several ex-wives whom he cares for financially. He maintains these relationships carefully, in order to ensure that the economic and social security of much of the community is contingent upon his own. Despite their institutional power, the police are not immune to Matt's power, and most of them are content to shirk their professional responsibilities so that the Mitchams can serve justice themselves by harassing and intimidating members of the community.

Robin does not just refuse to comply with her colleagues' submission to the Mitcham family shadow government; she identifies insidious motivations running beneath Matt's desire to control the state the way he controls his family. Robin believes Tui's rapist is likely a member of the Mitcham family, possibly Matt himself, but the family's power makes this line of investigation all but impossible to pursue. Robin has to clear a number of hurdles before she can get colleagues to take her theory seriously, because they refuse to contradict or question Matt, the patriarch of not just his family but the community as a whole. Matt is deviant and threatening, but this consolidates rather

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because he is gay and because he chooses not to speak, responding only to "yes" or "no" questions with the words written on each of his palms. Through Jamie, the show reinforces itself as an indictment on those who benefit from gendered systems of violence -- and an empathetic depiction of all subjects harmed by those same systems.

than diminishes his social capital; his power blinds those under it to the fact that he is dangerous. Unsupported by the police department, Robin informally observes and questions members of the community to glean information about the Mitchams. Working outside the carceral system is both freeing and limiting: Robin can look into any leads she desires without stepping on her colleagues' toes, but she has to be careful so that no one knows what she is doing -- especially not the Mitchams.

When she does gather enough information to justify a formal investigation, her colleagues continue to patronize and invalidate her. Much of this invalidation hinges on Robin's traumatic personal history in Lakewood: she was gang-raped as a teenager and never got justice for the crime. Over dinner one night, her boss Al Parker (David Wenham) says the case is making her "crazy" because it is too close to her own experience. He confirms that her colleagues all know what happened to her and believe she is not only biased but too vulnerable to handle the job. Robin *is* biased, of course; the show makes it difficult for the viewer to determine whether she empathizes deeply with Tui or projects her own experiences onto the girl. But the men around Robin also act on their own biases in invalidating the case's importance, and they do not call out one another's limited perspectives as liabilities. In particular, no one calls out Matt Mitcham's obvious madness; they treat him as a rational subject simply by virtue of his power. In depicting these divergent responses, the series illustrates how gendered social systems make men's instability illegible while women's becomes hypervisible -- and how Matt's social power not only makes others see him as more rational, but also makes those same people see Robin as more erratic.

In the end, Robin's closeness to the case only damages her well-being, not the investigation. Early in the series, G.J. tells her that the investigation will devastate her; the show realizes this prediction in increasingly horrifying ways, and calls into question whether the unlikely-to-be-resolved case is worth Robin's health. Over the course of the investigation, Robin's mother passes away, her fiance breaks up with her, and she loses her job after getting in a bar fight with one of her rapists. She has an affair with Johnno Mitcham (Thomas M. Wright) -- a thoughtful, protective man who is estranged from his family -- but their bond turns sour after Matt claims he is Robin's biological father. All these moments of horror and loss break Robin down until she begins to see herself the way the rest of Lakewood sees her: a pitiable, abject, irrational subject whose perceptions and memories are too damaged to be trusted.

The resolution of Tui's disappearance validates Robin's observations and beliefs -- but this of course amplifies the anxiety, horror, and trauma of the situation. Tui is alive; she disappeared of her own volition into the mountains, where she gives birth. Matt tracks her down and attempts to kidnap her baby, but she kills him -- at which point Robin finds her and the baby. After they all return to Laketop, the state tests the DNA of all involved parties in order to solve Tui's rape case. The results reveal that Matt is the biological father of the baby, Tui, and Robin -- but not Johnno. Robin and Johnno become surrogate parents to Tui and her baby, living on the Paradise compound in a supportive, non-traditional family unit[57]. Everyone seems relatively well and stable in these moments, until one afternoon when Tui asks if she can hang out with Al and her

[57] The show does not explicitly draw this out, but Robin seems to be the de facto leader of the commune. Once Matt dies, G.J. decides she is no longer needed and that she will go to Iceland "to get away from these crazy bitches."

friends from the juvenile rehabilitation program he runs. Robin agrees, but once Tui leaves, she becomes convinced that something bad will happen. Johnno chalks this up to her frayed nerves and past trauma, and tells her not to check on Tui: "We need to be normal," he says. Then he corrects himself, "Try to be normal… pretend to be normal."

Robin disregards this advice and tracks the teenagers to Al's. Tui is safe, but Robin realizes that Al's "juvenile rehabilitation program" is a front for a child pornography ring and kills him. This, the final "the call is coming from inside the house" moment, draws out in stark detail how the carceral state produces trauma rather than protecting the social body from danger. Of course Al and his colleagues in the police department discouraged too deep a look into the violence of the Mitcham family; the two groups of powerful men are all part of the same assemblage of violent heteropatriarchal power. This violent power produces traumatized subjects -- and then uses that trauma as a means to invalidate those subjects in the event that they observe and speak out against that violence. Robin, Tui, and the women of Paradise are not inherently "crazy bitches" -- they are traumatized, and further degraded by a social system that treats their efforts to speak their trauma as the very opposite of objective fact. This trauma does not happen to them in a vacuum. Deviant men actively produce this violence, and they get away with it because of their position within systems of state and familial power. As a result of the show's institutional critique, formal legal justice cannot provide a resolution. Neither can Robin and Tui's vigilante justice, which are acts of violence in their own right. However, I argue that the show's conclusion represents a moment of justice. Paradise supplants Laketop and Robin and Tui's chosen family supersedes the nuclear family, and this

points toward a future that centers women's healing rather than reproducing their gendered traumas.

Conclusion

As Amy Taubin argues, gender-conscious crime narratives spike in production and consumption at moments when the heteropatriarchal nation state becomes particularly and obviously hostile toward the women who live within it. Such narratives give the viewer the opportunity to live vicariously through a viewer who exposes -- and occasionally dismantles -- heteropatriarchal violence. The narratives discussed in this chapter are part of this lineage, and they pay particular attention to the toll this social and interpersonal violence takes on women's mental health. In each of these texts, women expose hypermasculine violence and thus threaten the social institutions that uphold the heteropatriarchal order of things. They position themselves as protectors of a community of human subjects, fighting within institutions that protect an assemblage of norms, regulations, and differentially disciplined subjects. As a result, others not only label them "crazy", but enact traumatic -- and often distinctly gendered -- violence against them. These acts of violence often sustain systems of heteropatriarchal power, as women's trauma becomes observable proof of their irrationality that justifies the heteropatriarchal system that regulates and contains them. Of the three narratives discussed in this chapter, only *Top of the Lake* radically exposes dismantles violent social institutions; *The Fall* remains bound to the carceral state, albeit critically and uncomfortably, and *Homeland* deconstructs the nuclear family and the imperialist nation-state only to reconstruct them later.

Despite these inconsistencies in their orientation to power, these narratives do largely and effectively expose a viewing context that is actively hostile to women -- though whether they reinforce this hostility in representing it is ultimately a decision each viewer must make for themself. Yet what is not debatable is the fact that these texts often fail to interrogate the ways in which this gendered power is hostile to particular men as well. Certainly, the assumption of rationality grants men many material privileges, but it also hides their mental health experiences. The narratives discussed here often deconstruct masculinity, but do not apply this deconstructive lens to stigmatizing discourses that make men's madness visible only in its most dangerous forms. As such, these narratives not only often reinforce the power of the social institutions that shore up the heteropatriarchal systems of power their characters critique; they also all fail to dismantle the pervasive, damaging notion that a mentally ill man is a uniquely dangerous force from which these social institutions must be protected.

CHAPTER SIX:

"Everyone Wants to Go Back in Time Sometimes": Dismantling Linear Narratives of Recovery in Streaming Television about Mental Illness

The previous chapters in this project navigate how the content of particular texts negotiates contextual discourses and practices of mental illness. However, the narrative forms on which these texts rely are arguably just as significant to how we think about and regulate mental illness -- and changing these forms can open up new ways of speaking and thinking about mental health. In particular, the temporal structures used in mental health narratives must negotiate a cultural context in which time is used to define and discipline mentally ill subjects. Cultural discourses and regulatory practices of mental illness center compliance with a linear, "rational" temporality as a sign of mental health. Like other subjects who are constructed as non-normative and thus irrational, mentally ill subjects are often constructed as outside our cultural norms of time -- including historical time, human-lifespan time, and sequential character time, while mentally healthy subjects are presented as compliant with the temporal expectations of historical progress, human maturity, and everyday productivity.

On top of this, narratives of mental illness almost always depend upon a progressive teleology that presents being cured as the expected or desired endpoint of any mental illness narrative.The limitations of storytelling and the cultural expectations of creators and consumers work together to reinforce normative temporalities and teleologies of mental illness -- including some of the narratives discussed previously in this project. In such narratives, the onset of a mental health impairment creates the conflict from which the story emerges, and characters make progress toward recovery

throughout the text. Ultimately, they are either "cured" of their impairment and restored to normative subjecthood, or permanently exiled from structures of communal belonging. This formulaic narrative construction echoes many medicalized approaches to handling mental health impairments. It reinforces the notion that the goal of any mentally ill subject should be full compliance with normativity and subsequent recuperation into the social body -- a notion that once again positions mentally healthy subjects as the idealized, centered focus of mental illness discourse.

However, shifts in the media landscape -- including streaming technologies[58] -- have enabled storytelling strategies that are less dependent on straightforward episodic structures and thus move away from linear teleological constructions of mental illness as a problem to be solved. Narrative techniques like flashbacks, repeated images and plotlines, multiple plotlines, and dream/fantasy sequences defy the rules of traditional episodic, sequential storytelling. In using these techniques, these texts are better equipped to reflect the lived experience of mental health impairments, especially those linked to historical and personal traumas. Deviance from normalized structures of time is not treated as a symptom of a mental health impairment that must be cured, but a material and experiential consequence of the trauma, marginalization, and isolation that many mentally ill subjects face. In playing with conventions of time and linearity, narratives like Netflix's *Orange is the New Black* (2013-present), *Unbreakable Kimmy Schmidt*

[58] To be clear, while streaming television has clearly shifted the media landscape, it does not have a monopoly on the techniques discussed here. However, it is much easier to keep track of a non-linear narrative when one watches multiple episodes -- if not a whole season -- of a series in one sitting, rather than waiting a week or more between episodes.

(2015-present), and *Lady Dynamite* (2016-2017)[59] dismantle the notion that being permanently "cured" should be the goal of both the stories we tell about mental illness and the medical, legal, and cultural practices we use to regulate mentally ill subjects within the social body.

The subject matter of these three series differs dramatically: *OINTB* depicts the experiences of incarcerated women in an increasingly privatized prison; *Unbreakable Kimmy Schmidt* tracks a young woman's reintegration into society after years of being held in a bunker; and *Lady Dynamite* follows the misadventures of an actress seeking work-life balance. Yet all three engage with gendered trauma and mental illness, and they critique models of mental health that idealize being "cured" of an impairment. These critiques are stated explicitly in dialogue, and reinforced in character development and narrative trajectories that accurately reflect the material and affective dimensions of historical and personal trauma and thus cannot be depicted in a linear teleology. Strategies like flashbacks, recurrent dreams, repeated events, and scrambled timelines not only accurately represent the lived experience of particular mental health impairments--they move beyond the expected narrative framework of onset, suffering, recovery, cure and thus open up new ways of conceptualizing mental illness. These shows are radical not because they deconstruct time, but because that deconstruction allows a recognition

[59] While no chapter's selection of texts are exhaustive, these are a very small sampling of a massive trend. *Transparent, How to Get Away with Murder,* and *Enlightened,* analyzed earlier in this project, all deploy deconstructive approaches to narrative time. Many shows not included in this project also fit this trend -- for example, *Bojack Horseman*, an animated Netflix series about depression. *The Sopranos* and *Twin Peaks* (obvious predecessors of many of the texts included throughout this project) also used such techniques. However, both are outside my temporal scope and also, the last thing the world needs is more academic writing on them.

of mental illness as a relationship between subjects and contexts whose challenges can be mitigated (and, conversely, amplified) through cultural and structural change.

Theorizing Time as a Regulatory Technology

Feminist and queer theorists have extensively critiqued linear teleological accounts of political and social progress. They argue that such temporal constructions lend themselves to factual flaws in articulating individual and collective history, and that tidying up historical narratives into a straightforward arc toward progress excludes complications, nuances, and inconsistencies in a way that is detrimental to the pursuit of social change (see Halberstam, 2005; Freeman, 2010; Kafer, 2013; Love, 2007; Muñoz, 2009). These tidy progress narratives rely on discourses of gradual inclusion: by including those subjects who are least marginalized, communities can appear progressive without radically changing traditional structures that define who does and does not belong. This conceals the messy, recursive nature of social change and thus enables assumptions that continued marginalization is the responsibility of individual subjects who are somehow, of their own volition, out-of-sync with progressive time -- rather than the communities and institutions which continue to reproduce material and cultural inequality while presenting themselves as progressive.

This complicated construction of progressive time takes on particular contours when it comes into contact with our discourses and practices of mental health. In "The Times We're In" (2014), Robyn Wiegman discusses the traumatic experiences faced by marginalized within institutions and communities that present themselves as progressive and inclusive. Marginalization is traumatic in itself, but the masking and denial of

marginalized experiences amplifies distress and difficulty. Wiegman ties this theorization of what it means to be a subject left behind by alleged social progress to the lived experience of having a parent with bipolar disorder: a recursive and inconsistent experience that linear, "rational" temporal frameworks cannot account for. Ann Cvetkovich's *Depression: A Public Feeling* (2012) also engages with the temporality of trauma and mental illness, articulating the everyday affective dimensions of depression as a cultural/social event. This articulation is reinforced by an account of inconsistencies and recurrences in the production and regulation of depression across time and space, which reveals significant flaws in the assumption that contemporary Western treatment of mental illness is the most evolved and humane point in a linear history of medical progress.

Theories of disability expand and complicate our frameworks for understanding the individual and collective temporality of mental illness. As Lennard Davis (1998) and David Mitchell and Sharon Snyder (2000) note, narratives of physical disability take shape in a linear trajectory and culminate in the disabled subject being cured of their impairment. Such narratives ultimately reinforce able-bodiedness as not only normative, but an aspirational ideal. They also justify neoliberal narratives of political progress that place the onus of inclusion on the "deviant" subject rather than the exclusionary social body. Susan Wendell (2001) notes that disability theory and activism are not immune to troubling temporalizations of disability. Much political discourse about disability relies on particular conceptualizations of visible physical disability, and often excludes invisible chronic and/or recurrent impairments -- including mental health impairments. The temporality of chronic impairments negates the possibility of a permanent cure,

rendering them outside political frameworks that center the concept of being cured into able-bodiedness, whether these frameworks are assimilationist or radical.

Though their disciplinary approaches and subject matter differ, all these theories articulate that linear teleologies recenter normative subjects under the guise of social progress. Drawing on them, I argue here that linear temporalities for discussing and narrativizing mental health impairments operate similarly as a mechanism of gradual inclusion that ultimately disregards mentally ill subjects. Linear narratives of historical and medical progress reinforce norms of rationality that exclude and stigmatize mentally ill subjects, and mentally ill subjects are themselves treated as individual subjects outside of linear time, in need of legal, cultural, and medical intervention and/or isolation. I conceptualize time broadly here, a category that includes historical and political progress as well as lifespan time and day-to-day ways of measuring and ordering time. Adherence to these multiple structures of temporality is treated as evidence not only of social progress, but of individual rationality -- and deviance from these structures thus becomes tantamount to madness. The texts discussed here reappropriate the notion that mentally ill subjects (particularly women) are irrational/outside of time in order to defy formulaic narratives of diagnosis, suffering, and recovery and thus decenter the mentally healthy as the idealized, centered subjects of mental illness narratives.

Orange is the New Black *and Cyclical/Repetitive Trauma*

A representation of women inmates at Litchfield Correctional Facility, Netflix's *Orange is the New Black* depicts the amplified vulnerability of experiencing mental illness under privatized incarceration. The series acknowledges the contextual reality that

people with mental health impairments are disproportionately at risk for incarceration in the United States (NIMH/CDC, 2004), often due to intersecting material inequities that drive them to self-medication and/or crimes of survival (Ford, 2015). However, the show does not stop there in its factually accurate articulation of the relationship between mental illness and incarceration; it also depicts incarceration as an impairing, maddening experience both materially and emotionally (Ford, 2015). Mental illness is common among the show's characters; as prison counselor Sam Healy (Michael Harney) says early in the series, "Half this prison is on Zoloft." Characters experience both explicit and implied delusions, depression, anxiety, and post-traumatic stress, and every episode references mental health in some capacity. Each of these many distinct stories of mental illness relies on flashbacks to give context for characters' past traumas, and the series deploys repeated motifs that show how characters' experiences of mental health resonate with one another's. These strategies produce a cyclical, repeating narrative about mental illness and incarceration that always puts responsibility back on the carceral nation-state, thus fully resisting the idea that an individual medical cure can solve mental illness. The problem, the show suggests, is not the lack of sufficient mental health care in prisons -- it's that incarceration is actively damaging to subjects' mental health, yet it is constantly used to regulate and penalize mentally ill subjects.

To be clear, the show does not contextualize mental illness within the carceral system in a universal manner. The recognition and management of characters' mental health is shaped by their race and class, as are the contours of how they experience their mental health impairments. Prison counselor Sam Healy (Michael Harney) often reaches

out to white inmates in distress[60] -- including Lolly Whitehill (Lori Petty), Tiffany "Pennsatucky" Doggett (Taryn Manning), Galina "Red" Reznikov (Kate Mulgrew), and Piper Chapman (Taylor Schilling) -- while ignoring women of color. In later seasons, he actively sabotages the mental health of inmates of color. When the warden hires Berdie Rodgers (Marsha Stephanie Blake), a black counselor whom he believes women of color will better related to, Healy conspires to have her suspended. At the same time, this institutional inequality is often mitigated by informal structures of social belonging. For example, the tight-knit social group of young black women see when Suzanne Warren (Uzo Aduba)'s delusions and erratic emotions intensify, and they work to keep the guards from noticing her behavior and sending her to the psychiatric ward. In contrast, Brook Soso (Kimiko Glenn), one of two Asian-Americans in Litchfield and Poussey Washington (Samira Wiley), who becomes isolated from her fellow black women, are not recognized as mentally ill by either their peers or Litchfield employees until their distress becomes too severe to ignore.

While having a sense of social belonging or particular institutional privileges can mitigate one's distress and enable access to resources, the show always reminds us that this social cushion cannot fully counteract the mental health consequences of incarceration or offer any sort of permanent cure. We see many characters cycle back into their distress after periods of feeling at peace. In framing distress as circular, the series argues that there is no possibility of resolving a mental health impairment while

[60] While Healy's attention to white women grants them disproportionate access to Litchfield's mental health resources, these resources are not particularly helpful. Healy does not listen to women's accounts of their experiences, defaults to medication as treatment, and treats women's feelings as gendered hysteria rather than a valid response to their living conditions. Healy's misogyny thus cuts into the privileges of whiteness.

incarcerated, because mental illness is inherently contextual, and no one -- not even the most comparatively privileged or included subjects -- is going to resolve their distress in an inherently maddening system of discipline, regulation, and isolation. This is reinforced most fully in the show's flashback sequences, which treat mental illness as something that not only recurs across the lifespan of a given subjects, but repeats and echoes across characters' storylines that seem, at first glance, fully unrelated.

This cycling, repetition, and connection is perhaps most clearly revealed in the show's depiction of Healy's relationship with Lolly. Lolly's delusions and paranoia led to the loss of her career as a journalist, which created the conditions of poverty and homelessness that led her to the crimes of survival that led to her incarceration. This cycle is continued as the routinized violence of incarceration amplifies her paranoia -- though her conspiracy theories are not always inaccurate, such as her assertion that the prison is under the control of "a fascist juggernaut" -- and this cyclical pattern leaves Lolly left behind by the linear progress of the people and social contexts around her. To Healy, Lolly functions as repetition of his image of his mother, and similarities in their behavior destabilize his linear lifetime temporality by taking him back to his childhood, in which he was ashamed of and frightened by his mother's schizophrenia. He tries to help her but in his usual, horrible way; her distress heightens and culminates in an effort to build a time machine inside a supply closet. When Healy discovers it, he says, "Everyone wants to go back in time sometimes. To go back to the moment when everything seems possible." Lolly agrees, saying that time travel seems "more feasible" than finding peace in the present. She knows she cannot resolve her distress while incarcerated, and she wants to go back to a time before the onset of her mental illness so

that she is never incarcerated at all. Healy recognizes that he is treating Lolly as his own time machine and that both need inpatient treatment.

Lolly's cyclical narrative of mental illness overlaps with that of Soso and Poussey, who use the time machine as a space to imagine what their relationship might become in their post-Litchfield future. Like Lolly, both Poussey and Soso's narrative arcs are shaped by fluctuating cycles of distress and trauma. Soso, an idealist who is incarcerated for her political activism, becomes depressed as she realizes that there is no community available to her as an Asian-American Litchfield. "This is the loneliest I've ever been, and I lived alone in a tree for eight months," she says. Poussey, a queer black woman, initially belongs to the most familial social circle on the show, but she becomes isolated from it as her friends are manipulated by Vee (Lorraine Toussaint). She begins secretly drinking, depressed not just because she is isolated but that she believes her isolation is permanent, as she insists, "I'm lonely. I'm always going to be lonely." She is proven wrong, however, because alienation brings her and Soso together. Soso knows she is depressed and requests talk therapy, but the staff will only medicate her. While talking to a psychiatrist, she steals a pharmaceutical sample that she later uses to attempt suicide. Poussey finds her unconscious, and decides to help her and keep her from landing in the psych ward -- but she must seek the help of her estranged friends to do so.

While Poussey and Soso find support and intimacy with one another, their relationship does not cure the distress of either: they are still under tremendous stress, and Poussey's impending release makes them anxious about the future. Furthermore, these anxieties prove cruelly unfounded in the season four finale, in which Poussey is murdered by a prison guard. During a cafeteria riot, a guard restrains and accidentally suffocates

her because he is focused on Suzanne, who is in the midst of an outburst he finds threatening. Poussey's death is not her ending. The season leaves us on a flashback to Poussey's pre-incarceration life, a sprawling and surreal night in New York City. But this is not really her ending either; in season five -- which represents a few days in Litchfield where previous seasons represented months -- her murder catalyzes a collective uprising against the many forms of traumatic biopolitical regulation the women face. In this set of moments, the series most fully interweaves its rigorously contextualized articulation of the relationship between mental health and incarceration, its decisive critique of the carceral state, and its deconstruction of linear time and our cultural narratives of historical progress. While the show presents its mentally ill subjects as outside of linear time, it does not suggest that this is a problem in which to intervene. Instead, it repeatedly turns the viewer's attention back to the fundamental problem at hand: incarceration is fundamentally retrograde; it stunts individual and social progress by punishing the marginalized -- including the mentally ill -- under the guise of protecting the privileged from the alleged danger they pose.

Post-Traumatic Stress and Deconstructed Time in Unbreakable Kimmy Schmidt

Unbreakable Kimmy Schmidt also uses cyclical storytelling techniques in representing its titular character's (Ellie Kemper) post-traumatic stress after she is released from being held captive in an bunker by apocalyptic cult leader Reverend Richard Wayne Gary Wayne (Jon Hamm). The show depicts Kimmy as a figure outside of our expectations of linear time in both a lifespan and a historical-cultural sense. In the

first episode, she appears on *Today*[61] and realizes she will always be seen as a "mole woman" if she returns home to Indiana -- so she decides to stay in New York City, hoping the anonymity of the metropolis will allow her to create an identity that has nothing to do with her kidnapping. Yet she is emotionally stunted at the age she was kidnapped, engaging with the world around her like a child would. She explores the city's landmarks in a dreamlike state of naive wonder, freeing a Central Park carriage horse and gorging herself at a Times Square candy store. She carries her personal effects around in a backpack, drinks milk out of wine glasses, and accepts cartoon stickers as a reward for coming to therapy. Not only does she seem stuck at the age she was kidnapped, but she is also stuck in the historical year she was kidnapped, totally oblivious to contemporary culture and technology -- a comedic well which the writers constantly dip into. Yet in exchanges like "I've been Googling you." "You have? I didn't feel it," Kimmy is not the punchline; contemporary culture is. The show uses these jokes to draw out modern-day absurdities of technological growth and rapid-fire cultural production that alienate many subjects, not just those who are cut off from social and cultural progress by intense trauma[62].

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[61] Though the show is not about popular media production in the way that *30 Rock* and *Great News* are, *Unbreakable* is very much a typical Tina Fey production in that many of its episodes are loaded with critiques of contemporary popular culture. However, these critiques are not always successful. Much of the critical and audience discourse surrounding the show focuses on its inconsistent and often troubling takes on racism in the entertainment industry (see Chu, 2015; Hill, 2015; and Petersen, et. al., 2015 for an overview of this debate).

[62] Often, these jokes savvily call into question whether we've made as much historical progress as we'd like to believe. Sometimes they retrench retrograde ideologies, as in episodes that lazily mock online discourses that critique media representation and millennial campus culture.

Kimmy's endearing ahistoricity lends a (much-needed) levity to her attempts to outrun her trauma and create a self-image totally divorced from her kidnapping, which often veer into uncomfortable -- but realistic -- territory. While the show never explicitly labels Kimmy as having post-traumatic stress disorder, she experiences all the hallmark, time-distorting symptoms of the impairment: nightmares, flashbacks, and intrusive thoughts (NIMH, 2016). She also goes out of her way to avoid acknowledging her kidnapping or captivity. In season one, she hides her true identity from her new friends for weeks, desperate they believe she is a "normal person." Unable to turn to her friends lest she reveal herself, Kimmy privately grapples with whether she should testify in the Reverend's trial; even though she knows it might lead to justice, she simply does not want to talk about what he did to her. Yet while Kimmy avoids any conversation of her captivity, she is constantly thwarted by her body. As her roommate Titus (Titus Burgess) says after she insists she does not need to talk about the past, "Kimmy! You yell in your sleep. You bite *my* nails. And we still don't know why you're afraid of Velcro." These unconscious bodily responses intensify throughout the show's first two seasons, peaking at the end of season two as Kimmy experiences increasingly violent stress burps whenever she is confronted with a reminder of the bunker. Though she insists the burps are nothing, her regular rideshare customer and soon-to-be therapist Andrea (Tina Fey) tells her, "If you move all your problems down, they're going to bust out in weird ways."

Sensing Kimmy's distress, Andrea suggests that they work through the talk therapy process together -- which Kimmy of course refuses, adamant that there is nothing wrong with her. Yet she eventually concedes that she needs help and enters therapy -- a process the show depicts as a one step forward/two steps back process that can only

mitigate, not fully or permanently resolve, Kimmy's distress. In her first session, Kimmy is upset at the end when she does not feel better. "Frasier Crane can solve people's problems in one phone call!" she shouts at Andrea. She is particularly disturbed by Andrea's questions about events in her life from before her kidnapping, but Andrea explains, "Therapy is not a quick fix. It takes time. And the bunker is not the only thing that defines you." Yet even when they dig into her early experiences with her largely absent mother, Kimmy spends weeks fighting Andrea's suggestion that she could speak to her mother (Lisa Kudrow) in order to better understand her abandonment issues. The show's therapy scenes dig deeply into the nonlinearity of Kimmy's mental health experiences -- and the ways that her desire for them to be linear gets in the way of actual healing.

The show reinforces this in repeated instances where Kimmy gets sucked into social circumstances that replicate the experience of her captivity, even as she consciously tries to avoid any reminder of her past. In season one, at the height of her distress about the Reverend's trial, she becomes obsessed with a popular spin class. She excels thanks to her bunker-induced belief that she can handle anything if she just breaks it into ten-second increments, and quickly becomes one of the instructor's (Nick Kroll) favorites. She quits after Titus points out to her that the instructor is, like the Reverend, a fraudulent but charismatic man who manipulates the suffering of women while letting them think he's solving their problems. Yet Kimmy encounters a similar figure in season two. Her fellow captive Cyndee (Sara Chase) invites her to what she thinks is a meeting with Cyndee's therapist but is actually an appearance on an exploitative *Dr. Phil*-esque "Superstars of Trauma" daytime television special. The show's host Dr. Dave (Jeff

Goldblum) manipulates Cyndee and Kimmy, turning them against one another like the Reverend would when he feared the women might band together to overthrow him. Like her brief stint in spin class, this crisis is resolved when Kimmy has an open, honest conversation with Cyndee, who is, like Titus, a genuine friend who loves her as a full, complex person rather than just pitying her as a victim.

Kimmy repeatedly landing in circumstances that replicate the bunker dynamic echoes *Orange is the New Black*'s cyclical, contextual depiction of mental illness: belonging to a community shapes her experience, but it doesn't solve her distress. While Kimmy finds and develops many mutually supportive relationships in New York, she also uses helping others as a means of avoiding her own need for help. Throughout the series, Kimmy tries to cure her therapist's alcoholism, channel a fellow mole woman's (Lauren Adams) cult-follower personality traits into more socially significant work, and solve Cyndee's relationship issues with her boyfriend. This assistance, while generous, often reflects a lack of awareness of others' boundaries, and a desire to solve herself by solving others.

In positioning Kimmy within the social body but outside structures of time, *Unbreakable Kimmy Schmidt* replicates the way in which trauma distorts one's perception of time and memory. While this approach to historical, lifespan, and recovery temporalities is often surreal, it is also accurate. And, as Kimmy's desire to not be defined by her trauma reveals, linear narratives of mental health flatten distressing experiences into something outsiders can comfortably consume. Such narratives center the mentally healthy as the normative subjects of our conversations about and representations of trauma, rather than engaging deeply with what it means to live as a

mentally ill subject in a traumatizing context. The primacy and consistency of these palatable narratives places pressure on those who have suffered trauma to "solve" their past. Kimmy fully internalizes this, and tries to get around this set of cultural and social dynamics by simply pretending her trauma never happened at all. Her repeated failures to reproduce a linear mental health arc reveal how cultural pressures to recover in order to be accepted as a full member of the social body are not only factually flawed -- Kimmy has a community that loves her even at her most distressed -- but actively detrimental to finding a peaceful relationship between one's self, one's past, and one's present context.

"But, hey, I'm on a journey!": Lady Dynamite's *Decentering of Recovery through Alternate Dimensions*

Where other narratives of mental illness use flashbacks and repetition, *Lady Dynamite* alternates between multiple timelines in the life of its main character Maria (Maria Bamford[63]), an actress/comedian with bipolar disorder, quirky friends and love interests, and absurdly cute pugs. Most episodes begin and end in the timeline labeled Present, in which Maria returns to Los Angeles to re-start her acting career after spending time in outpatient treatment. In the Past timeline, a pre-outpatient Maria becomes increasingly manic as she finds acting success -- and the pressure that comes with it. The timeline labeled Duluth depicts Maria back in her hometown, where she lived with her parents while seeking outpatient treatment. Smash cuts between timelines are clarified by

[63] Bamford is best known for her stand-up comedy, which also tells stories about mental illness. Her most popular special is *The Special Special Special!* (2012), an uncomfortable, meandering set recorded in her childhood basement with an audience of just her parents. The title of her most recent stand-up special, *Old Baby* (2017), references both Bamford's childlike speaking voice and the way her life does not comply with linear lifespan expectations.

title cards, styled in a neon, 1970s disco aesthetic. The show -- which critics described as "hallucinogenic" (Nussbaum, 2016) and a reflection of "the strange currents of Bamford's mind" (Felsenthal, 2016) -- cycles through these timelines and emphasizes their respective states of being in a way that echoes how Maria's understanding of time, space, and being are shaped by her bipolar disorder. The show's narrative approach to time encourages the viewer to experience and empathize with Maria's reality, forcing them to give up their expectations of linear, sequential storytelling[64] along with the notion that Maria can ever (and should ever) be a fully normative, mentally healthy subject.

Each episode of the show is organized around a particular theme rather than a plot point within a season-long narrative -- themes that explore mental health in relationship to friendships, dating, and/or labor. These themes are not resolved at the end of each episode; instead, every episode concludes with Maria finding new (but often flawed, incomplete) insights into the topic she's been exploring in each of the three timelines. The show fully commits to destabilizing the viewer's expectations of time not just in its narrative choices but in its aesthetics as well. Though they are used consistently, the title cards gradually become unnecessary to guide the viewer, as each timeline has a distinct visual vocabulary. Present is photorealistic, though it is more color-saturated than real life, bathing characters in warm yellow light that is both flattering and a bit uncanny. Duluth is a wash of gray-blue. Its dim, low-contrast lighting echoes not only Maria's own depressive state, but also her mother's (Mary Kay Place) philosophy that "it's better to

[64] Two of the timeline labels -- Past and Present -- are words typically used to designate time, while Duluth -- still signifying a time period within the universe of the show -- is a geographic place. This inconsistent labeling convention blurs rational designations of temporality and spatiality as discrete conceptual categories while also blurring distinctions of time itself.

just keep things bottled up -- you know, the Midwest way" and her best friend's (Mo Collins) belief that "everyone's depressed; it's called being an adult." The high-contrast visual register of Past echoes the edginess of Maria's hypomania. It uses an aggressive amount of red, a wink to Bamford's own experience as the wild-eyed star of a surreal series of Target ads[65].

Each of these three timelines is granted equal weight in the narrative of each episode, but the show cycles rapidly between them, and often not in the order one might anticipate -- for example, Maria does not look to her past timelines to mine easy lessons for her present-day experiences; she often repeats and worsens past mistakes a traditional sitcom would have her learn from. In playing with these expectations, the show presents the Maria-in-crisis of Past, the institutionalized Maria of Duluth, and the inconsistently recovering Maria of Present as coexisting entities that carry equal weight in Maria's subjectivity. For example, the episode "Loaf Coach" explores the lived complications of how American culture glamorizes the hyper-productivity of mania (Martin, 2007). In it, Present Maria becomes concerned that becoming too busy will trigger her hypomania and consults a relaxation coach (Jason Mantzoukas). This effort is contextualized through Past Maria, who is obsessed with remaining productive at all times in an effort to stave off the precarity of the entertainment industry. Realizing she's neglecting her personal life, Past Maria over-corrects her skewed work-life balance by proposing to her irresponsible boyfriend (Dean Cain). At the same time, Duluth Maria shows us these

[65] The show deploys this real-life context to critique late capitalism's exploitation of the marginalized and obsession with individual achievement at the expense of collective action. In this as well as its other acknowledgements of inequities and exploitation in the entertainment industry, *Lady Dynamite* echoes both *OINTB*'s anti-privatization ideology and *UKS*'s media satire. It also echoes the critiques of the regulation of productivity presented in *Enlightened* and *The Good Wife*, discussed in Chapter Four.

pressures of productivity are not exclusive to the entertainment industry or even paid labor. Duluth Maria's mom encourages her to mentor aspiring teenage comediennes and re-start her childhood violin practice in her free time, as though outpatient treatment is not enough to occupy Maria's time and mind. Yet these suggestions remind Maria of the value of participating in productive, creative labor that exists outside her career. This epiphany carries us back into Present, where Maria has taken relaxation too seriously and over-corrected into total neglect of her work. Present Maria synthesizes the experiences of Present, Past, and Duluth Maria into a resolution to "be [her] own mother," providing enthusiastic support for both her paid labor and the free-time endeavors that balance it out. Maria is prone to extremes, as we see in Past and Present, but her surreal temporality allows her to reach into Duluth to find a resolution to the questions she experiences in all three timelines -- even though the answer she locates works more effectively in Present than it did in Duluth.

Work is a frequent source of difficulty in Maria's efforts to find a mentally healthy way to negotiate her subjectivity in context; she is often anxious about losing herself and her values in her labor, but knows that she must work to survive. We see this play out in every single timeline, across multiple episodes. Past Maria feels tremendous guilt about serving as the face of a corporation that perpetuates all the injustices of late capitalism, and she is fired from a sitcom for improvising dialogue that calls out the low-grade misogyny of the script. Present Maria regrets working on a show which plays on stereotypes of Russians and only portrays black characters in degrading, low-wage jobs. Maria attempts to solve the show's racism are thwarted by institutional barriers and the precarity of her industry; she doesn't want to risk her job or any other actor's. These

dilemmas would be stressful for anyone with a conscience, but they are made more difficult by Maria's desire to please others and not be perceived as a difficult mentally ill woman, which often manifests in a pathological avoidance of confrontation.

This people-pleasing also complicates Maria's familial, romantic, and interpersonal relationships in all three timelines. Afraid to hurt anybody's feelings by rejecting their affections, Maria rushes into dating relationships with men who are walking red flags in both Past and Present. In Present, she momentarily considers forgiving a man she has just started dating after he cheats on her with a stranger -- until she learns that he is cheating on his live-in boyfriend with her. In Past, she rushes into commitments to a man so financially irresponsible that he does not have a credit score. This tendency to tamp down her own needs and desires in order to accommodate others' manifests in her friendships as well. Past Maria buys a house she does not want to please her best friend's new realtor friend, and Present Maria hesitates to fire her friend/assistant Larissa (Lennon Parham), even though she is terrible at her job in ways that amplify Maria's stress. Duluth Maria continues to stay in contact with her best friend despite her demeaning jokes about Maria's mental health and career. This accommodating behavior amplifies Maria's distress but there is not necessarily a direct proportion between Maria's people-pleasing and her mental health. If anything, Present Maria's tendency to accommodate is most severe even when she finds stability, because she wants to make amends for Past Maria's hurtful behavior. This lack of a tidy correlation between people-pleasing behavior and emotional wellbeing often makes Maria's desire to find a comfortable place in the world feel like an unsolvable problem.

Yet, toward the end of the first season, Maria begins to reframe her focus, turning her questioning toward complex collective relationality rather than her individual positionality in relationship to others and her context. Well-being is not, she realizes, an individual journey. It is not a matter of locating a comfortable place of belonging for herself but also of offering a place to others; it is not just a matter of finding people who love her when she asserts herself, but also of finding ways to provide that same love to others. The show does not require Maria to be restored to mental health to have this epiphany -- she moves toward it in fits and starts across all three timelines, and her intellectual awareness of it often does not translate into action. Yet her missteps and failures do not disqualify her from having insight into what makes a person part of community any more than her mental illness does. Rather, her mistakes and flaws are, like her mental illness, a consequence of being a person who belongs actively to the world, in all the complexity that entails. The show fully defies those discourses that would contend that Maria does not have to sacrifice her messiness and perfect herself into a stable, productive angel. Rather, it presents an alternate timeline to the viewer's context, one in which an authentic, inclusive community can be produced if everyone embraces their own messiness as well as others, in the spirit of fostering collective love and respect rather than protecting exclusionary norms and expectations.

Conclusion

When cultural discourses of mental illness depend upon a teleological narrative that culminates in a medical cure, they reproduce the idea that people with mental health impairments are problems to be solved. Like prosthetic narratives of physical disability,

narratives of mental illness that rely upon a cure as an idealized conclusion ultimately center the normative, mentally healthy subject rather than those who live with mental illness. This decentering reinforces a broader cultural lack of empathy for people with mental health impairments, and it enables a representational regime wherein mentally ill individuals who comply with particular behavioral and emotional expectations are reincorporated into the social body, while those who do not comply are cast out entirely. Yet, as narratives like the texts discussed in this chapter insist, incorporating mentally ill subjects into community without forcing them into compliance with the directives of normalized mental health -- including those that define our lifespan, historical, and day-to-day temporalities -- benefits everyone.

This is not to suggest that people with mental health impairments cannot find peace or should not strive to resolve their distress and trauma, or that there is shame in using formal medical treatment to help manage one's well-being. However, positioning these activities as the ultimate goal of a person's mental health journey reflects a profound failure to grasp the complicated, inconsistent, and recurrent nature of trauma and mental illness. It also fails to account for the way in which our experiences with mental illness take shape within complex, constantly fluctuating cultural assemblages and in relationship to our intersectional social locations. Furthermore, this discursive production and regulation also puts the onus on those who live with mental illness to demonstrate particular "cured" behaviors in order to be granted love, support, and collective belonging -- rather than putting the onus on communities to include, understand, and materially and emotionally provide for their many, many members who live with mental health impairments.

Though they rely on different narrative strategies to do so, *Orange is the New Black*, *Unbreakable Kimmy Schmidt*, and *Lady Dynamite* all reject the formulaic approach to mental health storytelling that presents distress-as-incitement and cure-as-resolution. All three texts adopt an approach to mental health that is grounded in the day-to-day lived experiences of the characters they depict; trauma is not conceptualized as a cataclysmic one-time event that draws shock and pity from others, but as the ordinary, everyday experience of managing one's past and one's self in relationship to one's present context. Because it is unstable and contingent, this management of course does not have a clear beginning or a clear ending, and the traditional linear narrative is thus inadequate to depict it. Relying on strategies like flashbacks, repeated images, disordered timelines, and concurrent histories reflects the lived sense of being out-of-order that past trauma can lend to one's present way of being in the world.

These texts' serious, empathetic engagement with women's grappling with their past, deeply socially-located traumas also foreshadowed a significant in shift in the context in which these narratives are produced and consumed. In early October 2017, the *New York Times* and the *New Yorker* both published detailed investigative reports about film producer Harvey Weinstein's decades of rape, harassment, and exploitation of actresses who worked with him, long an open secret in Hollywood circles (Farrow, 2017; Kantor and Twohey, 2017). These first stories seemed to break a seal, and dozens of additional women who worked the entertainment industry came forward with their stories of violence, degradation, and exploitation at the hands of Weinstein and his enablers -- and then, at the hands of many known, repeat abusers in multiple industries. Subsequent months brought forth a massive wave of accounts of sexual violence and trauma, both

inside and outside the workplace, and many powerful men -- including many who were important in shaping cultural narratives in film, television, news, and public radio -- have been held accountable for their mistreatment of women.

This moment is not just a dislodging of individuals' past experiences; it is a serious reckoning with widespread trauma and the way sexual violent has been consistently enabled and normalized by a culture that presents itself as a beacon of social progress. Of the many recurring patterns that become visible across these accounts, one of the most striking is how frequently those who previously spoke out against their abuse in the workplace faced professional retaliation -- and how much of that retaliation involved being shamed as "difficult to work with" and, of course, "crazy." Yet few of these accounts have taken strides to shed the mantle of mental health stigma; instead, many have leaned into it, offering honest and open accounts of their mental health struggles, of the ripple effects that trauma has created in their subjectivity. Of course, there are those who will continue to use these accounts to discredit and dehumanize these women in particular and women in general. Nonetheless, it is heartening that the disclosure of mental health impairments has, in this moment, become concrete evidence in an argument that the system is broken where before it was treated as proof that a speaker was too irrational and unstable to be trusted to account for that brokenness.

While these accounts of pain and suffering can be overwhelming and retraumatizing, they have also created a space in which we might lay responsibility for trauma, marginality, and mental illness not at the feet of those who struggle, but the structure that creates and normalizes particular struggles. These narratives have proven time and time again that mental illness is not a personal failing or a medical condition,

but the product of an interaction between a complicated, fully human subject and their unequal, unstable context, and I can only hope that this currently radical way of thinking becomes normalized, that we stop thinking of individual subjects as either crazy or normal, and start thinking about the many ways in which the contexts we live in can become maddening, and how they are more maddening for some subjects than others. The stories we tell about mental illness, both fictional and not, in both their form and content, have often reinforced mental health stigma and its intersections with gender, sexuality, and race -- and many will continue to do so in the future. Yet when narratives actively resist these stigmatizing discourses, they have incredible potential to open up more humane, empathetic ways of thinking and speaking about mental health that can improve not just the health of individual subjects but the healthiness and justness of our culture as a whole.

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