The Imaginary Patient: Honouring the Complexity of Mental Illness in Fiction

Nathan Filer

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Abstract

This essay reflects on my efforts to write fiction honouring the unyielding complexity of mental illness. It draws on my experience working in healthcare, considers seminal works of literature (most notably *The Catcher in the Rye* and *The Bell Jar*), and interrogates relevant mental health theory and practice. It pays specific attention to my creative decisions when writing *The Shock of the Fall*. This novel tells the story of a young man dealing with his grief at the death of his brother and his experience of mental healthcare services for schizophrenia.

Introduction

I was still a newly qualified mental health nurse when I began drafting my first novel, *The Shock of the Fall* (nine years before it reached the shelves). The novel tells the story of a young man experiencing psychotic symptoms consistent with a diagnosis of schizophrenia.

In writing this work, I hoped to honour the unyielding complexity of serious mental illness. This essay will interrogate some of my main creative choices, but first it is worth briefly unpacking these terms.

At first glance, the meaning of "mental illness" may seem obvious and universally understood. It is not. As I observe in my book of nonfiction, *The Heartland*, "there is no uncontroversial language when talking about mental illness – and that includes the phrase 'mental illness'" (Filer 2019: 5). Much of the current controversy, especially in the US and UK, relates to differing ideas about whether perceived patterns of distressing thoughts, feelings and behaviours should be viewed through a predominantly biomedical or psychosocial lens (McCarthy Jones 2017). For now, however, it's enough to emphasise that when I write about mental illness, I refer to uncertain and contested ideas rather than absolute facts – and that is never more the case than when considering schizophrenia.

It is also worth pausing on the word "honour". I sought to *honour* the complexity of mental illness in my fiction. It's a term that draws from the work of the American physician and literary scholar, Rita Charon. The subtitle of her seminal book on narrative medicine is "Honoring the Stories of Illness" (Charon 2006). She writes that during her medical training, she came to understand that her task was to "absorb [her] patients' multiple, often contradictory, stories of illness" and "listen expertly and attentively to extraordinarily complicated narratives" (p.4). Elsewhere, she has described this as paying "exquisite attention" to these narratives and to "cohere" them (Charon 2011). It is with this interpretation that I use the word "honour". It reflects my efforts to pay exquisite attention to complex, contradictory ideas. Finding ways to explore such uncertainty is central to my storytelling.

The Imaginary Patient and Diagnosis

"It takes around 30 seconds to diagnose Holden Caulfield," writes the psychologist Lucy Foulkes. "Sixty, maybe, if you look at more than one website.

> *The unhappy protagonist of The Catcher in the Rye has post-traumatic stress disorder (PTSD), brought on by the death of his 13-year-old brother several years before the novel begins. The diagnosis explains a lot: the distressing thoughts, the trouble sleeping, his habit of drinking to numb the pain. Other critics say he might have depression instead, or an anxiety disorder, or maybe all three. The details don't actually matter. One thing is clear: Caulfield is a teenager in need of a diagnosis (Foulkes 2021: 77).*

Foulkes is lamenting a recent social trend. Increasingly, she observes, we seem compelled to reduce difficult and distressing human experiences into medical-sounding labels, including, evidently, the experiences of people who don't even exist and so cannot benefit in any way from the exercise. Foulkes doesn't limit her observation to Holden Caulfield. Dorian Gray, King Lear, and even dear Winnie-the-Pooh have been analysed by readers in the context of the disorder they're presumed to have (body dysmorphia, Bipolar and ADHD, respectively). I pause on *The Catcher in the Rye*, though, because of its influence on my own fiction. In truth, I feel unimaginative when I say that J.D. Salinger's most famous work influenced *The Shock of the Fall*. And yet, I say precisely this whenever I am questioned about their shared themes by A-Level students and teachers from Northern Ireland, where the two books are sometimes taught alongside each other. I'm made nervous by these questions. I've never been a reader who engages with stories through the critical lens of literary theories or comparative studies. So I answer with something vague: How the legacy of *The Catcher in the Rye* is such that even if I hadn't consciously invited aspects of its "style" into my work, they'd have likely still found their way. My novel's protagonist, Matthew Homes, is part of an established lineage of young, male, disaffected "outsiders" looking over their shoulder to that most conflicted, irascible, funny, and, ultimately, sensitive of forebears, Holden Caulfield.

As I think of Holden now, I wonder why anyone would feel a need to reduce him to a psychiatric label. What could that possibly tell us about him that the 220 pages of unfiltered access to his every vibrating thought, feeling and behaviour hasn't already told us?

As Foulkes (2021) concludes: "Maybe Holden Caulfield does have a mental disorder. He is certainly troubled and needs support. But it takes a whole book – as it should – for us to even begin to understand him." (p.77).

Another way of expressing this is that it takes his *story* to understand him. Holden Caulfield, we are led to believe through one or two of his more oblique references, is narrating from within a psychiatric institution. It would have been around 1950, so it's no surprise that he mentions a "psychoanalyst guy" who keeps asking him questions. Psychiatry at this time – especially in the United States – was still enamoured of psychoanalysis and Sigmund Freud. Holden Caulfield would have been asked a great deal about his life story; his parents and "lousy childhood" and "all that David Copperfield kind of crap", as he caustically dismisses it (Salinger 1951).

We might speculate on what a psychoanalyst would have written in Holden Caulfield's notes. It's safe to assume that he wouldn't have ascribed his patient's behaviour to any of the disorders that readers like to diagnose him with today. The reason: they didn't exist yet. The first edition of the Diagnostic and Statistical Manual, often abbreviated to DSM and commonly – if increasingly with a tone of sarcasm – referred to as "psychiatry's bible", wasn't published until 1952.

The DSM was an attempt by the *American Psychiatric Association* to create a comprehensive guidebook for mental disorders – to improve the discipline's woeful reputation for diagnostic reliability. Psychiatrists at this time could seldom agree on what was wrong with their patients (Aboraya et al. 2006). It's widely acknowledged that this first attempt failed in its objectives, as did the DSM-II, published in 1968. In both editions, the descriptions of each mental disorder were rather vague and brief, rendering them of little practical value to clinicians. Notwithstanding that, they serve as valuable artefacts, offering a glimpse into prevailing attitudes about mental illness at the time. The disorders, as listed in the first DSM, were considered to be reactions to events occurring in an individual's environment. The same thinking informed DSM-II, where "depressive neuroses", to take a commonly cited example, is described as "an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession." (American Psychiatric Association 1968: 40).

Putting aside that this description lacks scientific validity, there is, we might agree, something pleasingly literary about it.

Internal conflicts! The identifiable event! Loss of love objects and cherished possessions! It's a miniature novel in itself!

Four decades later, when Matthew Homes is first detained in a psychiatric ward in *The Shock of the Fall*, the theoretical landscape is utterly transformed. Moreover, the language of psychiatry has been severed from the language of storytelling.

We can pinpoint this change to the publication of the DSM-III in 1980. That was the moment psychiatry officially reinvented itself as a biomedical discipline.

Gone was "depressive neuroses" with its implied narrative backstory. Instead, "major depression" had a definition that ran to several pages replete with checklists of discrete symptoms, including dysphoric mood, insomnia, loss of appetite, suicidality, etc. (American Psychiatric Association 1980).

Crucially, the emphasis had shifted away from the "identifiable event".

The implication inherent to this new model of psychiatry was that what we call mental illness begins and ends in the brain (Filer 2019). That was especially deemed to be true for the most severe psychotic disorders.

I have written elsewhere about the social and political forces behind these changes – some laudable, others deeply problematic. And I've added my voice to criticisms of the DSM and the increased medicalisation of distress. Detailed checklists may have the *veneer* of science, but to quote the former director of the National Institute for Mental Health, Dr Steven Hyman, the DSM is "an absolute scientific nightmare" (Belluck and Carey 2013). It's beyond the scope of this essay to revisit those arguments. The reason I'm highlighting psychiatry's wholesale shift to the biomedical model is to present a picture of the mental health landscape when *The Shock of the Fall* is set (the novel covers a period from the early 1990s to 2010). And to remind myself of the environment that I was still working in when I began to write it.

In acute psychiatric wards at this time, there was little attention given to the role that social and environmental factors might have in causing or sustaining serious mental illness, a line of inquiry that leading researchers had virtually abandoned through the 1980s and 90s (Murray 2017). That is now gradually being addressed by some NHS services, and in recent years there has been a move towards a more trauma-informed approach, emphasising social factors.

That being said, most people using psychiatric services are still not asked about potentially traumatic events from

childhood such as abuse and neglect, and men diagnosed with psychotic disorders, including schizophrenia, are the least likely to be asked (Read et al. 2018). This is all the more problematic given the strong correlation between traumatic early life experiences and serious mental illness: one review by Read et al. (2008) found that between half and three-quarters of psychiatric inpatients had suffered some form of abuse as children.

Other social risk factors, such as people's experiences of poverty, isolation, migration, racism and bullying, were similarly ignored by leading schizophrenia researchers – and, by extension, clinicians – for decades (Murray 2017). And they were virtually never discussed when I first started working in hospitals.

It is also the case that modern psychiatry is considerably more interested in the presence or absence of psychotic symptoms than in their *content*. That is especially true where "delusions" are concerned, often seen as the archetypal characteristic of madness. It's a source of regret for some in the profession. "Delusions, like all thoughts produced by the mind, have meaning," writes Joel Gold, Clinical Associate Professor of Psychiatry. "Yet psychiatry today is not inclined to this view, has no interest in why different brains choose different delusions, and is simply interested in eradicating the psychotic symptom" (Gold and Gold 2014: 228).

Delusional beliefs, almost by definition, are a story.

They will typically revolve around conspiracies, subterfuge and perilously high stakes.

The first known case study of a delusional patient describes James Tilly Matthews (1770 - 1815), a financially ruined tea merchant who believed himself at the centre of a terrifying conspiracy involving the Prime Minister of England, the Duke of York, the king of Prussia and a supporting cast of fully-realized imaginary villains with impressively creative names: Bill the King, Sir Archy, the Glove Woman and Jack the Schoolmaster (Haslam 1810).

Reviewing this case, Gottschall (2013) observes that James Tilly Matthews' delusional creations had "all the quirks and tics that turn flat characters round". He goes on: "When Matthews was about thirty years old his brain decided, without his permission, to create an intricate fiction, and Matthews spent the rest of his life living inside." (p.91).

So we might begin to see that madness and stories are inextricably linked. There is usually a story, a comprehensible narrative – with its biological, psychological and social subplots – that can help make sense of why a person becomes mentally unwell. And for people who lose touch with reality and become psychotic, their distress often literally expresses itself *as a story*.

And yet, patient stories (at least, of the more exploratory variety for the most poorly people) were out of fashion and favour by the time Matthew Homes was admitted for his first stretch on a psychiatric ward – which coincided with my time working on one as a nurse.

I suppose, in a sense, that is how we "met".

It was around 2004, the final year of my mental health nursing degree, and I was on clinical placement. The ward was challenging to say the least – lots of extremely unwell people, not nearly enough staff or resources.

As a student, I was technically supernumerary, but it never felt that way, and besides, if I was there, I wanted to be fully involved.

However, there was one nursing intervention that trainees were never allowed to participate in, for which I was grateful. Control and Restraint: physically holding people down and medicating them against their will. There had been a few instances recently. I'd observed them from the sidelines, feeling weird and conflicted. That must have been on my mind as I walked home from a late shift. Whatever the weather, I always preferred to walk home – a bit of quiet time to process what I'd learned and decompress.

So I'm walking home, knackered. It's dark and cold. I'm leaning into the wind, hands pushed deep into my pockets. When from nowhere, a couple of sentences are circling in my head. Well, no, that's not strictly true. They're not exactly *inside* my head. I'm muttering them out loud beneath my breath.

"I had no intention of putting up a fight, but these guys weren't to know that. And nobody was taking any chances."

That's what I was saying.

Over and over.

"I had no intention of putting up a fight, but these guys weren't to know that. And nobody was taking any chances."

I didn't know that I had started writing my novel yet. But when I got home, I turned on my computer and quickly typed the sentences out. I then wrote, rewrote and tweaked a scene depicting a Control and Restraint incident. I wrote this from the patient's perspective, the person who was being restrained. I have never been restrained and drugged against my will, so I don't know how close I got to capturing that sensation, but clearly, some part of me wanted to explore what it might feel like – to imaginatively *inhabit* the experience.

I drew on my limited experience as a student nurse to get the setting right, the terminology spoken in hushed tones by the nurses, an incongruous calm.

I spent an hour or so writing and carefully editing that scene.

Then I deleted it.

I do a lot of my writing with the delete key. The scene never made it into *The Shock of the Fall*. And yet, by the time I switched off my computer, I could see him. I gave him his name straight away.

Matthew Homes, nineteen years old, a chipped front tooth, a tentative diagnosis of schizophrenia – and a dead brother who refuses to stay dead.

It was a start.

There would be no guessing game required for readers wishing to diagnose my protagonist. It may be symptomatic of the time, or my medical outlook as a trainee nurse, that I had his diagnosis in mind from the very beginning. I knew that I would write a character exhibiting some of the thoughts, feelings, and behaviours we frequently call "schizophrenia". And yet, just as Holden Caulfield seems to buck against the idea of a neatly presented "inciting event", I anticipated that Matthew Homes would reject the neatness of his label or any perception that this diagnosis might somehow be enough to contain his experience. In other words: I knew it would take me a whole book to understand him.

The Imaginary Trauma and Recovery

In an interview with me in 2018, the psychologist and author Dr Lucy Johnstone described *The Shock of the Fall* as being not dissimilar to a "formulation" for Matthew Homes. She was referring to a therapeutic intervention frequently employed by clinical psychologists. Written in a joint effort with the patient, a formulation is a carefully structured story. It summarises the patient's difficulties in a way that explains why they might be happening, making sense of them. And it will acknowledge their strengths and resources. Developing this kind of account is helpful for many patients, and some practitioners advocate for it to be used instead of diagnosis.

If we can briefly overlook the fact that novelists are responsible for creating their protagonist's suffering (lousy form in a psychologist), then Lucy Johnstone's interpretation of my novel as "formulation" offers up a surprisingly

robust framework through which to examine fiction. Consider, for instance, this description of formulation from the British Psychological Society (2019):

> Working on a formulation is like two people putting together a jigsaw. The pieces of the "jigsaw" are pieces of information such as:
>
> • How you feel at the moment
>
> • What's going on in your life now
>
> • When the difficulties or distress started
>
> • Key experiences and relationships in your life
>
> • What these experiences and relationships mean to you

I would argue that these are precisely the questions that virtually every novelist must ask when developing their characters and plot, and certainly authors of "psychological fiction", with its emphasis on the emotional and mental lives of its characters. That being said, *The Shock of the Fall* can be seen to mirror formulation in a more specific way that is not quite so ubiquitous. Namely, for Matthew Homes, the very process of reflecting on and sharing his story is integral to his recovery.

Novels tell stories of change. Storr (2019) asserts that this change will often involve a protagonist identifying and accepting their flaws. "Changing who we are," he writes, "means breaking down the very structure of our reality before rebuilding it in a new and improved form. This is not easy. It's painful and disturbing. We'll often fight with all we have to resist this kind of profound change. This is why we call those who manage it 'heroes'" (p.63.).

Matthew Homes and a hundred thousand other fictional protagonists represent this kind of hero. But again, where *The Shock of the Fall* can be seen to mirror formulation more closely is that it isn't only the events detailed *within the story* that culminates in Matthew's profound change. Rather, the therapeutic process of him *telling the story* enables this. Simon McCarthy-Jones, associate professor of Clinical Psychology and Neuropsychology at Trinity College, Dublin, acknowledges this point in an analysis of the novel. "We bury our dead six feet down, but memories inflated with guilt rise irresistibly," he writes. "They bob against the surface of our mind. They will not be pushed down. They must be let go. This is what Matthew Homes [...] is trying to do by telling his story." (McCarthy-Jones 2018: 237). Or, as Matthew articulates it himself: "We place memories on pieces of paper to know they will always exist. But this story has never been a keepsake – it's finding a way to let go." (Filer 2013: 306-307).

Another way of thinking about this is that my protagonist is engaged in a "meaning-making" exercise. Johnstone (2022) observes, "The book is essentially concerned with showing that Matthew's experiences are meaningful in the context of his life – the opposite of the pseudo-medical diagnostic process of attributing them to 'schizophrenia'." So, it will be clear enough to see why *The Shock of the Fall* might be interpreted as a fictional equivalent of a psychological formulation, at least by a psychologist. The construction of stories to make sense of our lives is, according to a key text on formulation, a fundamental characteristic of human nature that's "essential for psychological survival, enabling us to arrive at a coherent sense of identity through providing a vehicle by which we can understand the past, explain the present and prepare for the future" (Corrie and Lane 2010: 106-107). In this respect, Johnstone and Dallos (2014) argue, "it is not surprising if we can find examples of what could loosely be called 'formulations' in all aspects of our daily lives [...] and anywhere that is concerned with exploring what it is to be human such as novels." (p.281).

Whatever way we choose to frame Matthew Homes's "meaning-making" in *The Shock of the Fall*, it is clear from the plot that he's processing "trauma".

I am far from alone in using fiction to consider the aftermath of trauma. Increasingly, we may be hard-pushed to find work that doesn't delve into the traumatic events of a protagonist's past to explain their current traits, behaviours, or beliefs. It's an observation lamented by the literary critic Parul Sehgal: "Dress this story up or down: on the page and on the screen, one plot—the trauma plot—has arrived to rule them all." (Sehgal 2021, para. 4). For Sehgal, trauma has become synonymous with "back-story", which she argues is a recent phenomenon in literature. "Jane Austen's characters are not pierced by sudden memories," Sehgal writes, "they do not work to fill in the gaps of partial, haunting recollections. In contrast, characters are now created in order to be dispatched into the past, to truffle for trauma." (para 13). She concludes, "The trauma plot flattens, distorts, reduces character to symptom, and, in turn, instructs and insists upon its moral authority." (para 26).

All things considered, I don't think Parul Sehgal would like *The Shock of the Fall* very much. It principally concerns itself with the trauma Matthew endures following the childhood death of his brother, Simon Homes, for which he holds himself responsible. This "back-story" is woven through the present-day narrative. And as Matthew grows more disturbed during his adolescence, Simon reappears in various hallucinatory forms. "Grief haunts" and "trauma catches up with you", two notions dismissed as vague homilies by Sehgal (2021), would not be out of place in the novel's blurb. My defence draws upon many of the arguments I have already made in this essay. To wit: not examining back-story or trauma when writing about someone with schizophrenia would be *more* problematic by necessarily reducing their character to diagnosis.

That's not to say my approach hasn't any potential pitfalls. Seeking to explain all of a character's psychological difficulties as the neatly born outcomes of traumatic experience is a problematic – and, frankly, dangerous – simplification. It was precisely that kind of reasoning, fuelled by misogyny, that led to the now-discredited notion of the "schizophrenogenic mother", a dominant theory from the late 1940s to the 1970s that blamed mothers for causing their children's schizophrenia by either not caring for them enough, or caring too much (McCarthy-Jones 2017). In writing about Matthew's complex and not entirely healthy relationship with his mother, Susan Homes, I felt a responsibility not to propagate such harmful myths while at the same time not shying away from that most vital ingredient of fiction – *conflict!*

The solution: spend time developing Susan's character, revealing her flaws in the context of her vulnerabilities. It may have been tempting to create a villain, but I wanted the friction and collisions within the Homes family to more closely reflect those I witnessed as a nurse. That is to say, the conflict is generated by good people who desperately want what is best for each other but are at a loss as to how to achieve it.

I believe that what we call mental illness often exists as much in the spaces *between* people as it does *within* people.

My defence for writing a "trauma plot" is not to imply that I wasn't guilty of other literary tropes. Matthew's psychotic hallucinations of his brother – a reanimation of the dead – borrows wholesale from the genre of horror, and the classic trope of a protagonist bringing a loved one back to life only to be met with something far darker (McCarthy-Jones 2018).

Portraying Simon Homes as a manifestation of grief/guilt/schizophrenia proved one of my most demanding technical challenges, requiring a careful balancing of my desire to accurately portray psychotic hallucinations with a need to drive forward the plot and create pathos.

Generally, I felt most comfortable when writing Simon as an amorphous, partially hidden presence:

In my room, at night, if I stayed awake, filling the sink with cold water to splash my face, if the tap choked and spluttered before the water came, he was saying, I'm lonely. When I opened a bottle of Dr Pepper and the caramel bubbles fizzed over the rim, he was asking me to come and play. He could speak through an itch, the certainty of a sneeze, the after-taste of tablets, or the way sugar fell from a spoon.

He was everywhere, and in everything (Filer 2013: 196).

This quality of experience, poised somewhere between a hallucinatory perception and a delusional idea, felt to me a credible representation of psychosis based on my understanding from working in mental healthcare. Where I felt more conflicted, however, was in portraying Simon as a fully formed visual and aural presence, in the way that hallucinations – or ghosts! – are typically presented on screen. I limited this approach to one pivotal scene when Matthew is in hospital. Simon appears in his bedroom, crawling out from beneath the bed, and the two characters engage in an interaction that leads to Matthew absconding with a plan to take his own life (pp. 223 - 229). There was a neatness to this representation of Simon that was useful to me as a storyteller but was arguably less credible as a depiction of psychotic experience.

Here, we stumble upon a possible limitation of fiction. Or, at least, a limitation of my fiction. I have argued in this essay that "story" is integral to the causes and manifestations of psychosis. But that is not to say a typical story of madness will be nearly as neatly cohesive – or, indeed, *sensory* – as is desirable in a novel. My brief portrayal of Simon as a fully-formed auditory and visual hallucination arriving at the perfect moment to advance my plot was a creative compromise. Or, to use the hackneyed phrase, poetic licence.

I was less prepared to impose neatness and narrative order in my depiction of Matthew's recovery. If, as Sehgal (2021) suggests, the "trauma plot" currently has a vice-like grip on popular literature, the same might equally be said of the "recovery narrative" in mental healthcare.

Mental health recovery narratives are first-person lived experience accounts that typically begin by describing elements of adversity or struggle and conclude with survival and self-defined success. These stories have proliferated in recent years as popular resources used by practitioners and anti-stigma campaigns and are widely accessible online. Recovery narratives are almost certainly inspiring and helpful for many people, but their impact has not been well-researched. Recent studies seeking to address this knowledge gap have uncovered problems of authenticity, where narratives have been excessively edited, as well as evidence that they can contribute to distress and feelings of inadequacy in recipients if they perceive the narrator has made a "better" recovery (Rennick-Egglestone et al. 2019).

As with most terminology in mental health, "recovery" is a contested term, meaning different things to different people (McCabe et al. 2018). For example, a strictly medical definition might focus on remission of "clinical symptoms". But some prefer to conceptualise recovery as a journey involving the attribution of meaning to difficult experiences over time rather than necessarily returning to an earlier mindset. I have heard former mental health patients speak passionately about this – arguing that something as profound as psychosis *should* change people.

The Shock of the Fall is, broadly, a coming-of-age story. As is typical of this genre, it describes a "growth" or "positive change" character arc (Storr 2019). I knew that Matthew would need to experience some sense of recovery for the novel to feel complete. But I also wanted his recovery to reflect the nuance and complexity of the term as outlined above. For Matthew Homes, a medical recovery (again: remission of clinical symptoms) presents its own conflict:

My medication was changed yet again. More side effects. More sedation. In time, Simon grew more distant. I looked in the rain clouds, fallen leaves, sideways glances. I searched for him in the places I had come to expect him. In running tap water. In spilled salt. I listened in the spaces between words (Filer 2013: 276).

To clinically recover is for Matthew to accept a litany of chemical side effects and the further loss of his brother. As he explains:

This is my care plan: As a small boy I killed my own brother, and now I must kill him again. I'm given medicine to poison him, then questioned to make sure he's dead (Filer 2013: 280).

In no way are the specific details of Matthew Homes' psychotic experience intended to be representative of schizophrenia as a whole. They could not be. There are as many iterations of schizophrenia as people given the diagnosis. But in addressing Matthew's ambivalence about his recovery, I hope that I was able to touch upon a frequently overlooked truth: Too often, mental health professionals incorrectly assume shared priorities with the people they are treating. Recovery, we must remember, is not always without cost. It is also not a fixed state. In the final pages of *The Shock of the Fall*, we understand that Matthew remains on a journey but that his "formulation" – the act of telling his story, piecing together the jigsaw – has offered him hope.

The Imaginary Us and Them

Upon finding me in a pit of writerly despair, the novelist Fay Weldon once offered me these words of advice: "Novels are just essays to which you have attached names and characteristics to warring themes. Nothing special, just more work and a degree of chutzpa." (Weldon 2016).

I like this way of thinking.

So far in this essay, I have endeavoured to articulate some of the "warring themes" that I believe are crucial to consider when writing about mental illness and trauma in fiction.

But I have perhaps neglected a bigger question: *why fiction?*

I worked on a real ward with real people. The "medical memoir" is a wildly popular genre. Why bother with make-believe?

It isn't easy to fully recall this impulse to write fiction so many years later. However, I believe my motivation was at least partly grounded in something I've already briefly touched on. I wanted to imaginatively "inhabit" an experience of psychosis rather than "observe" it from the outside. This exercise was as much to do with trying to expand my own understanding as it was to illuminate the subject for potential readers. When writing an uncommissioned first novel, there is no way of knowing that it will ever be published, so it's a good idea, I think, for the process to be of some value in and of itself.

Novels invite empathy. Lynn Hunt, the Eugen Weber Professor of modern European history at the University of California, has written extensively around this observation and goes so far as to argue that novels played a key role in the emergence of the concept of human rights in the 18th Century. The novel helped to popularise the view that all people are fundamentally similar because of their inner psychic processes (Hunt cited in Stanford 2002). Hunt describes the empathy that can be

awoken by reading a novel. However, I would add that this also occurs when writing one – and perhaps with greater intensity when writing in the *first person*. I have commented elsewhere that "the creative act of imagining the life of Mathew Homes felt akin to an extended and deeply meditative exercise in empathy" (Filer 2020: 11). My writing process often felt like a kind of role-play, a sensation doubtless sustained by a central conceit that Matthew is sitting at a computer and physically typing out his story. I watched my fingers moving across my keyboard and saw his fingers, his bitten nails and tobacco-stained knuckles. I got to know my protagonist by spending half of my waking life being him.

I am not alone in using the imaginary first person to wrestle with complex questions about the experience of psychosis and to reflect on aspects of healthcare practice. A recent example is found in *Connections: The New Science of Emotion* by Karl Deisseroth, a professor of Bioengineering and of Psychiatry and Behavioural Sciences. This book is not a novel. It sits somewhere between a memoir and a collection of narrative essays. Still, it employs fiction, telling stories from the imagined point of view of patients experiencing psychosis. Deisseroth (2021) explains:

Where another person's inner depths – their thoughts or feelings or memories – are depicted in this way the text reflects neither science nor medicine, but only a reaching out of my own imagination, with care and respect and humility, to create a conversation with voices I have never heard, but only sensed in echoes. The challenge of trying to perceive, and experience, unconventional realities from the patient's perspective is the heart of psychiatry, working through the distortions of both observer and observed (p.4).

The first-person narrative of *The Shock of the Fall* seemed the ideal creative form through which to try to deconstruct this binary notion of "observer" and "observed" – or to use the terms favoured by many mental health campaigners: "us" and "them".

As I reflect on this now, however, it occurs to me that I may have been the primary beneficiary of the process.

As the author, I was able to inhabit my protagonist's experience (to try on the imaginary "I" through an immersive acting exercise), but where does that leave the reader? Consider this paragraph from page 5:

I'll tell you what happened because it will be a good way to introduce my brother. His name's Simon. I think you're going to like him. I really do. But in a couple of pages he'll be dead. And he was never the same after that (Filer 2013).

We clearly see the use of the first person, but I am also employing a second-person address: "I'll tell *you* what happened … I think *you're* going to like him". Does this not implicitly force the reader into the position of "observer" and so sustain the us/them dichotomy?

Well, yes and no.

As Brain (2019) observes: "What is crucial about second person narrative is that it establishes a relationship between the speaking 'I' and the 'you' who is being addressed. At the same time, it cements a bond between these 'I' and 'you' persona and the reader, who is made to occupy both of these positions at once. That is to say, the reader is simultaneously located as the person speaking and the person spoken to." (p.84). Brain makes this observation in the context of the works of Sylvia Plath, which brings us to *The Bell Jar*. If, as I have suggested, Matthew Homes is a literary descendent of Holden Caulfield, then he also shares a lineage with Holden's iconic contemporary, Esther Greenwood. Set in the summer of 1953, Sylvia Plath's roman à clef protagonist is an embodiment of internal conflict and the novel devotes far more of its narrative to depicting the psychiatric landscape than *The Catcher in the Rye* attempts. Esther describes in detail her time in hospital and the treatments she receives. It is among the first notable works of fiction that deal explicitly with mental illness in the post-DSM era. It also skilfully deploys an "intermittent, flexible second person" to "establish the reader's close relationship with the speaking 'I', and their shared positioning" (Brain 2019: 91.). Esther Greenwood shifts between the first and second person throughout the narrative, challenging the reader to associate themselves directly with some of her most distressing thoughts and preoccupations. For example, in this passage where Esther is wrestling with feelings of suicidality: "The trouble about jumping was that if you didn't pick the right number of storeys, you might still be alive when you hit bottom. I thought seven storeys must be a safe distance." (Plath 2019 edition: 131). Here, Esther co-opts the reader for the moment of impact. There is no escape. We're to countenance with her the agony of hitting the ground alive.

Of course, it can be easy to read more into a sentence than the author intended. As Brain (2019) acknowledges, the second person direct address in *The Bell Jar* may be principally born of the author's desire to give the effect of informal, spoken language. This interpretation may be doubly true of *The Catcher in the Rye*, in which the conversational style even evokes a kind of "turn taking", as though the narrator and reader are sharing the same physical space and time. Consider, for instance, these lines from its opening paragraph as Holden Caulfield describes his parents: "They're quite touchy about anything like that, especially my father. They're *nice* and all – I'm not saying that – but they're also touchy as hell" (Salinger 1951).

Myers (1982) notes: "The 'I'm not saying that' seems to mean 'I'm not saying what you (the reader) are thinking or saying – that is, that my parents may not be nice.' Thus, the narrator suggests that the reader is a participant who has taken a kind of half-turn, paraphrasing the narrator's comments in some way." (p.20).

It is this intimate, participatory connection with the reader that I wanted to create in *The Shock of the Fall*. My efforts to achieve this can be seen in "Make Yourself at Home" (pages 101 - 177). This chapter, which is the longest in the novel, captures Matthew Homes having a mental breakdown in real-time while he ostensibly recounts a previous mental breakdown. At the start of the chapter, we learn that he has disengaged from mental health services and retreated to his home. "I didn't tell you where I live yet," he begins. "It probably doesn't matter, but I'll tell you now, because then you can have some pictures in your mind as you read.

Reading is a bit like hallucinating.

Hallucinate this:

An ash grey sky over a block of council flats, painted jaundice yellow. I'll buzz you up. It's the sixth floor, No. 607. Come in. The narrow, dim-lit hall is cluttered with pairs of old trainers, empty Coke and Dr Pepper bottles, takeaway menus, and free newspapers.

To your left is the kitchen, sorry about the mess. The kettle's billowing steam onto the peeling lime green wallpaper. There is an ashtray by the window, and if you open those blinds you can spy on half of Bristol.

It can spy on you too (Filer 2013: 101).

In this passage, I'm attempting to locate the "I" and "you" in a shared physical and psychological space, inviting the reader to participate in Matthew's creeping paranoia.

The reader will briefly glimpse something untoward in the corner of the room, which Matthew later refers back to in a more challenging tone:

You saw it in the corner, and

stretching across the far wall.
Were you too polite to say
anything, to ask any questions?
The sprawling tubes and dirt-encrusted jars.

Strange, isn't it? (Filer 2013: 149).

Here, the distance between the narrator and the reader is re-established. It's a push-pull dynamic.

Later, the reader may be surprised to discover how elusive Matthew remains. "You don't think I'm really called Matthew Homes, do you? You don't think I'd just give away my whole life to a stranger?" (Filer 2013: 274).

This too echoes *The Catcher in the Rye*, where the reader is initially positioned as "a kind of interrogating enemy who will not prevail against the narrator and is kept at a distance from him." (Brain 2019: 91). That being said, in *The Catcher in the Rye* and *The Bell Jar*, the second-person "you" is most often simply a colloquial stand-in for "one", achieving the conversational style that their authors epitomised. From the above extracts of *The Shock of the Fall*, it will be apparent that although I sought to emulate this style, my imaginary "you" is seldom a substitute for "one".

Matthew Homes (or whatever his real name is) isn't talking to an abstract, impersonal pronoun. He's talking to, well… *you!*

And yet, you remain out of reach to him. He can't be sure who you've met, what you know, whether you truly understand him. Charon (2006) has observed how healthcare workers and patients can seem to each other like alien planets, "aware of one another's trajectories only by traces of stray light and strange matter." (p xii). Was I unconsciously recreating this dynamic between my troubled protagonist and his imagined reader?

It's possible. In any case, we have come full circle. Though Matthew differentiates himself and the reader, they can still – as we have considered – occupy both positions. Charon (2006) cites Georges Poulet's claim that "the extraordinary fact in the case of a book is the falling away of the barriers between you and it. You are inside it; it is inside you; there is no longer either outside or inside." (p.108).

In his last direct address, Matthew Homes quietly acknowledges that a shared understanding with the reader has been achieved. "You know what I'm like," he concludes, making a fleeting reference to a vaguely suspicious thought he's just entertained, requiring no further explanation (Filer 2013: 306). Ultimately, Matthew Homes feels *seen* by the reader. He feels understood by his ever-present confidant, with whom he has shared many of his most intimate vulnerabilities. Naturally, I hope readers of the novel – especially those with personal experiences that reflect Matthew's – will share this feeling of being seen and understood.

Where I have achieved this, my creative choices outlined in this essay, including my decision to write a first-person narrator who addresses the reader directly, is likely to have played a part.

As I draw this essay to a close, it feels important to acknowledge that my efforts to imaginatively inhabit the experience of my psychotic protagonist in *The Shock of the Fall* were precisely that: *imaginary*.

I am fortunate that I have not experienced the sustained intensity of distressing thoughts and feelings that might lead to a diagnosis of schizophrenia. At the same time, I believe that the boundaries between what we might call "healthy" and "unhealthy" mindsets are highly porous; there is a psychological fragility to everyone, and many of us will have at least glimpsed the edges of madness at dark moments in our lives, even if we have never received any clinical diagnosis or required specialist care (Filer 2020).

There is an irony to the fact that my writing about mental health has, on occasion, taken its toll on mine. I'll quote Flannery O'Connor: "Writing a novel is a terrible experience, during which the hair often falls out and the teeth decay. I'm always irritated by people who imply that writing fiction is an escape from reality. It is a plunge into reality and it's very shocking to the system." (O'Connor, 1970).

That being said, I believe the endeavour is wholly worthwhile. In its myriad forms, madness cannot be understood if examined only through a single lens. Research from health and science-based disciplines is essential. So, too, is input from the arts, uniquely placed to explore personal dimensions – and to bring us to a greater emotional understanding. Fiction is an ideal medium to honour the complexity of mental illness by deconstructing arbitrary notions of the "observer" and "observed". It invites the reader to explore the inner psychic processes of another, to exist for a while as more than one person – and to emerge, finally, changed.

Note: this essay is adapted from the author's 2023 PhD exegesis, which can be found in the reference list.

BIOGRAPHY

Dr Nathan Filer is an award-winning author of fiction and nonfiction. His works are published in thirty languages. He is a recipient of the Big Anxiety Prize, awarded in association with the University of New South Wales for "a creative thinker advancing the discussion of mental health". He holds an honorary doctorate from Abertay University, conferred in recognition of his role in raising awareness of mental health issues through literature. He is a Reader in Creative Writing at Bath Spa University, where he co-directs the Research Centre for Mental Health, Wellbeing and Creativity.

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