

An Intrinsic Malfunction / A Deliberate Social Construct? Framing Mental Variation beyond the Prescribed and Over- Medicalized Biomedical Context in Brian Yorkey's 'Next to Normal'

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Abstract

The present paper addresses the question of 'mental illness' as a complex lived moment of severe rupture, a 'spiritual' human variation, and a meaningful active sociopolitical experience. Aiming to reify and transform what is commonly referred to as a problem of disordered minds, deviant psyches and inherent inferiorities, the researcher draws on the 'Social Model of Disability' - an alternative framework that ideologically runs counter to the dominant orthodoxies of the functionalist biomedical perspective - for a more complex and nuanced understanding of the limitations associated with mental diversity. For this purpose, the study takes as its primary focus the experience of the protagonist with bipolar disorder in Brian Yorkey's radical rock musical, 'Next to Normal'(2009), to negotiate the multifaceted network of socio-political contexts informing madness and to offer new and transformative insights and unorthodox representation of the human mind. To this end, the study finally reaches the conclusion that madness is not necessarily a manifestation of intrinsic behavioural, psychological, or biological malfunction, but is culturally induced and deeply involved with the increasingly maddening politics of the dominant, social (purely clinical or psychiatric), and identifying community that is not set up to accommodate those who have been defined as mad.

Keywords: Ableism – Mad Pride Approach – Medical Model of Disability – Next to Normal – Psychosocial Disability – Social Model of Disability

I- Introduction

I.1. Research Problem

(Mad Identity: Mental disorder or Social Construct?)

In its present complex incarnation, 'identity' is an amalgamation of our physical, psychological, and interpersonal traits that are not wholly shared with any other person and that define who we are, how we think about ourselves, and how we are viewed by others. (Vandenbos2006: n.p.) There is, however, another 'social' level in the concept of identity apart from the 'personal' one. This 'social' level refers to the way societies create social constructs and structure social categories. As Goffman, a Canadian sociologist, indicates: "Society establishes the means of categorizing persons and the complement of attributes, felt to be ordinary and natural for members of these categories" (1963:3). Hence, identity formation and evolution are not only shaped by individual characteristics (biological and physiological markers) but impacted as well by a variety of external cultural markers like "family dynamics, historical factors , and social and political contexts" (Tatum 2000:9-14).

Given the way our identities are socially constructed, the present study aims to highlight an important social construct, namely, our perception of disability, especially psychosocial disability (PSD). So deeply ingrained within us and regarded as self-evident truths, our inwardly held beliefs about PSD affect not only the well-being of people with disabilities but also the moral compass of societies. Within the context of marginalized and underrepresented groups- especially those who are identified as mentally disabled-it is the social context (the place and time we live in) that defines standards, shapes meanings, creates diagnosis, values, or devalues difference, and makes things easier or harder for people who are mentally (or psychosocially) disabled. Arguing that mental health disabilities are defined by the societies and eras in which they exist in, Thomas Armstrong, the executive director of the *American Institute for Learning and Human Development*, maintains that "no brain exists in a social vacuum. Each brain functions in a specific cultural setting and at a particular historical period that define its level of competence" (2010:15). Assuming that the biological and the social are interactive in creating disability, Susan Wendell, an American disability scholar, claims that "neither impairment nor disability can be defined purely in biomedical terms, because social arrangements, and expectations make essential contributions to impairment and disability, and to their absence" (qtd in Jones1996:347). Liah Greenfeld, an American sociologist, as well, while not entirely dismissing biological factors in mental illness, in her

"*Mind, Modernity, Madness: The Impact of Culture on Human Experience*," argues that the phenomenon that was for a long time called 'madness' is an effect of our cultural environment (2013:84). To Greenfeld, 'madness' is a disease or a disorder "not of the brain but of the mind, of consciousness, which itself is a cultural phenomenon" (2). She thus states strongly that it is modern culture that makes the formation of the individual identity increasingly difficult (4).

It is for the above reasons that madness or the malformation of the mind - quite independent of any disease or disorder of the brain - becomes a mark of societies that are not set up to accommodate 'mental illnesses' as variations of human experience and ways of being. In this context, therefore, societal attitudes are significant since they largely determine the extent to which the needs of persons with disabilities will be realized, while their biological attributes are only one part of who they are.

I.2. Objectives

Apart from illuminating all sorts of intersectional realities, complex attitudes, abusive discourses, and exclusionary practices attributed to bodies that societies deem mad, the study seeks to advance a positive framing of a human variation that is conventionally viewed, narrativized and represented as inherently negative. Taking the psychiatric experience of bipolar disorder as a primary focus, the researcher negotiates the complex multi-faceted network of socio-political contexts informing it, with the aim of critiquing the increasingly maddening discourses and politics of a social (purely clinical or psychiatric) community that is not set up to accommodate those who have been defined as mad. Arguing against the medical model of disability and the tendency to assume it too readily in the case of madness, and reflecting upon how society is an active constituent of meaning and a vital determinant that can have direct or irrevocable effects on psychological well-being, the study reveals cracks in the social construction of mental variation. Reshaping our notions of the self, the other and the world, the study solidifies mad identity as the active and thoughtful positioning of the self with respect to an over - medicalized biomedical understanding.

I.3. Research Questions

In line with the researcher's objective to consider how societal discourses and politics intersect to produce 'disability', the study addresses the following key questions: **First**, what falls under 'Psychosocial disability' (PSD)? I.e., is failure to hold up to the expectations of a non-mad identifying community - that

constructs the boundaries of normalcy - really a disorder? **Second**, is mad experience the result of an actual (hereditary) mental disorder or is it a cultural production, a mere cry for help, and a way of expressing what would otherwise be left unsaid? **Third**, how far does psychiatry (its structural entities, authoritative discourses, and practices) have irrevocable effects on the psychosocial well-being of the mentally deranged? **Fourth**, does the social model of disability – the proposed alternative approach – offer a helpful framework for a more complex and nuanced understanding of non-normative minds? **Fifth**, in what way does *'Next to Normal'*, the theatrical rock musical under consideration, provide new and transformative insights into how culture acts upon the mentally deranged protagonist of this study? **Finally**, does *'Next to Normal'* manage to reconstruct social scripts and shape how we think about this form of human variation? **I.e.**, does it enable the distant 'Other' to speak back? Does it have the potential to offer a vigorous critical punch? And if so, what are the ethical considerations and carefully crafted elements of such representation?

I.4. Rationale

The rationale or the basic underlying reasons behind selecting this specific area of study stems from the researcher's moral obligation towards - and empathetic engagement with- the Other's experience. Rejecting the conventional received scripts and negative framings of 'madness' as an over-individualized problem or tragedy, the researcher seeks to cast an entirely new light on the question of 'psychosocial disability' and to call into question our accepted and culturally entrenched understandings of it. The researcher is inspired even more to promote social transformation by reframing the conditions of those who have been defined as psychosocially disabled and troubling the multiple politics of structural violence in both psychiatric sites and cultural discourses.

I.5. Significance

Apart from sustaining and developing timely questions about power, politics, minds and voices, the researcher hopes that the present paper would advance the field of psychosocial disability forward by prompting further reflections on how dominant culture works and how we need to accommodate a broader range of experiences and behaviours. The researcher does hope as well that this study would render us reconceptualize PSD and better appreciate its complexity in ways that reshape our sense of the self, the other, and the world.

I.6. Sample

For the above purposes, the researcher selects Brian Yorkey's and Tom Kitt's theatrical rock musical *'Next to Normal'* (2009). Within this intentional sampling, the study identifies recurring dominant biomedical norms and tropes of PSD, reveals oppressive power relations and authoritative politics and practices as problematic, and proliferates scenarios of PSD outside prescribed over-medicalized scripts.

II- Theoretical Approach

II.1. Mad Identity: Complicated Meanings and Causative Factors

An internationally recognized term, Psychosocial Disability (PSD) is one of the most challenging, misunderstood, and marginalized areas of disability. Frequently known as mental or psychic disorder, PSD involves actual or perceived impairment of the mind due to “a diversity of mental, emotional or cognitive experiences” (Ringland2019: 156-170), disrupting normal thinking, feeling, mood, behaviour, or social interaction. It arises when those with mental health conditions - those who are influenced by life experiences as well as maladjusted cognitive and behavioural processes - interact with social environments that set barriers, affect their ability to participate and hinder the full realization of their rights. Representing a large portion of the population, individuals affected by PSD experience a range of symptoms, from mild to acute or severe. These individuals may find it challenging to be in certain types of environments, interact with others, and participate in social activities. They may also find it difficult to set goals, make plans, cope with daily problems or time pressures, manage stress, understand constructive feedback, and engage in education, training, and employment (Kaufman 2010:182-209).

A wide range of complicated biological, psychological, and environmental factors have been identified by researchers as contributing to PSD. Risk biological factors include genetics, prenatal damage, infections, exposure to viruses or toxins, brain defects or injuries, and substance abuse (182-209). PSD may be influenced as well by psychological triggers like emotional, physical, or sexual abuse, neglect, bereavement, emotional detachment, feelings of inadequacy, low self-esteem, anxiety, anger, or loneliness. Environmental triggers are also implicated in the development of mental disorders. They include - but are not limited to - dysfunctional family life, financial problems, and stressful life situations (Huang et al 2016: n.p.).

Among the environmental factors that exacerbate the individual's experience of disability is social stigma. Despite centuries of learning, PSD remains a contentious concept. Individuals with PSD have always been stereotyped as characteristically weak, inadequate, incompetent, violent, unpredictable, and dangerous. They have been frequently labelled as victims, pathetic characters or 'the deserving mad' (Byrne 1997:618-620). Arising from a widespread belief system called 'Ableism', social stigma assumes that individuals with PSD are "less worthy of respect and consideration, less able to contribute and take part, and of less value than others" (Law Commission of Ontario 2012). A pervasive barrier, social stigma thus worsens mental illness and contributes to an environment where individuals with PSD may be hesitant to disclose symptoms, seek mental health care or adhere to their medication. Devaluing their experiences, thoughts, and choices, and making society have low expectations (Walker 2008: n.p.), social stigma renders patients find it hard to complain or assert themselves on their own rights because their experiences are minimized and attributed to their disabilities. A survey respondent once claimed:

I have never felt so disempowered, hopeless, helpless, and suicidal as I did then. Every single feeling, experience, or thought I have that my psychiatrist does not like, no matter how valid, healthy, or normal it is, is rendered completely and utterly irrelevant. I do not matter (Bloom 1997:10).

II.2. Mad Context

II.2.1. The Ableist Ideology and the Boundaries of Normalcy

The view that human life can be measured according to a benchmark of normality was, historically, the most pervasive human tendency. Still widespread and embedded within contemporary everyday practices and discourses, the experience of being on the 'other' side of the mental health/distress boundary thus emanates from the established norms that delineate the boundaries of normality, or more precisely speaking, from the classification systems that have been developed by the distinctive mental health fields such as psychology and psychiatry. Coming into play at all levels, these social boundaries determine what is normal and what is abnormal, who is in and who is out, and what is acceptable and what is not acceptable (Meynell 1989:419-432), but they do not explain differences.

Defining, dividing, excluding, rejecting, and disregarding those who do not fit in, the previously mentioned narrow conceptualization of normality has had a

negative impact on those deemed as mentally ill. For to be mad is ultimately to be socially positioned away from the mainstream and placed on the other side or, more precisely speaking, the wrong side of the social divide from those who are 'normal' or 'insane'. To be mad is to be defined as the 'bad', the 'crazy', and the 'imperfect', and to be labelled as the 'lunatic', the 'schizophrenic', the 'mental', the 'psycho', the 'nut case' and so on. To be mad is to be part of the process of exclusion- to be treated differently -with prejudice, discrimination, and 'psychophobia', of a severe kind, from the people around (Walker 2008: n.p.).

II.2.2. Psychiatric Contexts and Patterns of Authoritative Discourses and Politics

In tandem with the ideology of normalcy now posed, the authoritative psychiatric thought- which believes in the truth of its principles and the effectiveness of its practices - renders its patients pervaded by “rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing and judgmental explanatory systems” (Bloom 1997 :10). It becomes thus an irrefutable and inviolable belief system or part of what Foucault calls “a sort of semi judicial structure, and administrative entity which, along with the already constituted powers, and outside of the courts, decides, judges, and executes” (Meynell 1989:37). Endowed with the authority to explain, medicate, or exclude, psychiatry thus erodes the patients' self-esteem, undermines their autonomy, reduces -or excludes- their right to decide their activities, control their environment and manage their belongings.

In addition to its opting for “arbitrary commands whose disobedience will result in intervention” (Page 1904:592), psychiatry - primarily 'diagnostic' - fails to develop supportive and therapeutic cultures. For it neglects the need to build a positive relationship of care, trust, psychological containment, support, and mutual respect, thus accentuating the patient's 'inner battle' (Iglehart 2004: 507-14), corrupting the essence of what is to be human, exacerbating illness, and doing more harm than good.

Moreover, by constantly diagnosing the traumas of its patients using the language of psycho pathology, and by searching the courses of their misbehaviors 'within' the patients themselves, psychiatry disregards the social determinants of causation. Hence, it neglects the potential for the transformation of the conditions that may have given rise to the phenomenon in question. Progression in the mental conditions of these patients is thus largely mythical for a simple reason: “(The psychiatric mandate) is precisely to obscure, and indeed

deny, the ethical dilemmas of life, and to transform these into medicalized and technicalized problems susceptible to 'professional' solutions” (Szasz 1973: 11).

Significantly influenced by the fundamental psychiatric principles, many psychiatrists inflict a long catalogue of foul practices and horrific abuses on the mentally disordered patients. Conceiving these practices as a necessary evil - undesirable but justifiable and unavoidable in some situations- these practitioners legitimize and subtly misuse them to fulfil their 'duty of care', manage high risk behaviours, and ensure that control is exercised over the patients (Lord Widgery 1975:318). Viewing this psychiatric assault as treatment failure rather than health care intervention, Ward Haugh and Wilding, professors of psychology, describe this embarrassing reality as “an active betrayal of the values upon which the organization is supposedly based” (1993:5) for “the primary aims of care have become subordinate to what are essentially secondary aims such as the preservation of order, quietness and cleanliness” (Martin 1984: 708).

II.3. The Musical Theatre

Against this backdrop , and speaking of Brian Yorkey’s and Tom Kitt’s musical *Next to Normal*, this paper is set out to unfold the nature, meaning and scope of the ‘Musical Theatre’ as a concept and as an academic discipline. More effective than just a simple performance, Musical theatre is a form of theatrical performance where singing, dancing, acting , spoken dialogues, and technical aspects (set design, costumes, stage properties (props), lighting and sound) are given equal importance; and are all fully integrated into a well-made story ,with serious dramatic goals ,to evoke genuine emotions (humor, pathos, love, anger) other than laughter (Everett 2002:137-138).

Devoting more time to music than to dialogue in communicating the story and emotional content, musicals, therefore, have less time - than a straight play of equivalent length - to develop drama. For within the compressed nature of a musical, the writers must develop the characters and the plot. Besides, moments of greatest dramatic intensity in a musical are often performed in a series of songs, which are ideally crafted to suit the character (or characters) and their situation within the story. Thus, there is no separation at all between song and character (Jones 2003:10-11).

An artistic experience unlike any other, a musical plays a major role in moving the story forward, revealing the inner emotional life of a character, foreshadowing a vicious attack, commenting on the action onstage, and fostering

social awareness through exposure to social issues, events and cultures that are portrayed in the scripts. In short, a musical can make us laugh, cry, cheer, and sing.

III. Methodology

The priority given either to 'biological aspects' or to 'social context' in generating limitations has given rise to an array of different disability approaches. Among the many different current lenses through which PSD can be addressed, understood, and managed are the 'medical' and the 'social' models of disability. The study in question draws on the 'Social Model of Disability' as a radical model of inquiry, particularly well-suited to the objectives of the present paper.

III.1. The Medical Model Disability vs the Social Model of Disability

So strongly ingrained in society and so powerfully reinforced among professionals in both research and practice, the Medical Model of Disability (MMD) (or the clinical perspective) leaves no room within its framework for the social, psychological, and behavioral dimensions of disability. As Liz Crow, a disability activist, notes this standard medical approach holds that “a person's functional limitations (impairments) are the root cause of any disadvantages experienced and these disadvantages can therefore only be rectified by treatment or cure” (208) to fix the disability, approximate normal functioning, and become a part of society.

Perceiving disability as an individual problem or a 'personal tragedy' rather than a socio-political issue, and opting for a more individual, illness-based discourse and intervention, the medical lens thus restricts the range of possible inferences, denies agency to people with disabilities by reducing them to their limitations, and reserves power for medical professionals. Failing to analyze the socio-political contexts in which attitudes and values are constructed, and how these values are in turn transformed into oppressive actions and practices, the (MMD) sets a major barrier to people with disabilities who are often reported as feeling excluded, undervalued, pressured to fit a questionable norm, and conditioned into accepting a devalued social role as sick, pitiful, incapacitated, and 'a burden of charity' (Hutchinson and Tennyson 1986:33).

The Social Model of Disability (SMD), on the other hand, has created a quantum shift in the way disability is perceived. Providing a critique to the (MMD), the (SMD) views disability beyond the individualization of the medical

context and addresses it from within a socio-political framework- locating its causes squarely within the wider, external environment (i.e., society and social organizations). Proponents of the (SMD), thus, relate disability to a multiplicity of systemic factors, pejorative attitudes as well as inhospitable and unaccommodating social and cultural settings that have contributed to shaping the meaning of disability, exacerbating the disabled people's experience of disability, undermining their personhood, and ascribing them with the status of second-class citizenship.

Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society (UPIAS1976: 3-4)

Mainly theorized by the disabled British scholar and activist, Mike Oliver, the (SMD) provides conclusive evidence that disability “as a category can only be understood within a framework which suggests that it is culturally produced and socially structured” (1990:22). Through his groundbreaking conceptual framework, Mike Oliver affirms that it is not about “the personal experience of impairment but the collective experience of disablement” (2004:22). Hence, he advocates acknowledgment of what can be troubling about disability, what is valuable about disability, and what can be done to accommodate difference, re-define self-identity, re-think social values, question the foundations of 'normal', and face issues of inclusion as fundamental, moral issues.

Keeping the above aims firmly in sight, the (SMD) - in the words of Liz Crow - has done wonders for the disability rights movement. For apart from offering new and transformative insights and unorthodox representations of the human mind, the powerful core value of the (SMD) is that it has reshaped our notions of the self, the other, and the world as it has enabled

a vision of ourselves free from the constraints of disability (oppression) and provided a direction for our commitment to social change. It has played a central role in promoting disabled people's individual self - worth, collective identity, and political organization. I don't think it is an exaggeration to say that the social model has saved lives (1996: 207).

III.2. The Mad Pride Approach

A mad positive approach, ideologically related to the neurodiversity and disability subcultures, Mad Pride poses a radical challenge by urging cultural

change in society's customary understanding and treatment of madness as illness. Originated in 1993, in Toronto, by a group of psychiatric survivors, this mass movement is a considerable attempt to promote other sorts of framings, recognize those deemed as 'not normal', bolster self-esteem, win human rights, promote empowerment (Le Francois 2013: n.p.), and develop positive narratives of mental health phenomenon - narratives that can counteract the inherently pervasive, negative views in society and psychiatry.

Recognizing that madness can be a gift, a strength, or a ground for unique identity and culture, Mad Pride discourse thus rejects the reductionist, discriminatory, and disrespectful language of 'illness' that dominates public and professional narratives. As Le Francois, Menzies, and Reaume described, Mad Pride functions as "a project of inquiry, knowledge, production, and political action devoted to the critique and transcendence of psycho-centered ways of thinking, behaving, relating, and being" (2013: n.p.). For this purpose, it seeks to reclaim key terms often used pejoratively like 'mad', 'nut', 'crazy', 'insane', 'lunatic', 'maniac', and 'psycho'. It also reconsiders diagnostic labeling like 'disease', 'disorder', 'delusion,' and 'hallucination ' from misuse, and replaces their negative connotations with more positive understandings (Ruth2009:1-2).

Arguing that mental health conditions can be redefined or made into 'something beautiful,' Mad Pride discourse stresses the uniqueness of the mad identity- its claims to respect, recognition, equality, self-esteem, and self-determination. Solidifying it as a "culturally meaningful and active socio-political minority identity" (Quart 2009: n.p.), Mad Pride advocates that individuals labeled with psychiatric disabilities should be proud of their 'mad' identity for "what is often considered simply a horrible disease can be transformed into an ecstatic, creative, productive, or broadly 'spiritual' condition" (n.p.).

IV- Content Analysis

Brian Yorkey's and Tom Kitt's "Next to Normal"(2009)

Widely regarded as a groundbreaking, world premiere theatrical production to hit Broadway in a decade, *Next to Normal* (NTN) (2009) is a live, immersive, 60-minute American rock musical with a book and lyrics by the American playwright and lyricist Brian Yorkey and music by composer Tom Kitt. A positive step forward for people suffering from PSD, NTN honestly addresses the stigma of mental illness, shockingly shows straight forward facts about the

daily experiences of PSD, and courageously critiques cultural values, assumptions, and institutional structures - integral factors of social injustice - that impact PSD yet remain problematically unspoken, underrepresented, and perhaps even missed, ignored and unrecognized. A resolutely well-intentional, technically rife, thematically dense, and highly relevant piece of theatre to today's culture, NTN won three 2009 Tony Awards, was awarded the 2010 Pulitzer Prize for Drama, and was also chosen as 'one of the year's ten best shows' by the Los Angeles Times, the Washington Post, Rolling Stone, and The New York Time (Tobin 2009: n.p.).

NTN revolves around an upper middle-class, white, suburban wife and mother - Diana Goodman - and her worsening struggle with bipolar disorder (which was triggered by the traumatic experience of losing her son). The musical traces Diana's attempts to manage her illness and treatment (including ECT and psychiatric drugs), and the toll these attempts take on her family. Telling much of the story through songs, Kitt and Yorkey interweave various musical genres (rock, pop, classical and country music), flow smoothly between song, scene, and dance, and connect the text to the tone, mood, or style of music. The creators' aim is to move back and forth between literal and psychological realities and offer a unique, deep, and introspective glance into the minds, hearts, frenzied states, anxieties, mood swings, delusions, and imbalances of thought of those suffering with bipolar disorder. Their constant and perfect combining of genres is fundamental in upping the show's emotional effect, furthering the plot, strengthening the narrative, enhancing the characters, deepening their relationships, showcasing their interactions and difficulties, conveying their psychological realities, and illuminating and educating the audience.

Though ideally introduced at the very beginning of the musical as a very 'normal'-looking and beloved protagonist who would seem like leading a 'perfect' family life and having it all, Diana exhibits nothing of the stigmatizing traits of people who experience PSD. Instead, she is represented as an exemplary, sexy, sharp, and educated wife, possessing physical beauty. Appearing, as well, as a stable, albeit high strung, and concerned mother who cares for her family, always dressing nicely, and speaking with clarity and intelligence, the disoriented Diana is introduced as possessing a 'handsome,' loving and devoted husband and a talented (albeit stressed out) teenage daughter. This seemingly stable social standing and fake sterile life suggest that Diana and her family are models of normality - their life is free from any external factors that might contribute to madness, and all the vital aspects of Diana's mental

illness cannot possibly come from the environment, but stem solely from within Diana's body, psyche, neuro chemistry, and genetic predisposition.

This seemingly 'perfect' life (McNulty2010: n.p.) is disrupted, however, when signs of Diana's disorder and struggles with powerful side effects of medication and dozens of shock therapy are shown. A true representative of modern aimlessness and emotional emptiness, Diana begins to become delusional, to have a distant relationship with her husband and daughter, and to strive to, at least, become 'next to normal'. After brief moments, the audience are shocked by an unexpected, unusual, and manic episode. They soon come to realize that there is something wrong. For in her song "*Just Another Day*," the frantic and restless Diana – instead of preparing meals for her family – over-enthusiastically covers the table, chairs, and floor with extraneous sandwiches. What is also shocking is the scene where Dr. Fine, her psychiatrist, prescribes a cocktail of medications to Diana.

Dr. Fine: The pink ones are taken with food but not with the white ones. The white ones are taken with the round yellow ones but not with the triangle yellow ones. The triangle yellow ones are taken with the oblong green ones with food but not with the pink ones (Yorkey 2009: 11).

Equally shocking is the moment when Diana is receiving her prescriptions from Dr. Fine, Dan is seen as questioning his own depression in the car while waiting. Clearly frustrated that the love of his life is 'losing her mind', Dan - bursts out his inner confusion in the song "*Who's Crazy / My Psycho pharmacologist and I*" - the first sonic indicator of Diana's disability:

Dan: Who's Crazy? / The one who can't cope / Or may be the one who'll still hope. / The one who sees doctors or the one who just waits in the car. Who's Crazy? The husband or wife? Who's Crazy? To live their whole life believing that somehow things aren't as bizarre as they are (11).

Taking the audience through a wide range of typical weekly medical visits, the song depicts the complexities, absurdities and improvisational, even haphazard, nature of Diana's treatments, her fluctuation between confusion and clear thoughts, and the power imbalance or unequal doctor / patient relationship.

Diana: It's like an odd romance.

Intense and very intimate / We do our dance /

My psychopharmacologist and I / Call it a lovers' game /
He knows my deepest secrets / I know his ... name (12)!

To further illustrate the imbalance and current mental state of Diana, Kitt makes distant voices, in the style of a radio commercial, sing the song “*My Favourite Things*,” listing the myriad medications that Diana is being prescribed and their side effects to satirize the absurdity of the treatment process.

Zoloft and Paxil and Buspar and Xanax ...
Depakote, Klonopin, Ambien, Prozac...
Ativan calms me when I see the bills –
These are a few of my favourite pills (12).

The above exaggerated list of pharmaceuticals gives the audience a mental image of how tough and tedious to have a mental disorder where many pills are needed daily.

Adjusting Diana's medications over the visits, Dr. Fine seems satisfied with the results, reduces Diana to her diagnosis, and declares her stable - despite of her complains of being medicated unsuccessfully from sixteen years of sensing noticeable change and of not feeling anything.

Dr. Fine (spoken): Goodman, Diana.
Bipolar depressive with delusional episodes.
Sixteen - year history of medication, adjustment
often one week (12).

Diana (Spoken): I don't feel like myself. I mean,
I don't feel anything.

Dr. Fine (spoken): Hmph. Patient Stable (16).

Later in Act I, upon witnessing her daughter kissing her new boyfriend, Henry, for the first time, Diana begins to worry that her best years have gone. In the song, “*I Miss the Mountains*,” Diana - missing her clarity of mind and highlighting her ambivalence toward treatment - prioritizes severe mania and depression over a sense of stability.

Diana: I miss the mountains,
I miss the highs and lows,
All the climbing, all the falling,
all the while the wild wind blows, ...
I miss the mountains,
I miss the pain (20).

Triggered by memories of extreme highs and lows, she fondly recalls her youth, mania, and prescription-free past:

Diana: There was a time when I flew higher.
Was a time the wild girl running free
Would be me.
Now I see her feel the fire.
Now I know she needs me ...
All these blank and tranquil years –
Seems they have been dried up all my tears.
And while she runs free and fast,
Seems my wild days are past (20).

Seeming to miss her extreme mood swings and to slightly envy Natalie's youth and freedom, Diana is propelled to defiantly discard all her dulling new medications into the toilet. Resulting in unpleasant side effects and leaving her emotionally empty, the drug cocktails make Diana wonders: "What drugs have I been taking? How has that affected me? What did I do this morning and last night, pill-use? (12)"

Perfectly demonstrating the deranged stability of the family and their urgent need for the facade of normality, Dan - in the song "*It's Gonna be Good*" - convinces himself that Diana's new round of medication seems to be working well.

Dan: It's gonna be great. It's gonna be great ...
It's almost been a month and she's as happy as
a clam. Do I look great? (22)

However, Diana's dysfunctional behaviour is obvious when she looks at family photos with her daughter Natalie, who describes and complains about her mother's past deviant behaviour (e.g., jumping in the pool during Natalie's swim meet at school.)

Among Diana's delusional episodes is Diana's 17-year-old son, Gabe, who appears and sings a song entitled, "*I'm Alive.*" Full of bitterness and anger, Gabe's song is a provoking reminder that no matter what sort of treatment Diana chooses, she will still experience him in delusional episodes. Diana's delusion and inappropriate behaviour culminate in the song, "*It's Someone's Birthday.*" To the horror of her family Diana emerges, lovingly serving a birthday cake with flickering candles to her son, Gabe, who died as a baby seventeen years ago.

Diana (Spoken): Okay, it's someone's birthday!

Henry (Spoken): Whose birthday is it?

Natalie (Spoken): My brother's

Henry (Spoken): I didn't know you had a brother.

Natalie (Spoken): I don't. He died before I was born (24-25).

Attempting to control this uncomfortable situation, Dan whispers a song of gentle, loving support to Diana, "*He's Not Here*," explaining that Gabe died 16 years ago.

Dan: He's not here, he's not here love, I know you know.

Do you feel he's still real? Love, it's just not so.

Why is it you still believe?

Do you dream, or do you grieve?

You've got to let him go.

He's been dead 16 years

No, my love, he's not here (25).

Up till the pre-mentioned situation, Diana has remained relatively calm. However, her mounting frustration, anger and subversive manners are released in the song, "*You Don't Know*," when Dan urges her to go back to the psychiatrist and try a new round of medication. Powerfully describing to Dan what it is like to live with bipolar disorder, Diana sings:

Diana: Do you wake up in the morning and need
help to lift your head?

Do you read obituaries and feel jealous of the dead?

It's like living on a cliff side not knowing when you'll
dive.

Do you know, do you know what it's like to die alive?

When the world that once had color fades to white
and gray and black.

When tomorrow terrifies you, but you'll die if you
look back you don't know (26).

During her initial psychotherapy sessions, Diana shares with her therapist, Dr. Madden: "When I was young, my mother called me 'high spirited'. She would know. She was so high spirited they banned her from the PTA" (33). Dr. Madden's response to Diana suggests that the root of Diana's madness is genetic, inherited from her mother who experienced her own restless, dysfunctional 'high spirits' (33).

Dr. Madden: Sometimes there's a disposition

to illness, but actual onset is only triggered by some traumatic event (33).

Starting her healing process (using hypnosis) with Doctor Madden, Diana agrees that it's time to let her son go. However, in a haunting moment with her son, Gabe, Diana is convinced by him in the song, "*There's a World*," to commit suicide and to go with him to another world - to "a place we can go where the pain will go away," in "a world where we can be free" (45). The description of this suicide attempt comes across the psychiatrist's authoritative clinical language:

Dr. Madden: Goodman, Diana.
Discovered unconscious at home.
Multiple razor wounds to wrists and forearms.
Self-inflicted. Saline rinse, sutures, and gauze.
IV antibiotics. Isolated, sedated and restrained.
Damn it ... ECT is indicated (46).

Another agitated state of Diana's distress - after her failed suicide attempt - appears in "*Didn't I See This Movie*" (50). In this song, the distressed Diana aggressively confronts her psychiatrist while he tries to convince her to undergo the ECT procedure as it is the only alternative left. Fearing to lose her memories, Diana recalls seeing the film "*One Flew Over the Cuckoo's Nest*" (50) when she was young and admits that she found it distressing and walked out before it was finished.

Dr. Madden (Spoken): The modern procedure's
clean and simple. The electricity required is barely
enough to light a hundred - watt bulb.
Diana: What makes you think I'd lose my mind for
you? I'm no sociopath ... So, stay out of my brain
I'm no princess of pain ...
Didn't I see this movie
Where the doctor looked like you?
Where the patient got impatient
And said "sorry, doc, I'm through."
I know where this is going
And I know what you're about
'Cause I have seen this movie
And I walked out (50).

Act II opens with Diana undergoing the ECT treatment and Natalie's rebellious decision to cope with her growing depression by experimenting drugs, alcohol, and night clubs. Staged as Diana's double ,placed in a hospital bed, the 'real' Diana watches the ECT procedure and sings from another position on stage a song entitled, "*Wish I Were Here.*" Ultimately uniting both Diana and Natalie in an alternative reality where they are both hallucinating and their altered states of consciousness are represented, the song does critique psychiatry .It subtly describes the unfortunate side effects of treatment - how doctors do not know how the procedure will change Diana's mind. Describing being in an altered state of reality together, Diana maintains:

Diana: Sweetheart! What are you doing in my electricity?

Natalie: It's always about you, isn't it?

I'm Robot ripping. I can't feel my legs.

Diana: I don't want you doing drugs.

Natalie: That's persuasive, coming from the Pfizer
Woman of the year. You're the one who's
hallucinating.

Diana: It's my treatment. It's a miracle. Everything
is different now.

Natalie: I know what you mean (55).

As Diana sings about her sense of disorientation, her doctors remain silent, professional, and only indirectly responsible for what may be a necessary consequence of ECT - of appropriate care.

Diana finally reaches her breaking point when the painful memories and disturbing delusions of her son's death come once again in full force at unexpected moments. At her most aggressive and, inarguably, most intense scene, Diana confronts the psychiatrist one last time before ultimately deciding to abandon further medical treatment in the song, "*The Break.*" Accusing both Dr. Madden and the medical profession on their lack of knowledge in treating patients with bipolar disorder, Diana maintains

They tried a million meds, and they strapped
me to their beds, and they shrugged and told me,
"That's the way it goes"
But finally, you hit it!
I asked you just what did it
You shrugged and said that no one really knows.
What happens if the medicine wasn't really in control?

What happens if the cut, the burn, the break
Was never in my brain, or in my blood, but in my soul? (82)

In a transformative climactic moment, Diana decides to depart and go out on her own to fix herself. By choosing to leave her family, Diana thus allows Dan to recognize his own grief and take steps to address it, and Natalie to become more open with Henry. She (Diana) leaves “an existing unworkable reality to invent herself” (82). Moving toward leaving as well as embracing her disability, Diana sings to her husband, “*So Any Way.*”

Diana: So anyway, I'm leaving.
I thought you'd like to know. You're faithful,
come what may, but clearly, I can't stay,
we'd both go mad that way - So here I go ... (89)

Claiming that her madness makes it impossible to stay with her family, Diana maintains that she has done the right thing because she has released her husband from her problems. So, she must take the chance, strike out on her own to be ‘free’ and experience self-actualization – “the feel of solid ground” (90). For “with you (Dan) always beside me/ To catch me when I fall, / I'd never get to know the feel of solid ground at all” (90). After finishing the song and leaving the house, the show continues and the finale, “*Light,*” is sung:

Dan: Night after night
We'd sit and wait for the morning light
But we've waited far too long
For all that's wrong to be made right (93).

With the ending, the song, “*There will be Light,*” (96) is sung thus suggesting that everything has worked out for Diana and her family.

IV.1. Mirroring the Ableist and Normative Ideologies

Illustrating how a seemingly 'normal' family can be anything but normal, NTN thus does echo the basic argument of disability studies - that society constructs the impossible. Representing a family wracked with the seemingly irresolvable dilemma of bipolar disorder, NTN mirrors the ableist and normative ideologies that go unquestioned in our larger society - the typical social constructs and normative values that reject, marginalize, alienate, and disenfranchise those who deviate from the norm or are unable to meet the standard of 'normality'.

Serving as reminders of what she cannot be, Diana's 'normal' aspects affirm that society's construction of normalcy is not a relaxing standard but a burdening one. Living in a world of norms, Diana wants to be part of the dominant, more able group by endeavoring to be - if not normal-a 'next to normal' subject. Socially constructed to compare herself to others, to fear disability, and to become instead an unattainable ideal or perfect body, Diana becomes thus mentally controlled and internally stressed by tremendous social and psychological pressures to stay on the side of normality or sanity, to act in a certain way in certain situations and to exhibit 'appropriate', contextual, or functional behaviours. Rather than celebrating and working with her difference, Diana is thus hung on the frame of a sanitized 'normal' person and caught in this 'violent maintenance of the normative order' by the gaze of 'normal' members of society (Goodley2014:129).

Standing in this uneasy and exhausting relationship to the ideology of normalcy, Diana begins to exhibit the stigmatizing traits of abnormal persons - aversive responses, dysfunctional behaviours, diagnoses, treatment regimens, repeated relapses, and attempted suicide. No sooner than she is ultimately revealed as a disabled woman, Diana comes to be labelled and judged as different, wrong and need to be fixed- as a being in a state of unacceptable deviance for no longer sharing “the contemporary ideals on which the able, autonomous, productive citizen is modelled” (129). Failing to be cured by psychiatrists, Diana removes herself from her family in a gesture that echoes again the exhausting ideology of 'cultural normalcy.' Moreover, her unsure full independence after her final departure does expose the cruel and indecent consequences befalling those who do not meet the standards of ability and does demonstrate the inhibited view promoted by the ideology of ability, namely, full independence is a myth for all the disabled.

The key word in this musical is thus 'normal' - the concept that separates Diana from others, relegates her outside the margin of what is humanly acceptable, denies her human status, and considers her as a foil to 'normal' people for not being able to meet its standards. Ultimately ascribed inferior status as a human being by a normative culture that does not tolerate diversity but instead seeks conformity, Diana (the person with disability) thus is not the 'problem', the problem is in the way that normalcy is constructed to create the 'problem' of the disabled person. Commenting upon the pervasive nature and workings of ableist society - the societal measures and expectations of the body and mind, Brian Yorkey and Tom Kitt maintain: “We both feel that an awful lot

of people try to live up to a standard of what they consider 'normal' and that can be as destructive as anything” (Tobin 2009:17).

IV.2. Questioning the Contemporary Bio-medical Model and the Medicalization of Mental States

Positing that the individual experience of disability relates to the core ideology of normality, NTN questions another inherent form of disability, namely, the contemporary bio-medical model. A product of the strategic position of the medical profession that emphasizes clinical diagnosis, the biomedical model - the dominant, absolutist, and standard discourse - falsely frames and propagates a powerful social and scientific narrative. Within this narrative one is to regard psychological or emotional difference as a disease or individual impairment stemming from neurological, biomedical and/or biological flaw, interfering with 'normal' functioning, and can be understood, diagnosed, and cured.

This narrow, and far from perfect, pathologizing of non-normative thoughts, feelings and behaviours thus presume the defect to be part of Diana's genetic makeup rather than a problem of societal barriers. Instead of recognizing the matrix of influences and taking all the ecological considerations that affect Diana into account, the deficient biomedical model in NTN labels Diana as essentially defective and 'abnormal' body, dishonors her experiences and possibilities, and disregards other broader intersectional interpersonal (social and cultural) factors that continue to interact with one another to oppress and exacerbate her individual distress. For this reason, Diana's experience with bipolar disorder is intentionally represented in NTN as one that is limited to intrapersonal (biological and psychological) problems. It is only in other's eyes that she becomes limited by her actions. The only interpersonal trauma Diana has gone through happened 17 years earlier when her son Gabe died. This framing of Diana presents her true problem as a biological propensity toward bipolar disorder (as set forth and prompted by the biomedical model).

Arguing that the biomedical model fails to understand disability as a lived experience, NTN sets firmly that non normative thoughts, feelings, and behaviours need more than medical 'facts'-however necessary these are in determining medicalization. The problem comes when these medical facts determine not only the form of treatment (if treatment is appropriate), but also the form of life for the person who happens to be disabled (Brisenden1986: 17).

IV.3. Arguing against the Adverse Power Dynamics Wielded by Psychiatrists

Situating psychological or emotional differences in this way, the biomedical model - NTN suggests - ignores or deprioritizes many other forms of disability. The most important of these forms is the discipline of psychiatry - i.e., the adverse power dynamics (authoritative discourse and practices) wielded by psychiatrists and pharmaceutical companies. Widely and seemingly perceived as an empirical reality, an objective discipline, and the sole authority to structure how we relate to our everyday lives and to label, explain and treat 'pathological' difference, psychiatry - in NTN- is represented as part of the problem (though regarded as part of the solution). Viewed as a tool for helping people change and get along in society and as the main arbiter identifying what treatments are most effective for which patients, and at what point of their illness, dictating what is to be regarded as normal versus abnormal, and setting the boundaries as to who does the curing and who needs the curing, psychiatry - however - becomes even more perplexing than the disease itself. Hence, the claim that psychiatry has an objective position in society results in its undeserved authority due to its incomplete understanding, over - medication and poor treatment options (Bradley Lewis : n.p.).

Psychiatry's undeserved authority - NTN suggests - resides in creating an artificial binary between the sane and the insane, in failing to address how its clinical language and practices can add to the distress of the disabled, in judging its efficiency only on how well it ameliorates and/or fixes the mind's illness and attains or approaches normality. This powerful rhetorical tool of medical intervention as 'rehabilitation' or even 'cure' becomes an obvious end goal. Sidestepping issues that construct social identity, psychiatry decontextualizes people and reduces them to a set of numbers, averages, and statistics rather than producing a more complete, individualized picture. The framing of Diana's problem this way is thus well intentional - to highlight how psychopharmacology and other medical treatments remain the first line of treatment, and often the only treatments. This approach is demonstrated in Dr. Fine's treatment of Diana. For Dr. Fine, Diana's condition has nothing to do with society. The social factors are absent from his treatment plan. Reducing Diana to her diagnosis and understanding her case as a compilation of mental illness symptoms, Dr. Fine believes that Diana's illness stems not from an ecological relationship between her and the world , but solely from within her body and mind. His medical chart tracks Diana's story with details of dysfunctional

behaviour, diagnosis, treatment regimes, and repeated relapses as she spirals downward into attempted suicide.

Portraying Diana going through hardships of finding the right treatment and fighting through to become even marginally more stable, the musical does acknowledge as well that psychiatry does not have all the answers and, thus, is far from perfect. Diana's medication regime - psychotherapy, mood stabilizers, antidepressants, antipsychotics, or hypnotics, and electro convulsive therapy - all has done her no good but has resulted in unpleasant side effects and relapses in behaviour. For this purpose, NTN demonstrates the many possible treatments of bipolar disorder in negative light by portraying extremes in treatment as the standard procedure and by rendering us sympathize with Diana's perspective against multiple treatments. Among the moments that seem to be anti-psychic treatment is the song "*I Miss the Mountains*," when Diana has spent time talking about the negatives of medication and lamenting weight gain, tremors, and a feeling of emotional numbness. Another moment is evident in the song "*Wish I Were Here*," when Diana's sense of depersonalization is stressed - a clear indication that Yorkey and Kitt do question and critique psychiatry. Diana's last moment in the musical leading into "*So Anyway*" suggests as well that all the medications have worked out and proved unsuccessful.

NTN surfaces as well the discomfort in the uneven relationship between Diana (the patient) and her clinician (therapist). In this hierarchal relationship, near total (if not total) power of therapist is maintained. Diana (as a patient) yields power to her physician because he (the physician) has knowledge, and she (the other) is apparently ignorant. He decides and Diana follows. Consequently, the patient-physician interaction is unbalanced, encounters are short, and communication is replaced by diagnostic intervention. Critiquing this power imbalance, Diana - in her song "*My Psychiatrist and I*," - *ironically* notes that "while her doctor knows her deepest secrets, she knows only his name" (Yorkey2009:12).

IV.4. Sharing a New and Emerging Positive Approach

Arguing against normative ideology, psychiatry and the medicalization of mental states, NTN - a perfect venue for mental health advocacy- promotes another sort of framing by sharing a new and emerging positive approach, namely Mad Pride. Centering the self - reported lived experience of Diana, NTN utilizes Diana's voice to provide a narrative counter to the pervasive negative beliefs which are socially accepted as truth. Hence, NTN renders us consider and

make sense of the inherent value of madness and honor the critical knowledge that rises from this complex and challenging experience that defies easy understanding, despite or even because of the pain associated with it. Offering a viewpoint like the advocacy group of Mad Pride, NTN renders Diana tell her story, celebrate her different mental states, distresses, and experiences, and show others what she needs, wants, imagines, and experiences. Diana is thus allowed to carve out a space in the able normative world to consider, understand, and imagine multiple perspectives. Singing with sorrow - longing for her pre-medication days when she felt truly free and alive - in her rebellious song “*I Miss the Mountains*,” Diana recalls her past as “a wild girl running free” (20) and remembers - while a fire alights in her eyes - the “manic/magic days / And the dark, depressing nights” (20). Romanticizing the highs and lows of bipolar disorder, Diana uses nature as a metaphor for the energizing, refreshing essence of her life. The sensations of ‘fire’, ‘soaking rain,’ and air that ‘cuts ... like a knife’ remind her that she was ‘real’ (20).

Asserting that she cannot dismiss nor eliminate her mental struggles and that there is nothing wrong with them because these 'sick' or 'abnormal' feelings - that psychiatry rejects - constitute a positive aspect of her identity, Diana thus redefines madness and changes the way we all think about it. She renders us conceive her mental health struggles not as a faulty brain but in the context of an unhealthy physical / social environment that fails to contain or accommodate her. Though making no promises at the end of the musical about the horrors of an imperfect world, NTN demonstrates Diana managing to work toward identity making by showing her striving for pride and self-determination.

IV.5. Fashioning an Unbearably Emotional Musical

Never straying far from the therapeutic path of Diana, Brian Yorkey and Tom Kitt employ every carefully crafted element in NTN to heighten the intensity of the show, disorient the audience, stir their feelings, hold them in suspense, evoke their discomfort, and force them to experience these events rather than judge or think about them. This – Yorkey and Kitt believes – would bind the audience to Diana and give them a more profound empathy.

Among the genuinely powerful utilized artistic techniques is the constant interweave of songs and text. Believing that music provides pleasure and can connect to the audience’s emotions in ways that simple spoken words cannot, Kitt and Yorkey render NTN’s tone, mood and style of music perfectly express what the characters are feeling. I.e., the songs do not usually express what the

characters might be saying, but much of the time they convey the psychological reality of the characters— their inner thoughts and feelings. The songs are often part of the imagination of the characters that sing them, and the style of these songs relate to the specific character at the specific moment of the action. For example, early in *Next to Normal*, when Diana is speaking with Dr. Fine about how to take her medicine; suddenly Dan’s inner confusion bursts out in a song: “Who’s crazy? The husband or wife? Who’s crazy? (Yorkey 2009:11)” - basically interrupting the doctor’s explanations about the pills. This is a unique way the lyricist and composer connect the text to music.

Tom Kitt’s music does a lot of the storytelling in NTN. He expresses Diana’s bipolar mood swings through his powerful and subtle use of music as storytelling; something of which he is a master. The darker the emotions get, the more rock and roll the music becomes. And yet for those quiet, more emotional moments, there are these beautiful vocal phrases that lend such beauty and fragile emotion to the action. The violin and cello sometimes play in very discordant harmony, indicating musically that there is something “wrong” happening in the scene, even if only sub textually.

NTN is also very cinematic. Almost every scene dissolve into the next, sometimes even interrupting each other. Throughout the musical there are moments when a character in one scene simply turns around and becomes in another scene, in another time and place. There are often two scenes occurring onstage at once, juxtaposing the action in interesting, revealing ways. As just one example of many, Natalie screws up her piano recital on one side of the stage, while at the same time, Diana’s telling her doctor about not being able to hold Natalie as a baby. The two scenes juxtapose each other in a powerful, emotional way, delivering more character and relationship information than a much longer dialogue scene could. This happens throughout the show, often in a cinematic split-screen effect.

A rich, complex, and brutally honest account of the trials of a tormented mind, this brave, breathtaking musical ultimately fashions a score that was almost unbearably emotional. Focusing like a laser squarely on the pain that cripples the members of a suburban family, NTN never for a minute does it let us escape the anguish at the core of their lives. Such emotional rigor is a point of honor for NTN. The New York Times said, “No show on Broadway right now makes as direct a grab for the heart – or wrings it as thoroughly – as *Next to Normal* does (2009: n.p.).” Reminding us that we all go through essentially the same trials, that we are not alone, Yorkey and Kitt kept working on affirming

that though we do not all have bipolar disorder, we do all deal, in one way or another, with the same challenges Diana faces. We do not have to be bipolar to see our own daily struggles in Diana's more extreme struggles. We become immersed in her desperate search for a refuge from pain. In his review, Ben Brantley writes that the musical "gives full weight to the confusion and ambivalence that afflict not only Diana but also everyone around her (n.p.)."

Another compelling device in NTN is immersing the audience in Diana's roller coaster ride. To watch this tale of a haunted housewife – who lives in a metaphorical world as much as in the physical one - is to ride a speeding roller coaster of responses. And that ties into the central point of the musical, that a person's illness affects not just him/her, but everyone in their orbit. And because of the way Kitt and Yorkey have told this plight, we the audience are among those in Diana's orbit. We must live with her in her illness, her delusions, and her twisted world for two hours. When she sees the doctor as a metal rocker, we see that too. When she finds herself inside a delusion, we're there with her. The New York Times said, "Next to Normal is apt to produce bipolar reactions in anyone who sees it. One minute you're rolling your eyes; the next, you're wiping them. When the show ends, you're probably doing both at the same time (Brantley 2008:n.p.)."

One of the most potent elements of NTN is fights. Believing that conflict is the heart of drama, and that there is nothing so compelling and engaging onstage as a good, knock-down-drag-out fight, Kitt and Yorkey - with real and actual fight scenes like "You Don't Know" and "I Am the One," and later, the "Gonna Be Good" reprise and "Why Stay?"- are at their dramatic best.

Despite its dark subject matter, NTN has moments of humor that add some light-heartedness to the serious story. For example, at the end of "My Psychopharmacologist and I," after weeks of experimenting with medications, Diana tells Dr. Fine, "I don't feel like myself. I mean, I don't feel anything." Dr. Fine mutters and writes down in his notes, "Patient stable (Yorkey 2009:16)." The audience laughs, but it is a muted, ironic laugh. We see the dark humor from the outside, but we also see the horror from the inside. Likewise, late in Act I, the audience sees the dark truth in the humor when Dan asks Natalie, "Is this Henry a good influence?" Natalie replies, "Like, compared to what?" Dan says, "Okay, that's fair (49)."

NTN is very surrealistic, dreamlike, disorienting, disturbing, and revealing in ways that more naturalistic performances would not be. The story's narrative is so fractured, sometimes linear, but often rambling into fantasy, delusion,

flashbacks, and lots of time condensing. Having written a show as fragmented and deconstructed as Diana's world, Kitt and Yorkey's thus render the audience understand Diana's mental state and literally experience her broken perception of reality. The "Wish I Were Here" scene, for instance, does not really take place in the hospital; it takes place inside Diana's anesthetized mind, in a hallucinatory dreamscape. Though Diana is on the table and Natalie is at the club, the two meet here in Diana's dreamscape. She tells her daughter: "Sweetheart! What are you doing in my electricity? (Yorkey 2009:55)."

NTN's setting is minimal, relying mostly on the heights and multi-level structure. The floor, painted in a deep oceanic blue, and the misty stage lights make the confined theatre expand in a dream-like unconsciousness. This setting thus gives the appropriate illusion that the characters are drowning in their surroundings.

Skillfully mirroring the arc of Diana's story, Kitt and Yorkey opens NTN with a quiet introduction - the song "Just Another Day"- that serves as a perfect turning point of this family's life. Nevertheless, Kitt and Yorkey do not offer the characters, or the audience, an easy way out. The title of the show even seems to indicate that there are no easy answers or endings, in which we can see ourselves and our own lives much more clearly. So, instead of taking Diana on a journey from misfit to normal, Kitt and Yorkey give her a more modest and nuanced goal of finding a place next to normal. In the finale, Diana sings: "You find some way to survive, /And you find out you don't have to be happy at all. /To be happy you're alive (93)." There is no happy ending here because there are no happy endings in real life; there is always a next chapter. Diana decides and chooses to walk alone, but we have no idea how it will turn out. Like Diana, Natalie is also a misfit. Her goal throughout the show is to find normality. But by the end, she learns that she has the wrong goal. Instead of trying to be normal, Natalie finally realizes that normal is artificial and a construct. There is no such thing as normal in the real world. She understands that her real goal should be to figure out who she is and what her road is. She sings to Diana: "I don't need a life that's normal. /That's way too far away. /But something next to normal would be okay (87)."

With a daring topic, emotional rigor, superb characters, sensational music, and impressive creative elements, Yorkey's and Kitt's NTN is completely original and unrivalled.

V. Conclusion

For several decades, PSD has long been constructed as a disease, disorder, delusion, hysteria and / or hallucination. This tendency to adopt the ‘medicalized individual approach’ has resulted in PSD being often conceived as ‘inherently disabling’ and the cultural identities of those who are deemed as psychosocially disabled being viewed as ‘biologically deviant’ individuals. Hence, it is upon this (seemingly) positivist and absolutist medical model of disability that the ideology of ‘Normalcy’ is directly reinforced and framed. Setting and defining the standards of ‘what’ and ‘how’ one ought to be, the dominant postmodern principal of ‘Normalcy’ underpins the idea that those who are ‘more able’ are ‘more includable’ into mainstream society while those who ‘deviate’ to be considered ‘abnormal’ and ‘disadvantageous’. The ideology of ‘Normalcy’ thus orients the medical community’s focus towards the area of rehabilitation or treatment rather than acceptance, containment, and appreciation of diversity. Located within this ideological construction and measured according to a benchmark of normality, the disabled other is thus not only caught in the violent maintenance of the normative order, but is also stifled by the authoritative and coercive politics of psychiatric profession. Working in tandem with the above normative disability judgments, psychiatry’s emphasis becomes almost exclusively on neuroscience, genetics, biomedical diagnosis, and pharmacological treatments at the expense of an array of cultural and humanistic styles of inquiry.

Acknowledging the way psychosocial disability is authored, imposed, and culturally acted out, the present study has cited Brian Yorkey’s and Tom Kitt’s theatrical rock musical *Next to Normal* (NTN) as a case study. Touching upon the mad body and laying bare the unsettling, devastating effects of one of the underrepresented experiences head on with no apology- namely the tough dysfunctional bipolar disorder, NTN honestly examines the basis in which mad identities are performed and enforced and explains how the competing and alternating power structures and arbitrary inflictions upon the mad body are problematic.

To conclude, offering more than just a critique of the mental health system that only aspires to be evidence-based in its care and treatment, NTN expects from psychiatry to go beyond framing psychiatric illness as a medical diagnosis requiring a pharmaceutical solution. It expects society to go beyond psychiatric labeling that can still doom patients to a lifetime of battling stigma. Broadening what is possible, NTN reverses customary understandings and changes notions

fundamental to us as persons. Embracing the view that 'mental illness' can be grounds for a unique identity and culture, NTN thus advances the possibility of recognizing mental variation as a cultural production and a matter of social justice. It invigorates the possibility of uprooting fear, disrespect, distrust and over protection by pushing against the language and idioms through which we conceive the psychosocially disabled. It increases the possibility of resistance by dismantling the psychiatric biomedical complex that exacerbates the disabled other's predicament instead of coming to terms with the social solutions that can be put in place. It reinforces the possibility of empowerment by putting the disabled others' voices in focus and making them share their stories. It promotes the possibility of agency by making way for non-ritualized identities of madness and pushing them beyond their status as medical documents or case files. It strengthens the possibility of new (imagined) cultural performances authored by those who identify as mad. It heightens the possibility for a broader social accommodation, appreciation, and containment of difference. Finally, NTN boosts the possibility of other framings - the possibility of re-imagining madness.

VI. References:

- Armstrong, Thomas. *The Power of Neurodiversity: Unleashing the Advantages of Your Differently Wired Brain*. U.S.A: Da Capro Press, 2010.
- Bloom, S.L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York: Routledge, 1997.
- Brisenden, S. "Independent Living and the Medical Model of Disability." *Disability, Handicap and Society*, 1(2), pp.173-178, 1986.
- Brown, Tony. 'Next to Normal at Playhouse Square: An Unblinking, Rock Musical Look at Mental Illness.' *Cleveland.Com.*, 7 June, 2011.
- Bryne, P. "Psychiatric Stigma: Past, Passing and To Come." *Journal of the Royal Society of Medicine*, 90, 1997, pp. 618-620.
- Crow, Liz. "Including All of Our Lives: Renewing the Social Model of Disability." In Morris, J. (ed.), *Encounters with Strangers: Feminism and Disability*. London: The Women's Press Ltd., 1996, pp.207-208.
- Everett, William A. "The Cambridge Companion to the Musical." In Laird, Paul R. (eds.), *Cambridge Companions to Music*. Cambridge University Press, 2002, pp.10-11.

- Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday,1961.
- _____ . *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, New York: Prentice – Hall,1963.
- Goodley, D. “Professor Dan Goodley: University of Sheffield Profile Page,” 2014.
<https://mhs.group.shef.ac.uk/members/dan-goodley>
Accessed 12 Jan. 2023.
- Greenfeld, Liah. *Mind, Modernity, Madness: Culture on Human Experience*. U.S.A: Harvard University Press,2013.
- Hemingway, Laura. “Three Understanding Disability: From 'Personal Tragedy' to Social Disadvantage.” In *Disabled People and Housing: Choices, Opportunities and Barriers*. Bristol: Policy Press Scholarship Online,2011.
<https://doi.org/10-1332/policypress/9781847428066.003.0003>
Accessed 11 Jan. 2023.
- Hetrick, Adam. “Next to Normal Wins 2010 Pulitzer Prize for Drama.” *Playbill*, 2(4),2010.
<https://playbill.com/article/next-to-normal-wins-2010-pulitzer-prize-for-drama-com-167584>
Accessed 11 Jan. 2023.
- Huang, Jichong, et al. “Prenatal, Perinatal and Neonatal Risk Factors for Intellectual Disability: A Systemic Review and Meta-analysis.” *DLOS One*, 11(4), e0153655, 2016.
DOI: 10.1371/journal.pone.0153655
- Hutchinson, David, and Carol Tennyson. *Transition to Adulthood: A Curriculum Framework for Students with Severe Physical Disability*. London: Further Education Unit,1986.
- Iglehart, J.K. “The Mental Health Maze and the Call for Transformation.” *New England Journal of Medicine*, 300,2004, pp. 507-514.
- Jones, John B. *Our Musicals, Ourselves*. Hanover: University Press of New England,2003.
- Jones, S.R. “Toward Inclusive Theory: Disability as Social Construction.” *NASPA Journal*, 33(4), 1996, pp. 347-354.

- Kaufman, L. et al. "The Genetic Basis of Non-syndromic Intellectual Disability: A Review." *J. Neurodevelopmental Disorder*, 2,2010, pp. 182-209.
DOI:10.1007/511689-010-9055-2
- "Law Commission of Ontario." *The Framework for the Law as it Affects Persons with Disabilities: Advancing Substantive Equality for Persons with Disabilities through Law, Policy, and Practice*. Toronto: Sep. 2012.
www.ico-cdo.org/en/disabilities-final-report-framework-introduction
Accessed 10 Jan. 2023.
- Le Francois, Brenda, Robert Menzies and Geoffrey Reaume (eds.). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholars' Press Inc.,2013.
- Lewis, Bradley. *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Post Psychiatry*. Ann Arbor: University of Michigan Press,2006.
- Lord Widgery, R. (Rv. Bracknell J.J., ex parte Griffiths p. 318 E-G),1975.
- Martin, J.P., and D. Evans. *Hospitals in Trouble*. Oxford: Basil Black well,1984.
- McNulty, Charles. "The Family Next Door is Rocked by Crisis; The Pop Musical 'Next to Normal' Pulses and Ebbs in its Ahmanson Visit." *Los Angeles Times*, 3, Nov. 2010.
- Meynell, Hugo. 'On Knowledge, Power and Michael Foucault.' *The Heythrop Journal*, 30(4), Oct.1989, pp. 419-432.
<https://doi.org/10.1111/j:1468-2265.1989.tb01118.X>
- Oliver, Michael. *The Politics of Disablement*. London: Macmillan,1990.
- _____ . "The Social Model in Action: If I had a Hammer." In C. Barnes and G. Mercer (eds.), *Implementing the Social Model of Disability: Theory and Research*. Leeds: The Disability Press, 2004, pp. 18-31.
- Page, C.W. "Mechanical Restraint and Seclusion of Insane Persons." *Boston Medical and Surgical Journal*,1904, pp.590-595.
- "Promoting Rights and Community Living for Children with Psychosocial Disabilities." Geneva, Switzerland: The Who Document

Production,2015, pp. 15-21.

<https://www.Who.int>

- Quart, Alissa. "Listening to Madness." *Newsweek*, 18(5), May 2009.
<https://www.newsweek.com/id/195694>
- Ring land, Kathryn E. et al. *Understanding Mental Ill-health as Psychosocial Disability: Implications for Assistive Technology*. U.S.A: National Library of Medicine, Oct.2019.
- Ruth, Ruth. Mad Pride. *Consumer/Survivor Information Bulletin*,398,2009.
- Szaz, T. *The Manufacture of Madness*. Hertfordshire: Paladin,1973.
- Tatum, Beverly D. "The Complexity of Identity: "Who Am I?"" In Adams M., Blumenfeld, W.J., Hackman, H.W., Zuniga, X., and Peters, H.L. (eds.), *Reading for Diversity and Social Justice: An Anthology on Racism, Sexism, Anti - Semitism, Hetero Sexism, Classicism and Ableism*. New York: Routledge, 2000, pp. 9-14.
- Tobin, Nancy. "Tackling Stigma from the Stage." *BP Magazine*, fall 2009.
<https://www.bphobe.com/item.aspx/593/tackling-stigma-from-the-stage>.
- UPIAS. *Fundamental Principles of Disability*. London: Union of the Physically Impaired Against Segregation,1976.
- Vandenbos, Gary R. (ed.). *APA Dictionary of Psychology: 1st Edition*. U.S.A: American Psychological Association,2006.
- Walker, Herschel. *Breaking Free: My Life with Dissociative Identity Disorder*. U.S.A, NJ: Simon & Schuster, Inc.,2008.
- Wardhaugh, J. and P. Wilding. "Towards an Explanation of the Corruption of Care." *Critical Social Policy* 27,1993, pp. 4-31.
- Yorkey, Brian. *Next to Normal*. New York: MTI Music Library,2009. (The researcher has also consulted video recordings of performances in New York; Washington D.C.; and San Francisco.

خلل بيولوجي أم نتاج إجتماعي ؟ تأطير الخلل العقلي خارج السياق المعتمد للعلاج الحيوي في مسرحيه "أقرب الي العادي" لبريان يوركي

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المستخلص :

تسعى الورقه البحثيه الحاليه إلى مناقشة اشكاليه " الخلل العقلي " باعتبارها لحظة حياتيه معقدة من الانكسار النفسي ، فضلا عن كونها تجربه ذات مغزى اجتماعي. ومن أجل تغيير المفهوم الدوني المتأصل لدي المجتمع عن الخلل العقلي و السلوك المضطرب، وفي محاوله لفهم أدق للظروف و الملابسات المرتبطة بهذا الخلل وذاك الاضطراب ، تعتمد الباحثة على "النموذج الاجتماعي للإعاقة" - كإطار بديل يتعارض بشكل أيديولوجي صريح مع المعتقدات الراسخه للطب الحيوي العلاجي. لهذا الغرض ، تركز الدراسة بشكل أساسي علي تجربه بطلة العرض الموسيقي الاجتماعي الجاد " أقرب إلى العادي" لبريان يوركي مع "الاضطراب ثنائي القطب " ، لمناقشه الأوجه الاجتماعيه المتعدده و الرؤى الجديده الغير تقليديه للخلل العقلي. تتوصل الباحثة في النهايه إلى استنتاج مفاده أن الخلل العقلي ليس بالضرورة نابعا من خلل سلوكي أو نفسي أو بيولوجي جوهري، ولكنه نتاج اجتماعي لثقافات وأيديولوجيات مجتمعات مهيمنه لا تستوعب أولئك الذين يتم وصفهم على أنهم "مختلين".

الكلمات الداله: أيديولوجيه القدرة- الإعاقة النفسيه الاجتماعيه - نهج الاعتزاز بالجنون- النموذج العلاجي للإعاقة- مسرحيه "أقرب الي العادي"- النموذج الاجتماعي للإعاقة