Introduction

> Bodily decay is gloomy in prospect, but of all human contemplations the most abhorrent is body without mind.
>
> —*Thomas Jefferson,*
> letter to John Adams, 1816

If you are crazy, can you still be of sound mind?

This is not an idle question: I am crazy (although I don't usually use that word to refer to myself), and I make my living by using my mind. I'm a professor of composition and rhetoric. I spend most days thinking, talking, and writing.

Some of my students have been crazy. Colleagues too. Most of us are good at academic work, although the opportunity—or rather, the privilege—we have to engage in that work varies widely.

When you hear that someone is "crazy," a host of stereotypical images may come immediately to mind. For instance, you may picture a homeless person muttering on a bus; a figure lying restrained on a hospital gurney; or a dull medicated gaze.[1] You might also think of danger, for a common assumption about mental illness is that it goes hand in hand with violent behavior. Often, when I talk about madness with colleagues or friends, they mention film and television images of violent insanity; they associate madness and threat. Or they may refer to the recent shootings on college campuses: Virginia Tech, Northern Illinois, the University of Alabama–Huntsville (UAH). They might even say—as one commenter on a *Chronicle of Higher Education* blog did—that we seem to be in a new age of threat from "academic psycho-killers." In the face of such images, it is rarely persuasive to point out that madness is usually not threatening—at least not in the immediate physical sense. People with mental disabilities do move in an aura of constant violence within insti-

tutions, but as several scholars have observed, most of the violence comes not from these individuals but is instead directed at them.[2]

Alternatively, the image that springs to mind may be that of the extraordinary mad person, a star like Nobel Prize–winning mathematician John Forbes Nash Jr. as portrayed in the film *A Beautiful Mind*. That film upholds a truism about mental illness, namely, its link to creative genius. (It also upholds another truism, which is that in order to overcome one's madness, one must simply refuse to tolerate it—"Just Say No" as cure—but that's another story.) The commonsense link between madness and genius arises again and again, in stories about real people like composer Robert Schumann, who is said to have been bipolar ("Portrait"), as well as fictional characters like Sherlock Holmes, whose meticulous attention to detail has been suggested to indicate Asperger's syndrome (Sanders).

This book focuses on manifestations of madness—what I call "mental disability"—in the academic realm. I'm interested in the ways that mental disability affects the lives of students, faculty, and staff in U.S. higher education. I am also interested in the ways that mental disability is identified and valued (or, more often, devalued) in this space. Although I do refer to studies that make use of empirical data such as the prevalence of mental disabilities among college students, my concern is focused more upon the ways that we decide *who* is mentally disabled in the first place, and *what we do* once we have decided a person should be labeled as such. Put simply, I am interested in the stories that are told about mental disability in U.S. higher education. Who tells the stories? Who is privileged or deprivileged through the telling? In what ways might we want to change the stories we are telling, the ways we are imagining the proper place of the disabled mind in college? Indeed, do we even know what it means to have a disabled (unsound, ill, irrational, crazy) mind in the educational realm, a realm expressly dedicated to the life of the mind?

In U.S. higher education, both the "creative genius" and the "violent" stereotypes are referred to regularly. Faculty members who display "quirky" behavior are sometimes regarded with affection: think of funny Professor X, who mumbles in the hallways and perhaps wears outlandish outfits. (For what it's worth, my anecdotal observation indicates that quirks are more welcome in academe when displayed by a person who is white, male, and/or tenured; but that is only my observation.) Sometimes, less benignly, faculty members are labeled "difficult" and become

the object of administrative hand-wringing, or even formal sanctions. In this case we might think of Professor Y, who is notorious for her outbursts in faculty meetings and who is whispered to be "unbalanced." Students as well as professors populate the stories about madness in academe: in recent decades, stories about faculty "quirks" or "difficulty" have been joined by more urgently worded stories about violence. So, in addition to Professors X and Y, we now also have Student Z, whose writing contains violent themes and who, it is feared, may "go off" at any moment. Faculty and staff are encouraged to be alert for signs of imminent violence in student writing, in an atmosphere that Benjamin Reiss has called "quasi-psychiatric surveillance" (27), and many campuses have instituted "security" measures such as those outlined in the lurid (and expensive) DVD titled *Shots Fired on Campus: When Lightning Strikes*. With the relatively recent addition of UAH biologist Amy Bishop to the roster of "academic psycho-killers," writing by university faculty may soon draw the same level of attention and scrutiny.

I believe we must pay attention to this proliferation of stories, for several reasons. First, the abundance of stories indicates that mental disability is not now—if it ever was—a rare occurrence. Although the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) announces in its title that it identifies "disorder[ed]" states of mind, and thus implicitly deviations from the "normal," or at least more ordered, realm, its array of diagnoses is so copious that it seems to suggest that "human life is a form of mental illness" (Lawrence Davis). It's no coincidence that anecdotal stories about crazy people have proliferated along with the number of diagnoses in DSM, for a diagnosis is in essence a story—*especially* in DSM, which relies mainly upon descriptive criteria. Some, like Lawrence Davis, have argued that the explosion of DSM diagnoses is approaching the absurd. Davis wrote in a 1997 *Harper's* article, "Once the universe is populated with enough coffee-guzzling, cigarette-puffing, vigorous human beings who are crazy precisely because they smoke, drink coffee, and move about in an active and purposeful manner, the psychoanalyst is placed in the position of the lucky fellow taken to the mountaintop and shown powers and dominions." However, I argue that, while remaining skeptical of the motivations that have brought the enormous DSM into being,[3] we might also take this proliferation of stories as evidence of two important truths about disorderly minds. First, such minds show up all the time, in obvious and not-so-obvious ways; and second, recognizing

their appearance is not a yes-no proposition, but rather a confusing and contextually dependent process that calls into question what we mean by the "normal" mind.

That realization, that minds are best understood in terms of variety and difference rather than deviations from an imagined norm, is aligned with a theoretical and activist stance called disability studies (DS). According to DS scholars and activists, disability is popularly imagined as a medical "problem" that inheres in an individual, one that needs to be fixed ("cured") and is cause for sorrow and pity. DS countermands this dominant belief by arguing that disability is a mode of human difference, one that becomes a problem only when the environment or context treats it as such. To take a frequent example, using a wheelchair is not in and of itself a problem unless one must navigate a built environment, such as a bus, airplane, or building, which assumes stairs are the best and only way to ascend from one level to another.

In *Claiming Disability,* Simi Linton offers this description of DS:

> While retaining the word *disability,* despite its medical origins, a premise of most of the literature in disability studies is that disability is best understood as a marker of identity. As such, it has been used to build a coalition of people with significant impairments, people with behavioral or anatomical characteristics marked as deviant, and people who have or are suspected of having conditions, such as AIDS or emotional illness, that make them targets of discrimination. . . . When disability is redefined as a social/political category, people with a variety of conditions are identified as *people with disabilities* or *disabled people,* a group bound by common social and political experience. (12)

Adopting a DS perspective is not simple. The ramifications of the premise described by Linton are many, and often require a disorienting shift away from presumptions of tragedy, courage, or brokenness. Moreover, since the publication of *Claiming Disability* in 1998, DS scholars have continued an energetic debate about what DS is, how it manifests in various fields, and how it signifies differently for different kinds of impairments. Although DS is concerned with individual experience, it is foremost a social and political perspective. As such, it shifts the "problem" of disability away from individuals and toward institutions and attitudes. Strongly indebted to postmodern ways of knowing, DS generally

understands the institution as a system that produces human oppression (as well as privilege). This book examines the impact of one particular set of institutional discourses—those of U.S. higher education—on persons with disabilities of the mind. It is both an attempt to broaden the field of DS and a critique of the field's long-standing emphasis on physical and sensory impairments.

My analysis of academic discourse[4] focuses on certain commonplace beliefs, or topoi. Lawrence J. Prelli explains topoi (singular *topos*) as "lines of thought that bear on a [person's] credibility in this or that rhetorical situation" (90). A topos contributes to the construction of a rhetor's ethos, or perceived character. It is often an issue or theme with which she must contend in the process of presenting herself as a credible and persuasive person. Because common topoi are generally recognized by a rhetor and her audience, they can serve as points from which to begin arguments. However, when they are shared by an in-group, they also tend to be unexamined; thus, as Sharon Crowley explains, "commonplaces are part of the discursive machinery that hides the flow of difference" (73). Common topoi are often invoked when rhetors wish to reinforce dominant values or "challeng[e] the beliefs/practices of miscreants and outsiders" (Crowley 73).[5] This gives topoi great power, especially power on the part of dominant groups to exclude or punish marginalized groups or persons.

I argue that some of the most important common topoi of academe intersect problematically with mental disability. These include

- Rationality
- Criticality
- Presence
- Participation
- Resistance
- Productivity
- Collegiality
- Security
- Coherence
- Truth
- Independence

For instance, what does "participation" in a class mean for a student who is undergoing a deep depression and cannot get out of bed? Or a stu-

dent who experiences such severe anxiety, or obsession, that he can barely leave his dorm room or home? What about a student on the autism spectrum who has difficulty apprehending the subtle social cues that govern classroom participation, the difference between "showing engagement" and "dominating the conversation," the sorts of spontaneous oral performances that are considered "smart"? What does "collegiality" mean for a faculty member who has these same difficulties? What happens to the "productivity" of an academic writer who struggles to achieve the linear coherence that most academic writing demands? Or whose disability affects the many self-directed stages of writing and revising—initiation, organization, seeking and applying feedback, completion? Why, indeed, is "coherence" one of the most-often emphasized features of a thesis-driven academic argument; does the demonstration of coherence indicate a stronger mind? How do the new requirements for "security" in U.S. academic environments resonate with (or against) our cherished values of free speech and independence? Finally, what are we to make of the ever-growing number of "independent" scholars in the United States, many of whom occupy that "independent" status because their mental impairments or disabilities make a securely affiliated academic job impossible?

To a great extent, we don't know the answers to these questions, for academics (which I define, for the purposes of this study, to include students, staff, administrators, and independent scholars as well as faculty) with mental disabilities are largely excluded from academic discourse. The instruments of exclusion are not visible or dramatic—men in white coats dragging people away—but quiet, insidious: We flunk out and drop out. We fail to get tenure. We take jobs as adjuncts rather than tenure-track faculty. We transfer schools; we find a way to get a job or a degree elsewhere. Or not. Earlier, I said that mental disabilities are better understood in terms of variety and difference rather than "yes/no" diagnoses. That's true; but another truth exists alongside, which is that, in the institutional terms of academic discourse, a sharp rhetorical divide exists between those who are allowed in and those who are not. The fondly regarded "absent-minded" or "quirky" professor is a noticeable figure, but less noticeable is the student with severe depression who drops out of school; the adjunct with autism who never manages to navigate a tenure-track job interview successfully; or the independent scholar whose written works are widely cited but who cannot adhere to the social requirements of teaching in a classroom.

Those of us who do function successfully in academe tend to pass much of the time. Sadly, the necessity of passing for survival perpetuates the conventional view of academe as an "ivory tower"—an immaculate location humming with mental agility and energy, only occasionally threatened (from the outside) by the destructive force of insanity. Recently, this destructive force is often represented as a violent student or faculty member who is assumed to have gone mentally haywire, like a bad cog in an otherwise smoothly operating machine. But things are going to change, not least because those with atypical minds are entering academe in unprecedented numbers. (Or, as some arguments suggest, we are simply being noticed more often.) According to the U.S. Department of Education, in the year 2003–4, 22 percent of students with disabilities in college reported having "mental illness or depression"; 7 percent reported learning disabilities; and 11 percent reported attention deficit disorder ("Profile" 133). Results published in the *Archives of General Psychiatry* put the numbers even higher: according to analysis of data from the 2001–2 National Epidemiologic Survey on Alcohol and Related Conditions, nearly half (46 percent) of college students reported having experienced some psychiatric disorder in the year the survey was conducted (Blanco et al.).[6] Meanwhile, between 1994 and 2004, the percentage of students in K–12 schools labeled as having autism rose 525 percent (Monastersky).[7] Indeed, in particular locations, things *are* changing, and often for the better, as shown by programs such as "College Camp," which is designed to introduce students with intellectual differences to college life (Sunderland). This is a book about the violence of exclusion, but also about the ongoing negotiations and successes achieved by academics with mental disabilities—not through heroic feats of "overcoming," but through microrebellions, new forms of access and cooperation, a gradual reshaping of what academe is and might be.

My aim in this book is to use the activism and theory of disability studies to argue for changes to the ways that academic discourse is understood, taught, written, and evaluated. I believe that DS has much to offer academic discourse, ranging from our ways of understanding classroom practices, to our ways of gathering (at conferences and meetings), to our communication with audiences who have a stake in our work. Such audiences include students, families of students, legislators and public officials, alumni of colleges and universities, and, of course, instructors and professors—all of us who are concerned, one way or another, with the life of the mind. One of my grounding assumptions is that

school matters—how we learn, how we teach, how we work to develop new ideas that point toward a better society for all.

Why academic discourse in particular? In part, this is my focus because I have a personal stake in it. I am a professor, and I have observed firsthand how difficult it can be to negotiate academe with a disorderly mind. But there is a deeper urgency to this project as well: I perceive a theoretical and material schism between academic discourse and mental disabilities. In other words, I believe that these two domains, *as conventionally understood,* are not permitted to coexist. Academic discourse operates not just to omit, but to abhor mental disability—to reject it, to stifle and expel it. For thousands of years academe has been understood as a bastion of reason, the place in which one's rational mind is one's instrument. But what does that mean for those of us with atypical (some would say "impaired" or "ill") minds who work, learn, and teach in this location? In order to answer this question, we need to unpack not only the practices that characterize academic discourse, but also the attitudes and ways of knowing that underlie those practices.

Catherine Prendergast has asked, "Does some kind of al/chemical transformation need to occur before the mentally ill can be heard? And in whom does it need to take place?" ("Rhetorics" 203). Her question inspires me to follow with another: What transformation would need to occur before those who pursue academic discourse can be "heard" (which I take to mean "respected"), not *in spite of* our mental disabilities, but *with* and *through* them? What would have to happen to the dominant understanding of academic discourse, driven as it is by Aristotelian notions of rationalism, and largely "head-centered" (Garland-Thomson, "Shape" 120)? In the rest of this book, I examine the discursive processes by which academic discourse abhors mental disability. I also discuss ways that persons with mental disabilities *have* gained what Prendergast calls "rhetoricity" ("Rhetorics" 202) in various genres and spaces—through defiant writings, small victories, and our simple daily survival—thus pointing a way toward a more inclusive, and thereby enriched, academe.

My purpose is not only to offer new insights into the rhetoricity of mentally disabled people, but also into ways that we might reconstruct "normal" academic discourses to become more accessible for all. Far from being an altruistic project, this is an effort that will strengthen our current system of academic discourse generally, for ableism impairs all of us. Ableism contributes to the construction of a rigid, elitist, hierarchical, and inhumane academic system. We have already heard many calls for

ways that this system should be overhauled. Adjusting our practices for the thoughtful inclusion of mental disabilities will improve the ways all of us *treat* one another (pun intended). Put another way, I am not arguing that mentally disabled persons can measure up to current "standards" of academic discourse. I am arguing that academic discourse needs to measure up to us.

Naming and Definition

Who am I talking about? So far I've used a variety of terms to denote impairments of the mind, and I haven't yet exhausted the list. Contemporary language available includes *psychiatric disability, mental illness, cognitive disability, intellectual disability, mental health service user* (or *consumer*), *neurodiversity, neuroatypical, psychiatric system survivor, crazy,* and *mad.* "No term in the history of madness is neutral," Geoffrey Reaume argues, "not *mental illness, madness,* or any other term" (182). Moreover, as Ian Hacking has pointed out, particular names may thrive in a particular "ecological niche"—for instance, the intersection of the diagnosis "neurasthenia" with nineteenth-century French stories of the "Wandering Jew" (2, 120) or the diagnosis "drapetomania," applied to African American slaves who attempted to escape (Jackson 4). Keeping this dynamism in mind, the following analysis does not aim to accept some terms and discard others. Rather, I want to clarify the different areas they map and show that each does particular kinds of cultural work in particular contexts. Although I use *mental disability* as my own term of choice, I continue to use others as needed, and my overall argument is for deployment of language in a way that operates as inclusively as possible, inviting coalition, while also attending to the specific texture of individual experiences. In doing so, I follow the urging of Tanya Titchkosky, who argues that the aim of analyzing language about disability should not be to mandate particular terms but rather "to examine what our current articulations of disability are saying in the here and now" ("Disability" 138). The problem of naming has always preoccupied DS scholars,[8] but acquires a particular urgency when considered in the context of disabilities of the mind, for often the very terms used to name persons with mental disabilities have explicitly foreclosed our status *as* persons. Aristotle's famous declaration that man is a rational animal (1253a; 1098a) gave rise to centuries of insistence that to be named mad was to lose one's personhood.

Mad is a term generally used in non-U.S. contexts, and has a long history of positive and person-centered discourses. MindFreedom International, a coalition of grassroots organizations, traces the beginning of the "Mad Movement" to the early 1970s, and reports on "Mad Pride" events that continue to take place in countries including Australia, Ghana, Canada, England, and the United States. MindFreedom and other groups organize activist campaigns, sponsor exhibits and performances, and act as forums and support networks for their thousands of members. *Mad* is less recognizable in the United States, which can be to its advantage, since its infrequency helps detach it from implication in medical and psychiatric industries. In addition, *mad* achieves a broad historical sweep. Psychiatry, with its interest in brains, chemistry, and drugs, arose only in the last couple of centuries; however, writings on madness can be found in pre-Socratic discourse, and their historical progression through centuries spans medicine, philosophy, and literature, as Allen Thiher shows in *Revels in Madness: Insanity in Medicine and Literature.*

> The center of our discourses on madness has had many names: *thymos, anima,* soul, spirit, self, the unconscious, the subject, the person. Whatever be the accent given by the central concept, access to the entity afflicted with madness is obtained through a language game in which these concepts or names play a role, organizing our experience of the world even as the world vouchsafes criteria for correct use of these notions. (3)

Thiher does not discuss at length his choice of *mad,* but it is evident from the far-reaching scope of his study that this term achieves a flexibility that *mental illness* and *cognitive disability* do not: it unites notions of that "central concept" through time and across cultures. As with *queer,* the broad scope of *mad* carries the drawback of generality but also the power of mass.

Many persons in the mad movement identify as psychiatric system survivors. According to MindFreedom, psychiatric system survivors are "individuals who have personally experienced human rights violations in the mental health system." A more inclusive term is *consumer/survivor/ex-patient* (*c/s/x*). Drawing upon the work of Linda J. Morrison, Bradley Lewis argues that this term "allows a coalition among people with diverse identifications" while also indicating that the relationship between the three positions is neither exclusive nor linear (157). Lewis

goes on to suggest that we might add *patient* as well, making the abbreviation into a quatrad (p/c/s/x), to represent the fact that some persons within the psychiatric system are forced into this objectified and passive role (157).

When I first encountered the term *survivor,* I felt hesitant. It seemed to have unsettling similarities to "cure": a survivor, I thought, implicitly had *had* a traumatic experience and come out the other side. This doesn't describe my experience. I make regular use of the psychiatric system, and I consider myself the agent and director of my treatments; for example, I interviewed and discarded psychiatrists until I found one who agrees with my approach to my bodymind.[9] However, there is no avoiding the fact that he, not I, wields the power of the prescription pad. In addition, I possess the economic and cultural privilege that permits me to try out and reject various caregivers, a privilege not open to many in the c/s/x group. And finally, like any "patient," I am subject to my caregivers' power over information. For example, when my psychiatrist and my therapist conferred and arrived at one of my diagnoses, they chose not to share that diagnosis with me until some months later (their stated reason being that I had been in the midst of a crisis and was not ready to process the information). As it happens, I think they made an appropriate decision, but the fact remains that regardless of what I thought, the outcome would have been the same; I had no say in the matter.

In her ethnographic study *Talking Back to Psychiatry,* Linda J. Morrison interviewed activists in the c/s/x movement, which she defines as "people who have been diagnosed as mentally ill and are engaged in different forms of 'talking back' to psychiatry and the mental health system," as well as allies including "dissident mental health professionals, lawyers, advocates, and family members" (ix). Morrison found that they made use of the term *survivor* in various ways, and that a "heroic survivor narrative" is deeply influential in the movement, both through published accounts (such as Kate Millett's *The Loony-Bin Trip*) and in individuals' processes of identity formation vis-à-vis psychiatric discourse (101). Participants' survivor narratives "exist in a range of intensity, from high drama to muted skeptical observations" (129), but the narrative as a whole, Morrison argues, plays a crucial role in the movement, helping to build solidarity and empower resistant voices. Significantly, this narrative, and the term *survivor,* have also been singled out for denigration by critics (Morrison 152–53).

My own thinking on *psychiatric system survivor* was deepened when I discussed it with my colleague Petra Kuppers. One evening at a conference, sitting on the bed in her hotel room and chewing over my thoughts, I said that I didn't feel I "survived" the psychiatric system so much as worked within it, negotiating and resisting as I went. "But," Petra said simply, "that *is* survival." Her insight has shifted my view of the term: rather than thinking of a survivor as one who has undergone and emerged from some traumatic experience (such as incarceration in a mental institution), it can also denote one who is actively and resistantly involved with the psychiatric system on an ongoing basis.

Mental illness introduces a discourse of wellness/unwellness into the notion of madness; its complement is *mental health,* the term of choice for the medical community as well as insurance companies and social support services. This well/unwell paradigm has many problems, particularly its implication that a mad person needs to be "cured" by some means. One material consequence of this view is that mental health insurance operates on a "cure" basis, demanding "progress" reports from therapists and social workers, and cutting off coverage when the patient is deemed to have achieved a sufficiently "well" state. For instance, although the American Psychiatric Association recommends that persons with my diagnoses remain in long-term talk therapy, my insurance company (CIGNA) determined in 2006 that I was "well enough" and terminated my mental-health coverage, except for brief pharmaceutical consultations with my psychiatrist. During a months-long battle with the "physician reviewer" employed by CIGNA, my therapist's and psychiatrist's requests for continued coverage (which, according to CIGNA's rules, I was not permitted to make directly) were repeatedly turned down. Ultimately, my therapist was informed that the decision would stand unless I "actually attempt[ed] suicide," at which point I would be deemed unwell enough to resume therapy. This "well/unwell" paradigm reflects the larger tendency of American medical systems to intervene in "problems" rather than practice a more holistic form of care.

However, an advantage of *mental illness* is that it can be allied with the substantial—and sometimes contentious—conversation within DS on the intersections between illness and disability. In a 2001 *Hypatia* article, "Unhealthy Disabled: Treating Chronic Illnesses as Disabilities," Susan Wendell points out that activists in the disability rights movement in the United States have often sought to "distinguish themselves from those who are ill" (18). This has led to a schism between those she calls the

"healthy disabled," whose impairments "are relatively stable and pre-dictable for the foreseeable future" (19), and those who are chronically ill. Because those with chronic illnesses are often exhausted, in pain, or experiencing mental confusion, their very identities as activists come into question:

> Fluctuating abilities and limitations can make people with chronic illnesses seem like unreliable activists, given the ways that political activity in both disability and feminist movements are structured. . . . Commitment to a cause is usually equated to energy expended, even to pushing one's body and mind excessively, if not cruelly. (25)

Wendell acknowledges that "healthy disabled" and "unhealthy dis-abled" are blurry categories: a person with cerebral palsy, for example, may also experience exhaustion, pain, or mental confusion; indeed, a person with a physical impairment may also have a chronic illness. Usu-ally, however, "disabled" implicitly means "healthy disabled," and full inclusion of the unhealthy disabled must involve "changes in the struc-ture, culture, and traditions of political activism," with new attitudes to-ward "energy and commitment, pace and cooperation" (Wendell 26). As yet, such changes are largely unrealized. Consider the last conference you attended: did events run from 9:00 a.m. until late at night? Consider the "tenure clock," or activist efforts that call for attendance in public places for hours at a time: do such occasions assume each participant will have the ability to meet people, interact, and function for hours on end? Consider the persons who did not attend. Do you know who they are?

Andrea Nicki's theory of psychiatric disability picks up Wendell's point about energy and health, but reshapes it to critique the implicitly rational mind of the "good" disabled person—or, as Quintilian might have put it, the "good disabled person speaking well" (see Brueggemann, *Lend*). Not only must this person be of rational mind, Nicki argues; he must also adhere to a "cultural demand of cheerfulness," which is par-ticularly insidious because in some cases—for a person with depression, for example—this would involve not just an attitude *toward* his illness but a direct erasure *of* his illness (94). Like Wendell, Nicki calls for re-design of our social and work environments, emphasizing the importance of interdependence as a means to achieve this goal. Anne Wilson and Pe-ter Beresford have argued that the project will be difficult, and will in-

volve not just surface-level changes, but a full reworking of the social model of disability (145).

One part of this reworking will be the acknowledgment that, although discursive alliances can be drawn between physical and mental illness, important differences exist as well. For example, while members of the disability rights movement, including myself, proudly call ourselves "disabled," many members of the c/s/x movement view the term *disabled* with more suspicion. In the view of the c/s/x movement, when psychiatry assigns a diagnosis of "mental illness" to a person, that person is marked as permanently damaged, and as one whose rights may be taken away—unless, of course, she complies with psychiatry's requirements for "care," which may include medication, incarceration, or electroshock. Morrison makes this point by contrasting psychiatric diagnosis with the diagnosis of a cold:

> In modern psychiatry, a person who has been diagnosed with a serious and persistent mental illness (SPMI) is rarely considered "cured" or completely free of illness. The implied expectation is that mental illnesses are chronic. They may remit but they are likely to recur. Compare, for example the yearly cold symptoms with congestion and cough that many people experience, followed by recovery to a "normal" state. In psychiatric illness, recovery from the symptoms would not be considered the end of the problem. The likelihood of a return to a symptomatic state, with resultant need for medical intervention, would be assumed . . . [A] former patient is always expected to become a future patient and the sick role is ongoing. In fact, if a patient believes otherwise, this can be considered a symptom of exacerbated illness. (5)

This paradox, in which belief of one's own wellness may *in itself* be considered evidence of unwellness, lies at the heart of psychiatric diagnosis. To accept the psychiatric profession's definition of oneself as sick is considered a key move toward getting well; the technical term for acceptance of a psychiatric label is "insight." Although members of the c/s/x movement occupy a range of perspectives, generally the movement resists psychiatry's efforts to place its "patients" into the "sick role." Like Deaf activists, c/s/x activists have much in common with disability activists, but strong differences as well—one of which is the issue of whether or not to self-identify as *disabled*.

One thing c/s/x and disability activists agree upon, however, is the deeply problematic nature of modern psychiatric discourse. Working in concert with the gigantic forces of for-profit insurance companies and the pharmaceutical industry, mainstream psychiatry places ever-increasing emphasis on a biological and positivist definition of mental illness, all while claiming to remain "theory-neutral" (Bradley Lewis 97). However, dissident voices can be heard within psychiatry as well. As Morrison shows, some medical professionals are members of the c/s/x movement. Groups that bring together critical psychologists and psychiatrists and the c/s/x movement have proliferated since the 1990s, and include the Critical Psychiatry Network; Psychology, Politics and Resistance; the Mental Health Alliance; and Radical Psychology Network. This resistant strain of psychiatry is sometimes called *postpsychiatry,* a theory/practice that views "mind" philosophically and socially as well as biologically.

Postpsychiatrist medical philosophers Patrick Bracken and Philip Thomas argue that, once Descartes had established the now-conventional body/mind split (as well as valorization of the individual subject), subsequent theories of mind continued to perpetuate this belief, extending into nineteenth- and twentieth-century psychiatry, which expanded its effects still further. Bracken and Thomas identify three outcomes of this philosophy: the beliefs that "madness is internal"; that madness can be explained neurologically and treated (solely) with pharmaceuticals; and that psychiatrists have the "right and responsibility" to coerce their patients ("Postpsychiatry" 725). Postpsychiatry offers an alternative path, Bracken and Thomas suggest, not by replacing old techniques with new ones, but rather by "open[ing] up spaces in which other perspectives can assume a validity previously denied them"—especially the perspectives of those labeled "mentally ill" ("Postpsychiatry" 727). In addition to centering the agency of mad people, Bracken and Thomas argue for replacing the conventional separation of body and mind with an emphasis on social context, ethical as well as technical (chemical) modes of care, and an end to the claim that coercive "treatments" are applied for "objective" or "scientific" reasons. In a later, briefer article, Bracken and Thomas clarify the relationship of Cartesian dualism to postpsychiatry: human mental life, they argue, is not "some sort of enclosed world residing inside the skull," but is constructed "by our very presence and through our physical bodies" ("Time to Move" 1434).

Bradley Lewis offers an in-depth account of postpsychiatry in *Moving Beyond Prozac, DSM, & the New Psychiatry: The Birth of Postpsychia-*

try. Describing himself as a "hybrid academic," Lewis holds both an M.D. in psychiatry and a Ph.D. in interdisciplinary humanities (ix). From this unusual position, Lewis makes a call for postpsychiatry that is both pragmatic and theoretical: cyborg theory, neurophysiology, and the governing structure of the APA all occupy significant parts of his attention. *Moving Beyond Prozac* describes "a theorized postpsychiatry," which would "take seriously the role of language and power" as well as "work without the pseudo-foundations and pseudo-certainties of modernist science and reason" (17). Lewis does not wish to do away with psychiatrists and clinics, but rather to reform them. The reformed "clinical encounter," for example, would include "not only the modernist values of empirical diagnosis and rational therapeutics but also additional clinical values like ethics, aesthetics, humor, empathy, kindness and justice" (17; see also Lewis, "Narrative Psychiatry"). While pragmatic, Lewis's argument is not individualistic, but aimed at discourses and structures of power. Individual psychiatrists and practices do need to change, Lewis suggests, but the core project is revision of the psychiatric profession to become more democratic, less positivist, less capitalistic, and to include the voices and concerns of *all* its stakeholders, including the c/s/x group.

Neuroatypical and *neurodiverse* mark a broader territory than psychiatric discourse: these terms include all whose brains position them as being somehow different from the neurotypical run of the mill. *Neuroatypical* is most often used to indicate persons on the autism spectrum, including those with Asperger's syndrome (AS), but has also been used to refer to persons with bipolar disorder (Antonetta) and traumatic brain injuries (Vidali). In her "bipolar book" (13) *A Mind Apart*, Susanne Antonetta argues that neurodiversity acts a positive force in human evolution, enabling alternative and creative ways of thinking, knowing, and apprehending the world.

A potential problem with the rhetoric of neurodiversity is that it can read as overly chipper (like a "Celebrate Diversity!" bumper sticker); its optimism can flatten individual difference. However, it also carries a complement, *neurotypical* (or NT), which destabilizes assumptions about "normal" minds and can be used to transgressive effect (Brownlow). For example, Aspies For Freedom has used *NT* to parody the rhetoric of "cure" propagated by the organization Fighting Autism. Until very recently, Fighting Autism published and maintained a graphic called the "autism clock" (fig. 1) which purported to record the "incidence" of autism for persons aged three to twenty-two and the supposed

The "autism clock" (captured on June 6, 2009) published by Fighting Autism. This image was taken down in July 2010 in response to activists' protests.

Parody of the "autism clock" published by Aspies For Freedom.

economic "cost" of this incidence.[10] In response, Aspies For Freedom published a parody of the autism clock (fig. 2), which pathologizes neurotypicals and suggests that for the onrush of diagnoses ("1 every minute"), there will be "2 to take them."

While Fighting Autism viewed autism as a disease that must be battled and cured, Aspies For Freedom takes the stance that autism is a form of neurodiversity, that is, of difference, not something that should be eradicated. Although public opinion of autism tends to be dominated by the disease/cure model, resistant voices of neurodiversity have proliferated, especially through web-based communities, blogs, and webtexts (see, for example, Yergeau, "Aut(hored)ism").

Some DS scholars, including Cynthia Lewiecki-Wilson, have called for a coalition of those with psychiatric and cognitive disabilities; she suggests that the term *mental disability* can be used to denote the rhetorical position of both groups:

> For the purposes of this paper, I group mental illness and severe mental retardation under the category *mental disabilities*. Despite the varieties of and differences among mental impairments, this collective category focuses attention on the problem of gaining rhetoricity to the mentally disabled: that is, rhetoric's received tradition of emphasis on the individual rhetor who produces speech/writing, which in turn confirms the existence of a fixed, core self, imagined to be located in the mind. (157)

In other words, according to Lewiecki-Wilson, the notion that one's disability is located in one's mind unites this category, not because such a thing is inherently true, but because persons with these kinds of disabilities share common experiences of disempowerment as rhetors—a lack of what both Prendergast and Lewiecki-Wilson call "rhetoricity." My own struggles for adequate terminology follow Lewiecki-Wilson's call for coalition politics. Although it is important to note the differences between specific experiences, in general I believe we need *both* local specificity *and* broad coalitions for maximum advantage. Persons with impaired bodyminds have been segregated from one another enough.

For a while, I used the term *psychosocial disability*. I like its etymology, the fact that it bumps *psych* (soul) against social context; I like its ability to reach toward both mind and world. Its emphasis on social context calls attention to the fact that psychosocial disabilities can be vividly, and sometimes unpredictably, apparent in social contexts. Although it's common to describe psychosocial disabilities as "invisible," or "hidden," this is a misnomer. In fact, such disabilities may become vividly manifest in forms ranging from "odd" remarks to lack of eye contact to repetitious stimming.[11] Like queerness, psychosocial disability is not so much invisible as it is apparitional, and its "disclosure" has everything to do with the environment in which it dis/appears.[12] *Psychosocial disability* announces that it is deeply intertwined with social context, rather than buried in an individual's brain.

Although *psychosocial* has been used in narrow ways that comply with a medical model of disability, it also has considerable traction within disability studies. In her introduction to a 2002 special issue of *Disability Studies Quarterly*, Deborah Marks argues that a psychosocial perspective can "challenge the disciplinary boundary between psychological and social paradigms." Taking up her point, Patrick Durgin has amplified the term's radical possibilities:

> A "psycho-social formulation" is, in short, the none-of-the-above option in the diagnostic pantheon. It is the excluded middle or liminal space where impairment meets world to become disability. To use clinical language, it does not "present" clinically because it resists being given diagnostic surmise; and yet it won't "pass" as normal. (138)

Durgin goes on to argue that, although *psychosocial* may seem a kind of "golden mean" between medical and social paradigms, it too must un-

dergo critical examination; not least, I would add, because this term can and has been used in medicalized and positivist projects. For example, in the third and fourth editions of the *Diagnostic and Statistical Manual of Mental Disorders,* the authors have made a great show of considering social factors in their new classification of "mental disorders," and also of having involved a broad base of patients and clinicians in developing the manual. Yet, as Lewis points out, that show is largely illusory; the central developers of the landmark DSM-III (and inventors of its categories) numbered just *five persons,* and the overarching rationale for the manual is increasingly positivist and biological. Despite this history, I value the potential of *psychosocial* for reappropriation. In a sense, Durgin is saying to the authors of the DSM, "You want social? We'll give you social."

My appreciation of *psychosocial* has been affirmed by philosopher Cal Montgomery, who pointed out its usefulness in terms of sensory as well as cognitive disabilities, saying, "I do think we need a way of talking inclusively about people for whom access to human interaction is problematic." (See chapter 6 for elaboration of this point.) However, having spent the last couple of years trying this term out—on the page, in conference presentations, at dinner with friends—I've become increasingly uncomfortable with it, because in most cases it seems to provoke puzzlement rather than connection. Explaining my experiences to Cal, I wrote: "I've been using the term 'psychosocial disability' in various settings for over a year—at conferences, in casual conversations, in my writing, etc.—and it seems that, *unless* I'm writing an article where I can fully explain what I'm getting at, people just kind of go blank when I use the term. I have started to feel like, what's the point of using a term that no one gets but me?" Put simply, in most social contexts, *psychosocial* failed to *mean.*

So I have taken another tack. Following Lewiecki-Wilson, these days I'm using *mental disability.* As Lewiecki-Wilson argues, this term can include not only madness, but also cognitive and intellectual dis/abilities of various kinds. I would add that it might also include "physical" illnesses accompanied by mental effects (for example, the "brain fog" that attends many autoimmune diseases, chronic pain, and chronic fatigue). And, as Cal suggests, we should keep in mind its potential congruence with sensory and other kinds of disabilities—that is, its commonalities with "people for whom access to human interaction is problematic."

Finally, while I respect the concerns of those who reject the label *disabled,* I have chosen to use a term that includes *disability* explicitly. In my own experience, claiming disability has been a journey of community,

power, and love. Over the last twenty years, I have migrated from being a person who spent a lot of time in hospitals, who was prescribed medications and prodded by doctors, to a person who inhabits a richly diverse, contentious, and affectionate disability community. Let me tell a story to explain this migration: On a December day in 2008, I arrived in a fluorescent-lit hotel room in San Francisco to listen to a panel of scholars talk about disability. I had recently made a long airplane journey and felt off-balance, frightened, and confused. I sat beside disability activist and writer Neil Marcus, and when he saw my face, he opened his arms and offered me a long, hard-muscled hug. That hug, with arms set at awkward angles so we could fit within his wheelchair, with chin digging into scalp and warm skin meeting skin—that, to me, is disability community. Neil may or may not know what it is like to wake with night terrors at age forty, I may or may not know what it feels like to struggle to form words, but the reaching across those spaces is what defines disability for me. We write, we question and disagree, we are disabled. Simi Linton has said of the term *disability* that "We have decided to reassign meaning rather than choose a new name" (31).

And so, in naming myself a crazy girl, neuroatypical, mentally disabled, psychosocially disabled—in acknowledging that I appear (as a colleague once told me) "healthy as a horse" yet walk with a mind that whispers in many voices—I am trying to reassign meaning. In the best of all possible worlds I would refuse to discard terms, refuse to say which is best. I believe in learning the terms, listening to others' voices, and naming myself pragmatically according to what the context requires. I believe that this is language.

Overview of Chapters and a Note on Style

Many of us are mad at school. This includes not only those of us with mental disabilities who work and learn in academic settings; it also includes those who are *mad at school* in the other sense—frustrated, critical, and concerned. Such persons may include clinicians and social workers; the friends and family members of students, staff, and faculty with mental disabilities; and researchers of educational settings or mental disabilities from a great variety of disciplines. In other words, many different people, coming from many different backgrounds, have a stake in this book. For this reason, I have attempted to write in a manner that is ac-

cessible to a wide variety of readers. I've tried to imagine audiences including my students; my colleague who specializes in mathematical data-mining; my mother (a retired administrator in higher education); my father (a psychology professor); and my friend Sarah, whose youngest son has Down syndrome. This book contains stories about my own experience, because I believe stories are one way of accessing theory. It also contains stories told by others, those I've worked with and engaged in research with. And it does contain a fair amount of "academic jargon"—reviews of studies, speculation on theories, writing by teachers and researchers. I hope that you, as the reader, will pick and choose the parts of this book that are meaningful to you. I want to offer it as a kind of smorgasbord, not a single sustained argument that must be read from beginning to end.

Chapter 1 addresses the question of academic discourse itself—what it is, and how it intersects with the discourses of mental disability. Beginning with classical rhetoric, it explores the significance of topics including "rationality" and "the critical." This chapter also introduces my methodology, which is an adaptation of critical discourse analysis (CDA) and pays particular attention to rich discursive features (Barton) including juxtaposition, interdiscursivity, pronouns, and key terms.

Chapter 2 focuses on the classroom. I begin by introducing my theory of *kairotic space,* which I define as the less formal, often unnoticed, areas of academe where knowledge is produced and power is exchanged. Drawing upon rhetorical theories of *kairos* as well as DS theories of "crip time," I analyze topoi including "presence," "participation," and "resistance." Through close reading of students' writing, as well as teachers' accounts of their classroom experiences, I explore the role these features play in the exclusion of persons with mental disabilities from academic discourse, and consider digital as well as face-to-face pedagogical spaces. The chapter concludes with a series of concrete suggestions for creating more inclusive classroom spaces.

Chapter 3 examines professional kairotic spaces, including conferences and job searches. Such gatherings generally assume various abilities, including the ability to operate in crowds, to navigate unfamiliar geographies, and to cope with fast-moving and often agonistic exchanges (for instance, the question-and-answer session after a conference panel). Drawing upon published guidelines from professional organizations such as the Modern Language Association and American Psychological Asso-

ciation, as well as written accounts by faculty (including non-tenure-track faculty), I analyze these texts in terms of the topoi "collegiality" and "productivity." As with chapter 2, I conclude with concrete suggestions for creating a more inclusive professional infrastructure.

Chapter 4 shifts focus from the everyday spaces of academe to its representation in crisis—specifically, in the context of school shootings. Because the shooting at the University of Alabama–Huntsville occurred just as this book was going to press, my focus is on two other sites—Virginia Tech and Northern Illinois University. However, I stress that the myths and representations that played out in stories of students Seung-Hui Cho and Steven Kazmierczak are being reiterated in stories of faculty member Amy Bishop. This chapter argues that representations of school shootings usually presume that madness was the *cause* of the shooters' actions. But in such representations, madness tends to operate as the *mechanism* through which the shooters are placed in a deviant space separate from everyone else ("normals"). In this way, an attempt is made to construct academe as a "safe zone" that must be protected from the violent incursions of madness. Accounts of Cho and Kazmierczak can be read as medicalized case studies that perpetuate dominant discursive formations in which the topos of security is used to buttress myths of race, class, and violence.

Chapter 5 turns its focus to textual sites of microrebellion in which rhetors with mental disabilities find ways to speak on their own terms. This chapter analyzes *A Mind Apart: Travels in a Neurodiverse World,* by Susanne Antonetta; *Lying: A Metaphorical Memoir,* by Lauren Slater; and "Her Reckoning: A Young Interdisciplinary Academic Dissects the Exact Nature of Her Disease," by Wendy Marie Thompson. Using the rich feature of pronouns as a window into the larger dynamics of power and personhood that play out in these texts, I show that they subvert the conventional imperatives of autobiography by engaging in a strategy I call *counterdiagnosis.* Counter-diagnosis refuses a confessional position and refigures key topoi of autobiographical prose including "rationality," "coherence," and "truth." These texts claim cultural and academic capital not in spite of, but *through,* their authors' neuroatypicality.

Chapter 6 exists because, quite simply, I could not bear to publish this book without careful attention to those who operate outside the privileged borders of academe, whether by choice or by exclusion. The chap-

ter is a small-scale qualitative study involving interviews with three independent scholars, Leah (Phinnia) Meredith, Cal Montgomery, and Ty Power. Given the shocking statistics about academics with mental disabilities—for example, that 86 percent of students with psychiatric disabilities withdraw from college before completing their degrees (Collins and Mowbray 304)—I felt that there were important stories to be told by those who operate from contingent and marginal positions. In addition, I wanted to apply the principles of accessible design to qualitative research, exploring the ways that access must shift and stretch when participants and researcher have mental disabilities. The primary topos investigated in this chapter is independence itself: what does it mean to be an "independent" scholar in a social and academic system rife with the inequities of ableism? Ty, Cal, and Phinnia offer important correctives to my own thinking as well as provocative insights about how academic discourse and qualitative research might be reformed to become more accessible for all.

End Note

Much of this book is a story, or rather, a series of stories. I believe that incorporating narratives of experience is one way to improve access to academic prose. (Also, and admittedly, it's just the way I write.) Among the stories I like best are those that render their own occasions of telling—that is, the ones that explain how and why they came about, what the writer was thinking, what impelled the ideas to come into form. And so I begin my own storytelling with the tale of how this book began.

I can mark the moment with some precision, because—typically—I was taking notes. The moment occurred at the Conference on College Composition and Communication in early April 2008. I was sitting in a chilly conference room at the New Orleans Riverside Hilton for an afternoon session titled "Teaching Writing through the Lens of the Body: Disability in the Composition Classroom." Although the panel title implied a focus on physical disability, I knew from the presentation titles that there would be significant focus on mental disabilities: Muffy Walter Guilfoil was presenting "The Mad Hattress in the Composition Classroom," and George Williams was presenting "Depression, Anxiety and Empathy in First-Year Writing Courses." At some point while listening to the speakers, I opened my notebook and scribbled this:

The page of notes that became this book. From author's files.

The result is the book you hold in your hands, are reading from a screen, or are listening to. Simply put, I wrote this book because I could not go any longer without writing it.