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Coming Up from Underground: Uneasy Dialogues at the Intersections of Race, Mental Illness, and Disability Studies

As the field of disability studies has matured over the past few decades, especially in the United States, it has increasingly positioned itself as a minority discourse of social and cultural critique, pursuing unique, disability-specific analyses, but within a shared value system with race theory, gender/sexuality studies, and cultural area studies – especially in its commitment to challenge oppressive practices and pursue greater social justice. However, even with common values, building partnerships across disciplines has proven to be challenging. David Mitchell and Sharon Snyder suggest that one of the reasons the relationship between disability and multicultural studies has been “discomforting” is because as other minority fields have worked to liberate their identity categories “from debilitating physical and cognitive associations, they inevitably positioned disability as the ‘real’ limitation from which they must escape” (*Narrative Prosthesis* 2). Historically, this has been an important issue. The very real need to challenge fallacious biological attributes linked to race, gender, sexuality, and poverty – such as physical anomaly, psychological instability, or intellectual inferiority – has often left stigma around disability unchallenged – except by those specifically engaged in activism and in disability studies.

At the same time, in making claims for academic space and discursive legitimacy, disability studies scholars have often compared the extensive visibility of race and gender issues to the relative invisibility of disability perspectives. Lennard Davis, for example, argues that while race and ethnicity have become respected modalities from which to theorize and struggle politically over the last several decades, “disability has continued to be relegated to the hospital hallways, physical therapy tables, and the remedial classrooms” (xv). Mitchell and Snyder also stress the disparate academic fates between disability studies and other minority fields: “while literary and cultural studies have resurrected social identities such as gender, sexuality, class, and race from their attendant obscurity and neglect, disability has suffered a distinctly different disciplinary fate” (“In-

roduction” 1-2). While these arguments are valid and important, such comparisons have an unintended effect of putting these fields in unnecessary competition, as well as downplaying real differences and complicated intersections between gender, race, and disability. As Anna Mollow cogently points out, “if race and disability are conceived of as discrete categories to be compared, contrasted, or arranged in order of priority, it becomes impossible to think through complex intersections of racism and ableism in the lives of disabled people of color” (69). Following Mollow, I am distinctly interested in these connections, but at the same time, in looking beyond (multiple) identity categories, to the intricate ways discourses of race and disability have been linked historically, and continue to interweave.

This essay intends to consider some of the complex (dis)junctures between disability and race, specifically in relation to mental illness. My discussion is framed around Bebe Moore Campbell’s final novel, *72-Hour Hold* (2005), a provocative narrative of an African American mother who struggles tenaciously to help her 18-year-old daughter, Trina, survive and manage the tumultuous, violent onset of bipolar disorder. Campbell’s fictional yet realistic account highlights some of the ways mental distress – through social shame and stigma as well as medical ineffectiveness – is forced underground. The novel provides an interesting backdrop to discuss intersections and some of the difficult barriers between racial critiques and disability studies, but also invites an intersectional analysis and helps to point toward greater collaboration between them.

Bebe Moore Campbell, a best-selling African American author of numerous novels dealing with racial and social inequities, died unexpectedly in 2006, just a year after the publication of *72-Hour Hold*. Like much of her writing on divorce, childhood, racism, and interracial relationships, her portrayal of mental illness is rooted in personal experience. Campbell drew upon the experiences of a close family member who struggled with mental illness as a teenager and an adult to develop her representation of Trina (Fox, pars. 2-4). This novel is of particular interest because her portrayal of mental illness suggests many ruptures, gaps, and potential areas of discussion around historical and contemporary intersections of psychiatric treatment, disability, and race. While the novel actively exposes many failings of the psychiatric system, ultimately Campbell endorses medical understandings and treatments of mental illness. This stands in

opposition to many psychiatric survivor approaches which largely reject “mental illness” as a coherent diagnostic category.

Also in potential conflict with disability studies scholarship, which has critiqued widespread and facile analogies between disability and disaster, tragedy, and hopelessness, stands Campbell’s extended metaphorical construct of mental illness as a form of slavery, and the positioning of her protagonist’s quest to “liberate” her daughter from this psychiatric condition as a radical journey on a contemporary Underground Railroad. I contend that while this metaphor deserves some critique, the imagery of a mother losing a daughter to slavery (illness) also provides Campbell with a foundation to connect contemporary resistance and distrust of the dominant medical establishment to racialized histories of mental illness, and the very real dangers of being read as both “black” and “crazy” in the United States.

While *72-Hour Hold* provides a rich source of discussion, this essay also draws upon psychiatric survivor literature to push beyond the terrain of the novel. As many former psychiatric patients have detailed, the system itself is often far more abusive and violent than actual experiences of mental distress. Richard Ingram, for one, argues that in contrast to stereotyped notions of the “mad” as dangerous, those diagnosed with “mental illness” are, as he states, “less violent than the general population and positively docile in comparison with psychiatrists who practice ‘involuntary commitment’ and ‘involuntary treatment’ – also known as arbitrary incarceration, forced drugging, and electro-shock” (240).

Because there is much debate about the meaning and even existence of “mental illness,” this essay makes a point of highlighting the contested nature of this term. In order to destabilize the dominant medical/psychiatric discourses around mental illness, which frame the experience in terms of “individual pathology” or “disorder,” I often refer to mental distress, which attempts to challenge the static nature illness diagnoses tend to impose. In addition, I refer to members of this group with terms that have emerged out of this movement, such as mental health service users, psychiatric system survivors, ex-users, and people with psychiatric disabilities. Anne Wilson and Peter Beresford rightly suggest that such language recognizes the self-determination of individuals who use or have used mental health services, but even more importantly, “disrupt[s] the perceived permanency of [diagnostic] labels” (“Genes” 543). While allowing that mental health services and traditional psychiatric diagnostic categories do fit the experiences of some people dealing with mental distress, these categories are

often highly reductive, and imply a biological determinism that many survivors and ex-users resist.

Even as this essay challenges and expands upon some of the subject matter of the novel, I argue that Campbell's perspective and resolution, while pursuing an "overcoming" narrative that has been widely critiqued in disability studies, should be taken seriously. The author articulates an important critique of African American resistance to psychiatric diagnoses and mental health services. As well, her ultimate resolution of building support across broad identity lines and involving family (in its most complex, postmodern formation) to develop a powerful personal and political support system, is actually very much in line with African American and disability studies theoretical perspectives in their attempt to bridge material, discursive, and interpersonal divides.

The "Shackles" of Mental Illness?

As the title indicates, *72-Hour Hold* develops a telling critique of the current commitment standards and treatment practices for mental illness and distress. Following the journey of Keri and her daughter Trina, who has recently been diagnosed with bipolar disorder, Campbell focuses on the profound difficulties parents face in helping their young adult children through the onset of psychiatric disabilities. The novel centers around a period shortly after Trina turns eighteen, and has stabilized on a medication regimen. Suddenly, however, Trina begins smoking marijuana, stops taking her meds, and begins a cycle of manic and depressive behaviors. As Campbell captures, rather than building greater awareness about and acceptance of psychiatric difference, the public venue for mental illness remains a theater for the spectacle of "madness" – and without psychiatric intervention, the risks (especially to a young African American woman) of being hurt, exploited, or going to jail, increase exponentially. Although forced hospitalization is a horrible "choice" for Keri, because there are so few options for better support for people in the midst of mental distress, this often becomes the only and best hope for intervening in her daughter's self-destructive cycles.

By positioning Keri as the narrative voice of the novel, readers discover and interpret Trina's experience of bipolar disorder through her mother. In fact, the novel is more about Keri coming to terms with the diagnosis than it is about Trina's experience, which will be discussed at more length. In order to convey the intensity of Keri's shock and pain, Campbell develops an extended metaphor of mental illness as slavery; Keri's experience of "losing" Trina to her illness

becomes a vivid and horrific reenactment of ancestral black mothers losing their children on auction blocks. Within this imagery, Keri is positioned as a figure reminiscent of Harriet Tubman in her determined quest to liberate her daughter from the “shackles” of her illness.

Early in the novel, Keri describes her reaction to Trina’s illness in terms of chattel slavery:

I could feel her breath on my face, see the flames rioting in her eyes. That’s when I knew she wanted to hurt me. I knew that what was wrong was soul deep and strong as chains. [...] *My baby is sick.* [...] I embarked on the Middle Passage that night, marching backward, ankles shackled. I journeyed to a Charleston auction block, screaming as my child was torn from my arms, as I watched her being driven away. Trina didn’t belong to me anymore. Something more powerful possessed her. (29)

On the surface, the conflation of Trina’s manic behavior with enslavement suggests a blanket rejection of disability and illness in troubling and all too familiar terms – as a hostile invasion, a sudden threat to autonomy, independence, and future dreams. This metaphor is highly problematic as a representation of Trina’s experience because it ties everything about Trina to her diagnosis – to a static idea of (people with) mental illness as dangerous, unpredictable, irrational, and wholly without insight. Slavery, which derives its very power from a cruel history of oppression and brutality, connects only extremely negative connotations to the experience of mental illness. In effect, the metaphor reduces mental illness to a dehumanized life. In many ways, the imagery of the auction block forecloses more generative ideas around psychiatric disabilities and accepts limited, socially imposed regulations about appropriate cognitive processes. Andrea Nicki, whose work focuses on feminist theory and psychiatric disability, points out that we are culturally trained to see specific kinds of behaviors as non-normative, even when they could be advantageous. She talks about mania in particular, as a form of thought that is not appreciated: “It is a world where abilities heightened in mania – fluency of thought, verbal fluency, or the ability to rapidly produce relevant, original, or innovative ideas – do not cause appreciation or admiration in others but, rather, distress, fear, or anger” (90). This belief system is imbedded within Campbell’s imagery, where Trina’s illness seems to be pulling her irretrievably into an abyss.

However, while the conflation of mental illness and slavery is deeply problematic, the imagery does provide an evocative narrative structure for Ke-

ri's struggle with her daughter's radically unpredictable behavior. Importantly, on a historical level, Campbell's evocation of slavery calls forth the particular legacies of white on black racism in the U.S. as constitutive of understanding the social and cultural constructions of mental illness. From a contemporary perspective, this reference mirrors the blatant failures of the medical and psychological establishments in serving people with psychiatric diagnoses. In addition, by haunting a twenty-first century, ostensibly realistic account of mental illness with slavery and the quest for liberation, readers are pushed to consider how forms of oppression, be they social, racial, medical, or physical, continually collide – often with rather messy results.

As the quote above demonstrates, Campbell's decision to narrate the novel from the mother's perspective provides an externalized perspective of disability, but offers a lens into Keri's parental (and political) choice to fight for (and sometimes against) Trina in order to protect her from the dangers of her own behavior as well as from the psychiatric system set up to treat her. In that moment of recognizing that Trina is *really* mentally ill – not on drugs, stressed out, or rebelling – she realizes she can't control or predict what will happen to her daughter. When Trina walks out into the night, her mind racing in her private mania, communicated in part by her provocative attire – a “micromini red leather skirt,” her mouth “a slash of iridescent white” (24) – and by her determination to fight her way out the door, she is “*gonegonegonegonegone...*” to her mother in a way that transcends ordinary teenage rebellion. The mantra ringing in Keri's mind “*gonegonegone...*” evokes the auction block, and places her fight for Trina's mental balance into a historical struggle to protect the coherence of the African American family against external and internal threats.

In his classic study, *Slavery and Social Death*, Orlando Patterson terms this process of familial destruction “natal alienation” (7), stressing that it was a crucial element of slavery. In order for slave owners to transform free human beings into enslaved captives, all ties to family and heritage had to be excised:

Not only was the slave denied all claims on, and obligations to, his parents and living blood relations but, by extension, all such claims and obligations on his more remote ancestors and on his descendants. He was truly a genealogical isolate. [...] Slaves differed from other human beings in that they were not allowed freely to integrate the experience of their ancestors into their lives [...] or to anchor the living present in any conscious community of memory. (5)

Within the novel, not only does Keri respond to the all too real history of African American mothers having their children stolen through institutionalized slavery, but she also confronts the potential loss of familial and ancestral memory that Trina's illness seems to threaten.

Prior to the onset of bipolar disorder, Trina had been an exceptional, devoted student who earned early acceptance to Brown University. Since Keri's divorce from Trina's father, Clyde, when Trina was very young, mother and daughter have lived together and forged a formidable, intimate bond with one another, the memory of which seems to fade for Trina when in the midst of a manic or depressive cycle. It is this loss of connection – of family cohesion – that most disturbs Keri. In the most extreme moments, Trina becomes violent and aggressive, at one point breaking every window in the house before leaving in a fury. Further severing their familial bond, the most common “delusional” accusation Trina makes is that Keri is not her real mother – that she is a demon trying to kill her. On one level, Trina knows this is the most cruel thing she can say to her mother, and it certainly elicits the most pervasive fear in Keri – that indeed her daughter (and perhaps Keri herself) might become a “genealogical isolate,” an individual whose most important familial bonds will be irretrievably lost.

While Trina ultimately is well served by psychiatric treatment, Keri's feelings of powerlessness and despair notably grow out of her intense desire to restore Trina to her pre-diagnostic state. The “shackles” Campbell depicts are fastened to Keri's ankles, not Trina's, and Keri's attachment to what she had imagined as her daughter's perfect future causes her most intense feelings of loss. Although Keri accepts Trina's diagnosis, she remains unwilling to envision a different future for Trina than the one her beautiful, smart daughter had been carving out before the onset of mental distress. Throughout much of the novel, Keri resists any suggestion that Trina will not make what she considers a full recovery – in other words, that she will return to Brown University, and continue to excel academically, open new doors of opportunity, and flourish socially.

As the novel progresses, however, Campbell makes clear that Keri's attachment to this particular future functions as a perceptual bind that must be released. This is not to say that Keri shouldn't continue to hope for and believe in a wonderful future for her daughter, but to stress that the only way she seems to be able to imagine a positive future is through removing Trina's mania and depression. Memory, in this sense, functions both to strengthen Keri's resolve to

help her daughter, and to limit her ability to imagine the multiple potentialities of Trina's future *with* a psychiatric diagnosis. Keri's struggle, however, reflects a problematic binary set up by psychiatric discourse itself, which pushes patients to come to terms with their diagnoses, and accept prognoses of greatly limited futures. In their experiences with psychiatric professionals, both Anne Wilson and Peter Beresford stress that they were encouraged to acknowledge the truth of their "illness" diagnoses, and an essential part of that process was to accept diminished (not just different) dreams for their futures. They were told they might be able to work at low levels, but not to expect too much: "With the benefit of hindsight, it seems to us now that the psychiatrists' 'prognoses' were concerned with devaluing and subverting our understanding of ourselves" ("Madness" 153).

Traditional psychiatric models classify people as either ill or not ill, and accepting illness diagnoses demands that compliant patients accept new, limited, and diminished understandings of themselves. From this perspective, Keri's refusal to let go of her dreams for Trina is partly an act of resistance, but the binary reflected in the contrast between Trina as ill/doomed to failure versus Trina as well/destined for success, is very much constructed by the medical model of mental illness as a static, lifelong condition that will greatly limit one's ability to achieve. In order to expand her ideas about Trina's potential futures, Keri has to deconstruct this binary that boxes her daughter into a predetermined future, and hinders her from believing in Trina's potentially exciting, unknown future. As Keri's journey reflects, limiting people's futures can be far more oppressive than the illness itself.

Campbell positions her critique of the psychiatric system within a historical structure in which cultural meanings of race and madness have been intricately entwined. By framing her narrative of modern mental illness within the memory of slavery and the arduous drive for liberation represented by the Underground Railroad, Campbell reminds readers of the long history of racist misappropriations of "madness," not only to justify social oppression, but to perpetuate the so-called rationality of slavery itself. For example, so convinced were many slave owners of the "natural hierarchies" of the races, they believed anyone attempting to escape bondage was exhibiting tell-tale signs of "mental illness." Medical doctors agreed, and offered up detailed sketches of such disorders in complicated language in order to solidify the medical "truth" of racially specific aberrations of the mind. In 1851, Dr. Samuel Cartwright provided the

following descriptions of psychopathologies to which African Americans alone were prey in the *New Orleans Medical and Surgical Journal*: “drapetomania” referred to “the diseases causing slaves to run away,” but an even more common diagnosis, one running rampant among plantation slaves was “dysaesthesia aethiopia or hebetude of mind” – the scientific and formal medical term for what overseers more casually called “rascality.” Clarifying this medical diagnosis (in political terms), Cartwright detailed the meaning of this mental condition: “According to unalterable physiological laws, negroes, as a general rule [...] can only have their intellectual faculties in a sufficient degree to receive moral culture, and to profit by religious or other instruction, when under the compulsory authority of the white man” (698). Racial, biological, and political authority were united under this theory to naturalize the continued oppression of African Americans, an oppression deeply tied to deterministic medical constructions of moral and mental (in)capacities.

Even more egregious was the idea that freedom from slavery actually caused mental illness. Sander Gilman traces how this argument was put forth in the U.S. in 1840 using the newly (and shockingly inaccurate) census data. According to their results, of the 17,000 cognitively impaired people across the nation, 3,000 of them were African American. As Gilman states, “If these staggering census statistics were to be believed, free blacks had an incidence of mental illness eleven times higher than slaves and six times higher than the white population” (137). Although the census turned out to be based upon flagrantly false data (such as a listing of 133 black insane paupers in Worcester, MA – a town with a total population of 151), this didn’t hinder anti-abolitionists from using census numbers to argue that slavery actually kept African Americans sane.

Such spurious arguments, of course, continued well after emancipation. In the International Medical Congress of 1887, J. B. Andrews claimed shocking increases of insanity and mental illness among the black population between 1870 and 1880, which he attributed directly to liberation from slavery: “The causes are briefly told: enlarged freedom, too often ending in license; excessive use of stimulants; excitement of the emotions, already unduly developed; the unaccustomed strife for means of subsistence: educational strain and poverty” (qtd. in Rosen 190). By the early twentieth century, eugenics continued this partnership between medical and scientific discourse to promote baseless connections between blackness and cognitive inferiority. Although many leading eugenicists focused upon the improvement of the white race, they were eager to

use mental testing and family histories to “objectively” demonstrate the lower mental capacity of targeted groups, especially poor, uneducated whites, growing immigrant groups, and African Americans.

These diagnostic practices could be dismissed into historical obscurity if scientific racism didn’t continue to target African Americans, and attempt to reduce social and economic issues to biomedical “pathologies.” Vanessa Jackson, who has attempted to reconstruct some of the lost histories of African Americans with psychiatric diagnoses, points out that in the late 1960s, a prominent study suggested that “urban violence, which most African Americans perceived as a reaction to oppression, poverty, and state-sponsored economic and physical violence against us, was actually due to ‘brain dysfunction,’ and recommended psychosurgery to prevent outbreaks of violence” (5). Not only were these studies taken seriously, but references to “brain dysfunction” in federally funded initiatives against violence continued to surface well into the 1990s.

Bridging Race and Disability Critiques

These examples, while only touching the surface of the various ways scientific and medical research have participated in racialized, oppressive practices, gesture toward the power of disability designations – especially psychiatric diagnoses – to discredit individuals and groups. Historian Douglas Baynton has documented how attributes of physical and mental disability were used against immigrants, African Americans, and women in early twentieth-century citizenship debates. As he explains, “not only has it been considered justifiable to treat disabled people unequally, but the concept of disability has been used to justify discrimination against other groups by attributing disability to them” (33). The most common methods of resisting such strategies of social disqualification, Baynton goes on to point out, has been to claim soundness of mind and physical competence – rather than to disavow prejudice based upon medicalized designations. In other words, while racialized biomedical or psychiatric diagnoses are rightly rejected and exposed, arguments resisting misapplied diagnoses writ large – in this case those of “brain dysfunction” and “mental illness” – often have the effect of solidifying the stigma already attached to disability. This passage from Baynton is useful in elucidating this dilemma:

This common strategy for attaining equal rights, which seeks to distance one’s own group from imputations of disability and therefore tacitly accepts the idea that disability is a legitimate reason for inequality, is per-

haps one of the factors responsible for making discrimination against people with disabilities so persistent and the struggle for disability rights so difficult. (51)

With the long history of those benefiting by a power structure based upon white privilege using medical and psychiatric diagnoses to manufacture “truths” of racial inferiorities, vehement resistance to such reasoning has been essential. However, a longstanding disconnection between the critiques of racial and disability prejudice tends to reinforce the idea that medical designations, unless false, are individual “problems,” not social or political issues in need of analysis. Deborah Marks suggests a useful way to consider the interaction of disability and race as processes of constructing otherness. Drawing from Stuart Hall, she argues that his most cited questions addressed to seeming outsiders – “Why are you here?” and “When are you going to go home?” – are analogous to questions constantly addressed to disabled people, which she frames as, “How did you get like that?” and “Can you be cured?” (47). While Hall frames these questions to migrants, they are worth considering as underlying mechanisms at work in perpetuating ideas of racial separateness and distance. Marks’ related questions, in their insistence upon explaining and erasing difference, provide a productive way of thinking about racism and ableism as intersecting processes of exclusion. As Marks explains further, “Both [sets of] questions interpolate an ‘outsider,’ someone not like me, whose existence presents a problem to me” (47). This layered interplay of racial and disability stigma informs contemporary responses to mental distress, and, as Campbell represents in her novel, compounds and complicates the struggles experienced by African Americans with psychiatric diagnoses.

By gesturing toward slavery and the (mis)associations between mental illness and blackness, Campbell traces out the several important contemporary issues among African Americans connected to this history. First, while Campbell clearly critiques the legacies of specious racialized misappropriations of science, she also suggests that the resistance to this racist history within some African American communities has been an outright denial of psychiatric disability, which often poses serious problems to people who could benefit from mental health support services. Second, in tracing out a story of an underground network of alternative support, Campbell develops a sustained critique of the psychiatric system and the limited choices available to people in mental distress and their allies.

Campbell portrays the common cultural resistance to mental illness and psychiatric intervention through Trina's parents' conflicting interpretations of her behavior and needs. Keri, who lives with Trina and bears witness to her daughter's extreme mental and emotional changes, comes to accept Trina's diagnosis of bipolar disorder, and seeks out medical and emotional support for both of them. Trina's father, Clyde, who sees his daughter only occasionally, insists that her erratic behavior stems from ordinary stresses. Further, Clyde implies that Keri is overreacting and only making Trina worse by forcing her into therapy. He insists that Trina would be "better off without some shrink putting ideas into her mind" (69). Even when Trina is put on a 72-hour hold for hitting someone in her therapy group, Clyde is incensed, and wants Trina released: "So what if she hit someone? Maybe the person deserved it. Maybe he did something to her. I'm getting her out of here" (92). Keri, who has been living with Trina and watching her slip into manic behaviors – smoking marijuana, refusing to take her medication, acting increasingly aggressive – agrees with the involuntary hold, and hopes it will get Trina back on her medication. Clyde's desire to protect Trina from being held against her will is understandable, but Campbell makes clear that his resistance to the hold comes from an ongoing denial of the seriousness of Trina's distress. His unwillingness to see all aspects of the situation makes him ill-equipped to help his daughter, and unable to consider Keri's viewpoint. Watching Clyde pace in the hospital halls, Keri realizes she has to rely on herself: "In theory, we should have gone to plan Trina's aftercare together, but it was clear we weren't playing on the same team" (93).

In her interviews with several African Americans diagnosed with mental illness, Vanessa Jackson describes such resistance as that depicted by Campbell as commonplace: "Even in extremely supportive families there was a willingness to talk about anything but the mental illness. Families were able to have weekly visits or phone calls to loved ones in the hospital yet still not acknowledge the mental illness" (17). Within the novel, Campbell suggests this denial extends beyond families to African American communities more broadly. This is portrayed in Keri's "trek" out of her neighborhood to seek support for Trina and for herself. As she describes, she travels a good distance from Crenshaw, a largely black community in South Central Los Angeles, to the west side, the "land of high real estate, fair-skinned people, and the coldest ice":

Part of me resented having to trek all the way from Crenshaw to get help for my child's issues. But the truth was, mental illness had a low priority

on my side of the city, along with the color caste and the spread of HIV. Some things we just didn't talk about, even though they were killing us. So I had to come to the white people, who, although just as traumatized, were a lot less stigmatized by whatever went wrong in their communities. (49)

Within this group, Keri quickly bonds with three other African American parents who have children in mental distress. Milton and Gloria, who are married, and Mattie, all become her new support group. Upon meeting the first time, they joke about being “the only black people in America willing to admit having mental illness in our families.” As Keri says, “[B]eing black is hard enough. Please don't add crazy” (50).

As Campbell goes public with the issue of mental illness within black communities, she firmly resists the legacy of white feminist representations of the “madwoman” as a figure of rebellion or empowerment. Campbell's depiction of Trina follows Shoshana Felman's assertion that “quite the opposite of rebellion, madness is the impasse confronting those whom cultural conditioning has deprived of the very means of protest or self-affirmation” (8). As Campbell argues, this is especially true for black people, who are also in particular danger of being arrested, treated violently, and even shot if they are seen in public acting “crazy.” She weaves the story of “Crazy Man,” a mentally distressed homeless man who has become a fixture in Crenshaw, as a way of illustrating the potentially fatal consequences of public displays of “madness.” During the period when Trina stops taking her medication and becomes increasingly unpredictable, Keri hears that “Crazy Man” has been gunned down in the street by police. According to people Keri talks to in the neighborhood, he had been running down the street, screaming that the CIA was after him, and tearing his clothes off. As Keri's friend concludes from the incident, “When somebody black get to acting a fool out in these here streets, the cops gonna shoot'em and go on about they business” (137).

Naturally, Keri's immediate reaction is fear for Trina: “It could have been Trina. [...] My child could have been the one being buried. She could have walked out of my house, bent on mayhem and destruction. There wasn't anything I could do to protect her” (137). The reality that public displays of mental illness can be dangerous, even fatal – especially to non-white people – drives Keri to participate in a radical underground psychiatric intervention for her daughter. Frustrated by the standards required to put Trina on a 72-hour hold,

especially now that she is over eighteen, and feeling increasingly isolated and desperate to effect some kind of stability, Keri joins a clandestine group of psychologists, parents, and other mental health providers who work outside the bounds of the law in order to provide what they consider to be better, more holistic treatment. The leader of the group, Brad, likens their work to the Underground Railroad: "Mental illness is a kind of slavery. Our movement is about freeing people too," he explains to Keri. "We won't always have to hide and run to do our work in the dark. The day is coming when people with brain diseases won't be written off or warehoused, when everyone will know recovery is possible" (175).

Keri and her friend Bethany, who introduces her to Brad and his group, decide to put their daughters into the program together. Worried about Trina's stability, they take her directly from the hospital after a hold. In order to get Trina to come with them, Keri lies and tells her a friend is giving them a ride home. Once in the car, however, as Trina realizes she's being taken against her will, she (reasonably) becomes angry and volatile, and as Keri explains where they're all going, Brad sedates Trina with Haldol, which makes both mother and daughter angry. Soon Keri realizes she has given up control to these people, and begins to wonder if she's made the right choice. As they travel, they meet with different psychologists who get Trina and Angelica, Bethany's daughter, stabilized on medications. They move from safe house to safe house, which are mostly homes of other parents whose children have been in the program. Keri gains perspective from their stories, and Trina, even as she becomes more calm emotionally, remains defiant about being under the control of strangers: "Why can't we just go home?" she asks Keri repeatedly, and when her pleas are ignored she complains, "These people are devils" (219). Keri hears Trina, but hopes that as she continues to stabilize on her medication, she will understand.

As they continue, the people involved in this psychiatric underground demonstrate their commitment and competence, even as they hit snags in the road. One of the most interesting aspects of the approach, which relies on a combination of medication, work, exercise, and structured entertainment, is the full involvement of everyone, including Keri and Bethany. Upon deciding to join Brad's group, both mothers also commit to traveling with them for at least a month. Angelica, Trina, Keri, Bethany, and Brad, sleep on cots in a locked room, so even though the two daughters are being held against their wills, they are always with Keri, Bethany, and others in the group. During this period, the

analogy between their psychiatric program and the Underground Railroad come into sharp relief as everyone involved realizes the risks they have taken. While staying in one safe house, Trina escapes long enough to wave down a car and yell for the driver to save her. Although the car doesn't stop, a few days later, the police show up, and the whole group has to move quickly. Keri doesn't like being out of the driver's seat, but in making this journey, she has chosen to tie herself to Trina and her psychiatric disability in a much deeper way. She isn't simply supportive; she's walking on the path with Trina. Thinking back to Tubman, Keri wonders to herself, "What would Harriet do with this? No time to plan. Nowhere to run. But the same imperative, the same need to cross the border. To save herself. To save another" (119).

Notably, "saving herself" becomes essential to the process, and the underground journey does cause Keri to change. Initially, she insists upon making comparisons between Trina and Angelica, whom she considers to be much sicker than her daughter, but gradually she realizes that these comparisons are useless and hurtful. In fact, the comparison game just provides a structure for excluding all people with mental illness, some more than others. As they learn more about each other, and fight battles together, Bethany and Keri move beyond the separations of white/black, of bipolar/borderline to being warriors together, sisters in their determination to be there for their daughters, whatever that means. Also, as she lives with more and more people and listens to their stories, she begins to let go of her defiant attachment to Trina's intellectual brilliance, and allow the future to be a real unknown. Although it is beyond the scope of Campbell's novel to suggest widespread systemic solutions, in tracing out a modern resistance to the ineffectual support offered to Trina, the author attempts to move the conversation beyond racial disparities and psychiatric stigma into one of collaborative support and dialogue among professionals, mental health users, and their allies.

Ultimately, however, this underground alternative doesn't provide the perfect panacea for Keri or Trina. At the first opportunity, Trina escapes one of the safe houses, and ends up back in the hospital. After this, Keri turns back to legal channels, gains conservatorship, and – with the help of Trina's father – has her daughter committed, which, in this fictionalized account, finally brings her back into mental "balance." This resolution, while remaining critical of an imperfect system, endorses the idea that coercion, confinement, and control are sometimes crucial to the healing process, and that the well meaning parents or

loved ones need even greater power over those struggling with mental distress. I don't dispute the tenor of Campbell's narrative of Keri, implying that decisions to incarcerate and restrict one's child or loved one comes as a last resort. However, the great irony of the novel is that the author's driving analogy of slavery, while successfully highlighting the fraught historical intersections of madness and blackness, too easily conflates illness with oppression, rather than challenging the myriad and complex ways psychiatric, medical, and social responses to mental illness enact forms of bondage often far more traumatic for those struggling with periods of distress.

Challenging Isolation, Listening to Distress, and Building Alliances

By focusing the narrative on treating and managing Trina's diagnosis, Campbell misses an opportunity to look at the ways her enslavement analogy might be applied to the medical and social oppression and disenfranchisement experienced by those considered mentally ill. In addition, because Keri is the central figure in this struggle (instead of Trina), the structure of the novel mirrors the cultural tendency to read people experiencing mental distress purely from a diagnostic perspective, and to silence their unique interpretations of their experience. Keri's initial reaction to Trina's diagnosis is telling in this respect. When the doctor says Trina is bipolar, Keri is incensed – and resistant: “That was the scariest part, the way he said it. She *is* bipolar, not she *has* bipolar *disorder*. You *are* cancer. You *are* AIDS. Nobody ever said that” (25). Keri doesn't want to see her daughter this way, but in many ways this becomes her central struggle. For much of the novel, she seems to bend to this understanding, in the sense that the illness becomes the *enslaver* – the enemy Keri feels she has to defeat to liberate her daughter. This intense medicalization, however, also drives the novel to challenge and question these reductive impulses. Campbell rehashes these limitations, but also poses crucial questions: How does one accept a psychiatric diagnosis, seek treatment, but also challenge the stigma associated with mental illness? How should the system change to allow for the need to occasionally protect people in mental distress through involuntary holds while remaining equally committed to respecting and protecting their personhood?

Some of the reductiveness inherent in psychiatric models are animated by Campbell's representation of Trina, both in what is included and what is absent. For much of the novel, Trina is figured largely as an embodiment of bipolar disorder. Although readers see Trina's perspective somewhat, her complaints and

comments during manic or depressive periods are used to demonstrate distress or delusion, rather than to offer forms of knowledge. Catherine Prendergast argues that the constructions of psychiatric diagnoses function to “rhetorically disable” those who find themselves so labeled. In her field of rhetoric, Prendergast suggests that this might be more aptly understood as “a life denied signification” (57). This denial of personhood is enacted by the psychiatric profession’s insistence that mental health clients have “no insight,” which from a clinical perspective, means they refuse to accept their illness diagnoses. In other words, as Prendergast stresses, once diagnosed, patients (as they are now defined) are not able to produce their own narrative of their experience, especially if this differs from medically imposed interpretations (53). Christopher Canning, an advocate of integrating psychiatric survivor testimonials into any kind of treatment program, echoes Prendergast’s concerns. He points out that very little attention is given to the ways people in mental distress understand their own world, because of a longstanding belief that an ill mind cannot, by definition, know itself (par. 10). The result of dismissing the words, feelings, and testimonies of people in states of mental distress is ultimately to rob them of personal signification, and to force their understanding of their own lives into an involuntary hold of its own.

In a similar vein, psychiatric system survivors Anne Wilson and Peter Beresford argue that the monolithic nature of the dominant discourse surrounding mental illness “accentuat[es] and perpetuat[es] [...] distress and ‘difference’ through the construction of users of mental health services as Other – a separate and distinct group” (144). This othering invokes a false binary, and continually pushes mentally distressed individuals outside the fold of personal autonomy and social participation. These authors admit that although they have both experienced mild and extreme mental distress, an approach that would integrate a social and medical model would see these experiences along a continuum, not as fixed or static expressions of psychosis or neurosis: “we place ourselves alongside everyone else on a continuum of mental and emotional distress and well-being: a continuum that does not show binary opposition between ‘the mad’ and ‘the not-mad’” (154).

Ultimately, Campbell provides more room for Trina’s perspective to emerge, and gestures toward this continuum. When she finally returns home after her extended hospital stay, Trina begins to talk about her illness with her grandmother, whose history with alcoholism provides her with unique insight and compassion. This conversation between Trina and Emma points toward the

idea that mental illness dwells within a broad continuum of human variation, not as something wholly other:

“How are you getting on?” [Emma] asked.

“I’m doing better, Grandma,” Trina said.

“Sometimes it takes a while to get better. I was sick for a long time. [...] I’m an alcoholic, Trina. When I go out in the evenings, I’m going to my AA meetings. They keep me from drinking.”

“I go to meetings too.”

“I know.”

“What do you do at your meetings?”

“Talk, mostly.”

“Mine too. But you don’t take medicine.”

“Not for being an alcoholic. I take high-blood-pressure medicine. If I don’t, I’ll get sick.”

“If I don’t take my medication, I’ll get sick. There’s something wrong with my brain.”

Emma laughed. “Mine too.” (317)

In many ways, Trina’s journey to understanding and proactively addressing her mental distress and health is in its beginning stages at the close of the novel, and her anger (and appreciation) over being hospitalized promise to inform her on-going knowledge of living with her diagnosis. Her grandmother’s presence also provides a sense of process, not of cure or completion. She reminds Trina that medication, meetings, and recovery may be a part of her life for a long time, and that these pieces are hers to situate and infuse with meaning.

Conclusion

Campbell’s decision to narrate the novel from Keri’s perspective, however, allows her to explore and value the unique struggles faced by family members and allies of those in mental distress. As Trina adjusts to experiencing manic and depressive states, Keri also has to face extreme changes in her daughter’s manner and behavior. As she witnesses Trina’s increasingly self-destructive tendencies, she decides the only way to help her is to forcibly get her back on medication. Any parent, family member, or ally who has felt compelled to make such a contradictory decision on behalf of someone in a state of distress understands the unyielding guilt, self-doubt, and pain involved. In taking on mental illness as the driving force of her novel, Campbell encourages a more public acceptance and dialogue of all forms of mental distress, so that the struggles people face

will no longer be compounded by cultural stigma. As well, the novel suggests that as better treatments are imagined – treatments which don't require parents and allies to break the law and retreat to underground collectives – an active dialogue between those diagnosed with mental illness and their families or chosen allies should inform new models as well. The perspectives of allies should never be used to silence the voices of psychiatric system survivors or mental health users, but Campbell's point that parents and allies are all deeply invested in and insightful about developing better mechanisms of support and treatment should be taken seriously.

Campbell's endorsement of psychiatric intervention might be seen as opposing the important insights of system survivors, but I would suggest that these perspectives should inform and complement each other. I agree with Elizabeth Donaldson, who argues that "it is possible [...] to begin with the premise that mental illness is a neurobiological disorder and still remain committed to a [...] disability studies agenda – an agenda that fights discriminations [and] seeks to dismantle ideologies of oppression" (112). In an effort to respect the voices of all people with psychiatric disabilities, challenging the stigma of mental illness must include guarding against monolithic discourses, and instead push toward expanding our ideas about and acceptance of cognitive diversity. The most inspiring notions tying the Underground Railroad to mental illness is that people without psychiatric diagnoses choose to link their fates to those with psychiatric diagnoses, in the ultimate sense of risking themselves (and ourselves) to the treatments designed for others. Perhaps in this deep connection, those without diagnoses will see more clearly what is at stake.

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