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THIS IS *US* SAYING WHO WE ARE: SPEAKING THE RHETORIC OF MENTAL DISABILITY

by

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DISSERTATION

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DEDICATION

For my beloved husband, Christopher Zemke, with so much gratitude: We did it!

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CHAPTER 1 THE SPEAKERS BUREAU AND ITS RHETORICAL CHALLENGE

Like any group of people whose identity includes some hidden element the dominant culture would consider “abnormal,” such as substance abuse or a history of incarceration, people with an undisclosed mental disability have a choice to make. Do we disclose our difference and face the potential of being stigmatized, a condition that can lead to discrimination, disrespect, and social exclusion? Or, do we keep the stigma, the differentiating mark, hidden, thereby treating an aspect of who we are as a reason for shame? In his foundational study, *Stigma: Notes on the Management of Spoiled Identity*, sociologist Erving Goffman calls this the decision of whether or not to move from being only “discreditable” to being “discredited” in the eyes of one’s community (4). In more recent scholarship on stigma, Lerita Coleman Brown observes that “stigma represents a kind of death—a social death. Non-stigmatized people, through avoidance and social rejection, often treat stigmatized people as if they were invisible, nonexistent, or dead” (156). While it would seem unlikely that anyone would willingly choose such fates, there are people who risk being discredited or suffering a social death. These people form groups that speak publicly about the characteristic that marks them. They believe their openness will lessen or even eliminate the stigma they and their compatriots bear.

In this dissertation, I describe and analyze the rhetoric of one such organization—a local, grassroots group of mentally disabled individuals known as the County Health Organization Speakers Bureau. I do so to explore how members of this group, fully aware of the negative perceptions their audiences may have about them as people and as speakers, approach the task of persuading these audiences to alter these perceptions. I define rhetoric as the purposeful use of language to persuade an audience to think differently about a given reality. My study assumes we can learn something about both stigma and rhetoric by analyzing the spoken presentations, rhetorical motivations, and rhetorical strategies of people who put themselves up in front of strangers to persuade them to understand, and therefore accept, the stigmatized “other.” It examines how these speaking experiences intersect with and are influenced by the larger cultural debates that currently structure rhetorics of mental disability. And it asks what these experiences might have to teach us about the rhetorical agency of a group of traditionally marginalized people. In this chapter, I introduce the Speakers Bureau, review the scholarly discussion regarding the way psychiatric diagnoses challenge the agency of mentally disabled rhetors, and present my study methodology.

Members of the Speakers Bureau have chosen to walk a path based on self-disclosure for over a decade. They regularly make presentations about their experience with mental disability to local high school and college psychology classes. Each presentation constitutes a fresh disclosure on the part of the speaker, who reveals himself as mentally disabled to a room full of strangers. Per its mission statement, the Speakers Bureau seeks to “put a face on mental illness, developmental disabilities, and substance abuse to overcome stigma and discrimination by sharing successful stories of hope and recovery.”

As indicated in its mission statement, the Bureau uses the term “mental illness” to refer to the psychiatrically diagnosed mental disorders of its members, disorders such as schizophrenia, depression, bipolar mood disorder, and Post Traumatic Stress Disorder. “Mental illness” is a highly controversial term, however, one rejected within the field of disability and Mad studies because it medicalizes conditions that members of these two communities view as “a way of being or processing that *psychiatrists* do not see as ‘normal’” (Burstow 83) (emphasis added). Following the lead of rhetorician and disability studies scholar, Cynthia Lewiecki-Wilson, I use the term “mental disability” throughout this piece to refer to people with psychiatric diagnoses.

Lewiecki-Wilson argues for this nomenclature because it accounts for both the disability studies argument that disability is a social construction and the existence of real impairments experienced by people with psychiatrically-diagnosed conditions and developmental disabilities (164). Members of the Speakers Bureau, however, all refer to their conditions as “mental illnesses,” so I honor that terminology in quotations attributed to them.

Speakers Bureau History

The Speakers Bureau began its work in the late 1990s. Its founder, Phil, decided in the spring of 1998 that he wanted to become a mental health advocate. As someone with a mental disability, he felt great compassion for others in similar situations. He wanted to help them, but at first was not sure how. At the time, he participated in the county’s Community Mental Health (CMH) department as a member of its Consumer Advisory Council. [Since then, CMH has been renamed Community Support and Treatment Services (CSTS).] According to Phil, members of the Consumer Advisory Council were and still are unsure of the use of the term “consumer” as a descriptor, feeling that it was not quite accurate. “Consumer” is one of the terms used to designate a mentally disabled person. It reflects the person’s use of supportive medical and social services and was popularized in the U.S. in the 1980s as a way to overcome the stigma associated with calling people “mental patients.” An Australian advocacy and support organization run entirely by consumers, “Our Consumers Place,” explains that although the term can be confusing, and even though many of the organization’s own members disagree with it, they use it because “[I]t’s the best term we have at the moment” (3-4)! For a while, what used to be known as the Consumer Advisory Council called itself the Community Support and Treatment Services Advisory Council or CSTSAC. In 2008, a larger County health organization took over the Speakers Bureau and renamed it the County Speakers Bureau.

At a meeting in the late 1990s, the Consumer Advisory Council members were brainstorming ideas for projects. Phil suggested educational outreach. The group agreed with this idea and asked Phil to develop and act as head of a Speakers Bureau. They wanted to do outreach within the faith community—to churches, synagogues, and mosques—and to local high schools. Phil started out by cold calling the leaders of ten faith organizations and saying, “We are the Speakers Bureau. Would you be interested in having us come speak?” At first, one pastor and the head of the local Islamic Center expressed interest, but after some time both withdrew their invitations. In the end, members of the Bureau only spoke at two churches. In 2008, the present head of the Speakers Bureau, Gloria, took over Phil’s job and expressed interest in trying again to reach out to churches. She, too, did not meet with success.

Phil had much better luck connecting with local high schools. He would call each school’s receptionist and ask if the school had psychology classes and health classes. The receptionists put him in touch with the teachers of these classes, and Phil would say “Hi. My name is Phil. I’m with an outreach program to teach students about mental illness.” Despite one instructor initially mistaking him for a solicitor, Phil notes that almost every instructor he spoke with wanted members of the Speakers Bureau to present to their classes. What started out as a few presentations per school year eventually grew to the present rate of approximately 30 Speakers Bureau class presentations per year. In addition to high schools, presentations at two local universities and the local community college were added to the schedule. The presentations consist of the story of each individual member’s experience with mental disability.

Asked to explain the purpose of the Speakers Bureau in his own words, Phil says “to bring knowledge of mental illness to students, to put a face on mental illness by showing students that people with mental illnesses can do things, like speak, and many other things.”

On a personal note, he adds:

> I want to help [the students]. That’s a huge goal—to inform people about mental illness, to help them nip mental illness in the bud if it is in their lives. There is the statistic that one in four people will have some sort of mental illness diagnosis in their lifetime. So, several students in any class will have some sort of diagnosis. I think the accurate statistic is that from the early teens to 24-25 is the time period when mental illness first comes about. So, I want to help them. And I tell students often that I want them to be able to help their friends and family members. It is so important for us to do that. My hope is that they will recognize symptoms, see there’s something wrong, and immediately get help. I sometimes wonder about when my mental illness cropped up. When I was in high school, there were no psychology classes.

Asked about instructor feedback about the presentations, he notes that all the high school teachers and some of the college ones want the Bureau members back for the following semester and year. He also recalls one instructor telling him that she thought her students would remember the presentations long after they had forgotten the things they had learned in her class. Other instructors have told Phil that a few days after hearing the presentations, some students have opened up to them about mental health difficulties in their own lives.

The primary change the Speakers Bureau has experienced over the years is the coming and going of various speakers. Currently there are eight standing members. Over time, some speakers have left, finding themselves too busy with other work in the mental health field. Some have left due to the demands of work as “peer support specialists,” mentally disabled people who provide support services to other mentally disabled people in the community. Others express limits, such as one speaker who enjoys the work but notes that he can only speak twice a month.

When the speaking sessions began, the only two speakers were Phil and a well-known, local mental health activist. After a while, however, the Consumer Advisory Council expressed its dissatisfaction with having the activist speak, as she did not have a mental disability herself. It was decided that only people with mental disabilities, substance abuse issues, or co-occurring disorders (mental disability diagnoses combined with substance abuse problems) would do presentations. Worried that they might not find enough speakers, the group also agreed that professionals, such as doctors and nurses, could participate. (It is not clear why the group did not see this decision as a direct contradiction of its desire to limit speaker status to those who had mental disabilities.) Currently, though, the group does not include any mental health professionals. Through 2007, the Bureau used word-of-mouth to recruit new members.

In 2008, the organization began interviewing potential speakers. As the head of the Bureau, Gloria had, and still has, the responsibility for finding and vetting newcomers. She meets potential speakers through her county job as a peer support specialist. People also refer potential speakers to her. She interviews each referred person to see if they match the needs of the organization. Asked what made someone a “good speaker,” Phil replied that he or she has to be a good speaker, someone with the ability to speak, he or she has to have “an interesting story to tell,” and he or she has to be someone truly concerned about mentally disabled people, someone with a sincere desire to help them. I describe Gloria’s vetting process in Chapter Five.

Besides finding speakers, finding transportation has been another key issue for the group. In the early years, the above-mentioned local activist provided a great service by driving members who did not have cars to speaking engagements. Phil used to do some driving but now does not drive because the side effects of one of his medications make this impossible. For a while, he had a friend who could drive him to presentations. He feels grateful that currently, several Speakers Bureau members have cars and can give him a ride on days when they co-present with him. The presentations often involve two people, which can be useful if each has a different diagnosis. In this way, students get a look at more than one disability. But when one presenter “flies solo,” this can also be a useful way for the speaker to provide the student audience with a much greater level of detail about his or her experiences.

Due to the chronic nature of mental disability, the other important issue for the group has been the wellness of its members. At any given time, a member may fall ill and find himself unable to do a scheduled presentation. Although this is true, the current rate of about 30 presentations a year suggests that the level of wellness in the group has been high. Phil did mention one year when the number fell below 30—the year he was hospitalized and could not do the necessary legwork to set up speaking engagements at the schools. He does not think that anyone else in the group took up the work. Gloria, also, has experienced periods of ill health, which affects the recruitment of new speakers. As long as these two group leaders remain healthy, however, the organization functions smoothly.

By studying members’ individual classroom presentations, interviewing them about their experiences as rhetors, and having them analyze their own speeches to identify rhetorical goals, I answer the following questions: If we agree with Goffman that being stigmatized requires a person to “manage” his or her own “spoiled” identity in interactions with the people Goffman calls “normals,” how does one group of mentally disabled people—well aware of the negative perceptions audiences may have about their capacities as individuals and as rhetors—narrate their experiences with mental disability with the goal of “unspoiling” or destigmatizing their identities? And what might a primarily auto-ethnographic inquiry into their experiences in these rhetorical situations teach us about the potential rhetorical agency of mentally disabled individuals who act as advocates for the larger group?

Background

Each member of the Speakers Bureau centers his advocacy on the act of publicly revealing his “mark” or stigma. During these acts of disclosure, he manages *how* he talks about his experience with mental disability, with the goal of changing the way audiences perceive people of “his kind.” He uses rhetoric to try to remove the stigma that adheres to the reality of his psychiatric diagnosis. Goffman defines “social identity” as the category into which the public expects a given person to fall and the characteristics associated with that category. He explains that a person possesses a stigma when her virtual social identity—the standard or “normal” attributes expected of her—comes into conflict with her actual social identity, which includes an attribute that marks her as undesirable and less than fully human (5). Goffman’s list of stigmatized categories of people includes physically disabled people and a group he calls “ex mental patients.” Stigmatized people, he notes, bear the constant burden of a desire for acceptance by the non-stigmatized population: “Those who have dealings with [the stigmatized person] fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving” (8-9). In rhetoric designed to win from audiences the respect and regard Goffman speaks of, Speakers Bureau members deliberately share details of their mental disabilities, the “contaminated” aspect of their identities. These disclosures may seem counter-intuitive, as they could heighten audience members’ fear or repugnance of the speakers. But, as this dissertation will show, they are the group’s key stigma-fighting technique.

The uneasiness and interpersonal tension caused by a stigmatized characteristic require the person who has one to "manage" her identity, as Goffman puts it, by using a variety of tactics designed either to put "normals" at ease regarding her adjustment to her situation or to make the argument that the stigmatized group she belongs to *is* fully human and does not deserve discrimination. Members of the Speakers Bureau do the latter. By "management of identity" Goffman refers to measures taken to adjust the face one presents to the world. While many of the management strategies he mentions can be considered rhetorical in that they involve spoken attempts to intervene in awkward social interactions—joking self-deprecatingly about one's stigma before others have a chance to comment on it, for example—one relates to the classic rhetorical situation of presenting a speech to an audience in order to persuade them towards action or a change in perception.

Goffman notes that stigmatized people have groups or individual "agents" that represent them as advocates, trying to influence public opinion through the media and public policy through legislation. These agents sometimes work in the classic rhetorical capacity:

> Another of their usual tasks is to appear as 'speakers' before various audiences of normals and of the stigmatized; they present the case for the stigmatized and, when they themselves are natives of the group, provide a living model of fully-normal achievement, being heroes of adjustment who are subject to public awards for proving that an individual of this kind can be a good person. (24-25)

By suggesting that "normals" need proof that their fellow human beings are "good," Goffman here, as elsewhere in his text, pokes gentle fun at them for stigmatizing their brethren. Members of the Speakers Bureau do present themselves as "living models of fully-normal achievement" and "heroes of adjustment" in the sense that they present stories of mental disability that follow a similar arc: initial onset of the mental disability, recognition that something is wrong even if this recognition takes a long time to achieve, attempts to get help, provision of help, and eventual recovery and achievement, which runs the gamut from simple day-to-day functioning, to employment, to the pursuit of higher education, to taking on the role of counselor and service provider for fellow mentally disabled people. As the Bureau's mission statement requires, the stories all strike a note of hope for people with psychiatric diagnoses.

Goffman's statement that speakers win awards for proving that the stigmatized people can be considered "good" suggests that spoken rhetoric can reverse the effects of stigma and lift the stigmatized up to the same social level as the "normal" who previously considered them "bad." What is presupposed here, however, is an audience that will take what stigmatized speakers have to say seriously. Catherine Prendergast argues that such an audience does not exist for mentally disabled people. According to Prendergast, audiences dismiss the rhetoric of the mentally disabled person automatically because her diagnosis marks her as irrational and therefore not capable of producing meaningful discourse. Prendergast assesses the rhetorical output of a friend with schizophrenia in the following way: "[G]iven the present configuration of discourses on mental illness, the writing of schizophrenics can only be seen as arhetorical, the test, the record of symptoms, Exhibit A . . . some personal expression that has no bearing outside itself, no transactional worth. That the mentally ill are devoid of rhetoric would seem to me to be and obvious point. If people think you're crazy, they don't listen to you" ("On the Rhetorics" 57). The key phrase in Prendergast's assessment of the rhetoric of mentally disabled people is that people "don't listen" to those who are deemed "crazy." Rhetorical agency, that force that achieves persuasion in any rhetorical situation, depends not just on the skill of the person who speaks but on the willingness of an audience to truly listen. If Prendergast is right, Speakers

Bureau members encounter a rhetorical impasse before they even enter the classroom. The students know the people visiting are "crazy" and thus may be primed to disregard their presentations, no matter what persuasive methods these include. Speakers in this situation would lack rhetorical agency.

Karlyn Campbell describes rhetorical agency, in its most basic form, as "the capacity to act, that is, to have the competence to speak or write in a way that will be recognized or heeded by others in one's community." She adds that "such competency permits entry into ongoing cultural conversations and is the *sine qua non* of public participation, much less resistance as a counter-public" (3). But Campbell does not consider rhetorical agency something that the rhetor possesses on his own. Instead, she describes the writer or speaker as a "point of articulation" through which historical and cultural forces, as well as the inventive powers of the writer or speaker, act (5). One of cultural forces that contributes to rhetorical agency in a speaking situation, then, is the force exerted by the complex elements that make up any given audience, including the history and viewpoints its members bring to the rhetorical situation. But this audience might be one that, at least initially, denies the credibility of the stigmatized person, as Prendergast suggests. The stigmatized speaker, the Speakers Bureau member, has extra work to do, rhetorically, because they bear a stain that discredits them in the eyes of the audience.

In later work, Prendergast indicates her understanding that some mentally disabled people, like members of any stigmatized group, *do* take steps to develop and raise a rhetoric to combat the stigma that circulates in the communities where they live and amongst the institutions with which they interact. They expect their words to have what she refers to as "transactional worth" ("On the Rhetorics" 57). As examples of this rhetoric, she mentions *New York City Voices* and *Schizophrenia Digest,* magazines containing articles written by people Prendergast describes as “unexceptional schizophrenics,” people who fit neither the mass killer nor the Nobel prize-winning stereotypes of people with schizophrenia (“Paying Attention?” 243). The editor of the initial version of *New York City Voices* celebrates the fact that the writers of the magazine’s personal narratives include their own names as bylines and often allow the inclusion of the writer’s photograph. He calls this forthrightness “a bold but necessary move” because disclosure must happen in order to begin the fight against stigma (Prendergast, “Paying Attention” 242). Members of the Speakers Bureau are even bolder with their disclosures, in that they appear in person to audiences to reveal what “craziness” can look and sound like. Also “unexceptional,” in that they don’t match either the stereotypes of violent criminals at one end of the spectrum or the brilliant artists at the other, they use their presence and speeches to promote an alternative perception of mental disability. A question remains, however: What exactly can speakers do to encourage student audiences to “heed,” i.e. to take the anti-stigma message they are hearing seriously?

Discussing the steps some mentally disabled writers take to increase the agency of their work, Katie Rose Guest Pryal describes the successful use of rhetorical resources in her discussion of “mood memoirs,” book-length narratives of mental disability experience written by people with disabilities such as depression and bipolar mood disorder. She concludes that the narrators she discusses work carefully to construct *ethos* for themselves by using four rhetorical techniques: the presentation of an apologia that offers the desire to help fellow mentally disabled people as the reason for focusing attention on one’s pain; description of a moment of awakening to the reality of having a disability and seeking treatment; criticism of doctors, to exert authority over one’s own health; and “laying claim” by making reference to other, often famous people with mental disabilities, with the goal of making the disability seem less exotic (499). By using these techniques, Pryal explains, the narrators bolster their credibility and authority in the eyes of their readers.

The commentary of Prendergast, Campbell, and Pryal raises issues pertinent to the rhetorical endeavors of the Speakers Bureau. Considering their discussion of agency, the biggest obstacle the mentally disabled rhetor faces is absent *ethos*, or at least severely weakened *ethos* as compared to that of a rhetor who the audience does not deem “irrational” before he even opens his mouth to speak. Given this weakened *ethos,* Bureau members must carefully craft presentations that generate the credibility necessary to persuade audiences of two things—that the speaker has the competence necessary to represent his reality of living with mental disability and, based on the nature of that representation, that the speaker is, indeed, fully human. In order to understand how members of the Speakers Bureau attempt to influence the rhetorical agency of their own public presentations—the means they employ to get audiences to “recognize and heed” their two concurrent messages--I employ the following methods.

Methods

To keep the study manageable in size, I chose not to attempt empirical measurement of the effect of our speeches on individual student audience members in the multiple classrooms the study participants visited. Instead, I focused on how rhetors up against a wall of stigma try to find ways through and around that wall, based on our assessments of how stigma operates in our culture. Because I wanted to study the rhetoric of people with “mental illnesses,” I only chose study participants from the Speakers Bureau’s total membership who have a standing diagnosis of “mental illness” rather than developmental disability or substance abuse. By “rhetoric” I refer to the purposeful use of language to persuade an audience to think differently about a given reality. My psychiatric diagnosis, bipolar mood disorder, allowed me to join the group’s stigma fighting work as a participant-observer. I did so to contribute to the collective effort and to develop research insights I believed could be gained only by undertaking the same rhetorical work as other study participants. Because I share the experience of mental disability with my fellow group members, I chose auto-ethnography as my study methodology. Auto-ethnography allows me to provide one particularly in-depth perspective to add to the others gathered in the attempt to answer my overriding research question—In what ways do people who are highly aware of themselves as stigmatized approach the task of using persuasive speech to fight that stigma?

There is a strong history and lineage of auto-ethnographic research in disability studies because the question of the personal offers the disabled researcher a particularly rich set of resources to draw upon in answering her research questions. Thomas Couser contrasts disability autobiography and disability autoethnography by explaining that the latter involves "the depiction of individuals as involved in a community of people with disabilities and/or a distinctive disability-based culture." He adds that autoethnography "[explores] the positive ways in which identity and life narrative are shaped by disability, the ways in which disability may *create* culture." Couser rejoices that:

> [a]lready there are a number of narratives whose authors address their membership in a larger community or culture of disability—*The Body Silent* (1987) by Robert Murphy, and anthropologist who had a spinal tumor that slowly paralyzed and finally killed him; *Lessons in Laughter: The Autobiography of a Deaf Actor* (1989), by the deaf mime, Bernard Bragg; *Missing Pieces: A Chronicle of Living with a Disability* (1982), by Irving Zola, a sociologist and

> polio survivor; and Anne Finger's *Past Due: A Story of Disability, Pregnancy and Birth* (1990). ("Empire of the Normal" 308)

He calls these auto-ethnographies "first-person *plural* accounts of disability because they all involve the authors' growing consciousness of themselves as disabled ("Empire of the Normal" 309). My dissertation, too, addresses the extent to which study participants, myself included, identify with their disabilities.

Couser notes that "[a]uto-ethnography is a slippery, ambiguous, but useful, and indeed indispensable term" as more disability-focused autoethnographies have been published ("Disability and Autoethnography" 126). He clarifies that term by citing Deborah Reed-Danahay's contention that:

> [a]uto-ethnography stands at the intersection of three genres of writing which are increasingly visible: (1) "native anthropology," in which people who were formerly the subjects of ethnography become the authors of studies of their own group. . .; (2) "ethnic autobiography," personal narratives written by members of ethnic minority groups; (3) "autobiographical ethnography," in which anthropologists interject personal experience into ethnographic writing. (qtd. in "Disability and Ethnography" Couser 127)

I argue that my description and analysis of the rhetorical production, motivations, and felt experience of this study's participants, myself included, meets the description of autoethnography that Couser presents in his discussion of the connection between this research method and disability: "Like other postcolonial subjects, disabled people are beginning to produce texts that are autoethnography in the senses of ethnographic autobiography and native anthropology—that is, texts that explore the creation of identity within particular subcultures and texts that contest the way the author's community is characterized from the outside" ("Disability and Ethnography" 128). I chose to pursue auto-ethnography because questions of identity stand at the center of auto-ethnographic research and questions about the discursive presentation of identity stand at the center of my study of the Speakers Bureau's stigma fighting efforts. (Smith 17). As a method in disability rhetoric, autoethnography allows me to gain deep insight into the rhetorical labors of Speakers Bureau members by examining these labors through the lens of personal experience.

My study seeks to understand the rhetorical strategies mentally disabled people employ in their attempt to "manage their spoiled identities" before audiences in ways that circumvent the obstacles they face as rhetors operating under the constraints of stigma. The particulars of that identity management, as I explain in Chapter Two, depend on which of two competing models of mental disability a Speakers Bureau member subscribes to—the medical model or the consumer/survivor/ex-patient (c/s/x) model.

By investigating both the classroom presentations and the thinking of Bureau members, I contribute to rhetorical studies a view from inside a relatively high stakes endeavor. Scenes of mental illness disclosure are fraught with both possibility and potential danger. My study examines how speakers work to contribute to the fight against stigma through their classroom presentations, but I have also been alert for any negative repercussions of these efforts, both to individual speakers and to the stigma-fighting effort overall.

My autoethnography involved the following research activities: As noted, I joined the Bureau as a participant-observer. To capture what it means to try to persuade others to respect one's identity while highly aware that that identity is "spoiled," by the presence of a psychiatric diagnosis, I took ethnographic field notes about my speaking experiences and my interactions with Bureau members. To this auto-ethnographic data I added tape-recordings of the classroom presentations of five other speakers, which I used to rhetorically analyze how they managed their identities before audiences. I also tape-recorded interviews with each speaker, interviews whose open-ended questions were designed to help me understand how speakers experienced the act of narrating their stories of mental disability (See Appendix A). To investigate the rhetorical motivations of the speakers in the study, I asked each participant to analyze a transcript of their taped classroom presentation, following these directions:

> Please read over the transcript carefully and either circle or highlight any words, phrases, sentences, or paragraphs that seem significant to you for any reason. Number the circled or highlighted word, phrase, etc. On a separate sheet of paper, write down that number. Then please answer the following questions for each passage/sentence/etc. that you marked as significant. If the answer to any of the questions is "I don't know," feel free to skip that question: Why did you say this? What effect were you aiming for? What did you feel like when you said this? How do you think the audience responded when you said this?

I used the data gathered from this exercise to develop an understanding of strategies individual speakers used to achieve their goal of fighting stigma.

The five speakers I recruited are people who present at schools regularly. I chose them for the study because Phil introduced them to me as potential participants, and they each agreed to take part when contacted by phone. They represent a cross-section of psychiatric diagnoses: schizo-affective disorder, paranoid schizophrenia, bipolar mood disorder, Post Traumatic Stress Disorder, and bipolar mood disorder/substance abuse.

Per IRB requirements, all participants received and signed consent forms that indicated they were comfortable with the potential research participation risks noted on the forms. The risks were outlined as follows:

> By taking part in this study, you may experience the following risks:
>
> - **Emotional**--(e.g., feelings of sadness or anxiety related to discussing experiences with mental illness.) This risk is likely, although it may be lessened by the fact that participants are accustomed to talking about their illnesses in public settings. Participants will also have the opportunity to skip any interview question they are not comfortable with or to stop answering a question part way through if doing so becomes uncomfortable in any way.)
> - **Social**—If the participant has not disclosed their illness in social settings outside of the community speaking sites, loss of confidentiality could lead to social stigma. This risk is less likely because the investigator will take every reasonable and appropriate protection to make sure risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
> - **Economic**--(e.g., a loss of confidentiality could possibly effect employment status or the ability to procure employment.) This risk is less likely because the investigator will take every reasonable and appropriate protection to make sure risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

I have taken steps to maintain the confidentiality of each participant. These include the use of pseudonyms and the storage of all study materials (tapes, transcripts, notes) on a password-protected computer stored in a locked file cabinet in my home.

During the study, the participants had enough psychiatric stability to be speaking to classrooms of high school students. Hearing the content of their presentations assured me that each person has a great deal of insight into the workings of their individual mental disabilities. Therefore, I trusted that they would inform me if they are not well enough to participate in an interview at any given time. While I could not be certain that the act of talking about one's mental disability in the interviews would not trigger a negative emotional reaction in a participant, I entered the interviews with the idea that the benefit of participating in the research—the chance to contribute to an in-depth study of the workings of their own organization—outweighed the risks. In addition, I came to each interview with the understanding that I would not probe a participant regarding a specific question if they showed any signs of emotional or physical discomfort with or prior to that question. I also planned to end any interview if a participant began to show discomfort. I believed that my prior training as a mental health service provider would help me to recognize signs of such discomfort. Fortunately, all the interviews proceeded without complications. I cannot, of course, account for emotions they may have raised after the interviews ended, but no one contacted me to report a problem. Gloria did mention to me one other study risk that concerned her—the risk that my research would reveal the Speakers Bureau's work fighting stigma to be ineffective.

Chapter Descriptions:

In Chapter Two, I narrate my experiences as a first-time speaker with the Speakers Bureau. My description and analysis emphasize my reactions to the questions and emotions raised for me by the act of talking about my mental illness in a highly public way I was not used to. The chapter also turns to outside sources to provide needed background on the larger mental disability-related debates touched on by my personal reactions to speaking and especially my interactions with one speaker whose views about mental disability contrasted sharply with my own. I provide analysis of how a speaker’s adherence to one of two culturally competing models of mental disability influences the nature of that person’s rhetoric in the stigma-fighting endeavor.

In Chapter Three, I focus on the rhetoric of two Speakers Bureau members, Phil, and Ruth. Like all my study participants, they offer their audiences what I call “deep disclosure,” the presentation of the sometimes-disturbing details of their disability-related experiences. Deep disclosure can make both speakers and their audience members vulnerable in distinct ways, which I cover in the chapter. Vulnerability in these rhetorical situations need not only be viewed as threatening, however. Rather, I argue, it has the potential to be highly productive, even conducive to rhetorical agency, when it encourages the speaker and audience member’s openness to each other’s influence.

Chapter Four takes up a moment when the stigma that adheres to mental disability intersected with my work as a writing teacher. I examine an incident in my classroom to understand my inability to react productively to my students’ apparent stigmatization of bipolar mood disorder. After providing analysis of this pedagogical failure, I describe and analyze a lesson plan I developed to guide how I would proceed in the face of future instances of mental disability stigma in the classroom.

In Chapter Five, I contrast the argument implied by the five group members who speak from within the medical model of mental disability with the argument implied by the group’s leader, who speaks from within the alternative consumer/survivor/ex-patient model. I explore the stigma-fighting implications of the two differing arguments. The former asks audiences to recognize that mentally disabled speakers are mostly “just like them” while the latter insists audience members expand their concept of what kinds of identities constitute “us.” In the chapter, I also look ahead to the possibility of future research linked to my concern about the Bureau’s practice of vetting potential speakers.

CHAPTER 2 THE MODELS BEHIND SPEAKERS' RHETORICAL CHOICES

As Tony Adams, Stacy Jones, and Carolyn Ellis explain in their description of auto-ethnography, theory plays a symbiotic role in an auto-ethnographic text such as this one: "Theory asks about and explains the nuances of an experience and the happenings of a culture; story is the mechanism that illustrates and embodies these nuances and happenings. Conceived in this way, theory is *not* an add-on to story. Instead, theory is a way to understand—think with and through, ask questions about, and act on—the experiences and happenings in our stories" (89-90). In this chapter, I autoethnographically examine the act of publicly sharing one's story of mental disability, using the lens of my experiences and observations as a new member of the Speakers Bureau. In telling my/our story, I combine my commentary with that of other scholars to understand what drives the rhetorical choices involved in representing experiences of mental disability in ways that hold true to their often-disturbing nature but still attempt to produce the social acceptance sought from audiences.

This chapter takes up the ongoing cultural debate about how to think of, and speak of, mental disability. After describing two competing visions—the medical model that views mental disability as an illness and the alternative consumer/survivor/ex-patient model (c/s/x) that views it as simply an alternative way of being human—I explore how Speakers Bureau members' choices of model influence the terminology we use when representing our identities in classrooms. Rhetorical choices regarding how to represent, or manage, one's identity in speeches made to students matter because these choices affect what "face" of mental disability those students see. Although we speak as individuals, none of the speakers in my study ever said in a presentation, "Now, remember, this is just *my* experience." Rather, each of us offered up our story of mental disability as *the* story of mental disability. Through our rhetoric of narrative disclosure, each of us presented the argument: “What I am describing to you is what mental disability *is*.” Given that our arguments differ, the question of which conception of mental disability—medical illness or alternative way of being human—audiences are more likely to find persuasive remains open. By examining how stigmatized rhetors navigate terminology to persuade audiences to accept them as equal human beings, we can gain insight into the stigma-fighting endeavor as a rhetorical endeavor.

As will be noted, through much of this dissertation I refer to the purposes and thinking of members of the Speakers Bureau using the pronoun “we.” While the group of six study participants (myself included) whose rhetorical product and motivations I examined closely do not in any way form a monolith in terms of identity, I did notice enough similarities in our experiences *as rhetors operating under the constraints of stigma* to make me feel comfortable using that pronoun. In other ways, outside of rhetorical production, Speakers Bureau members differ significantly from each other.

As indicated by the content of the speeches, by interviews with participants, and by participants’ self-analysis of transcripts of their presentations, Speakers Bureau members seek to secure freedom from stigma for ourselves and all mentally disabled people. We seek the respect that comes from finally being considered fully human (Goffman, 5). As noted in Chapter One, I use the term “mental disability” when referring to psychiatrically diagnosed mental disorders. I refer to “mental disability” instead of the more commonly used term, “mental illness,” which is disapproved within disability and Mad studies circles because it medicalizes conditions that scholars and activists in these circles believe should be more broadly considered states of “mental distress” (Reeve 99). In quotations of Speakers Bureau members, I have kept in their references to “mental illness” to honor the way other members of the Speakers Bureau and I speak about ourselves.

The narratives each speaker shares in the classroom share a similar arc—from initial diagnosis to experiences receiving treatment, to eventual recovery, a condition of relative wellness achieved, most speakers argue, through the use of medication. Each narrative consists of disclosure—first the large-scale disclosure of mental disability, followed by a series of disclosures of thoughts, emotions, and behaviors many in the audiences may find unfamiliar and quite possibly disturbing. Speakers Bureau members make these latter disclosures to establish our identities as people with mental illnesses and to give our audiences a glimpse into what it means to live with mental disability.

Asked if presenting at Speakers Bureau events has changed how she thinks about herself at all, the Bureau’s director, Gloria, answers in a way that emphasizes the link between mental disability and identity: “Yeah I would say so. I see myself as an educator, as a change-agent. . . there’s a big mass to be formed and I’m forming it. I’m not just sitting passively by and letting people form who I am. *I’m forming for myself who I am, forming for myself how people think about me*” (emphasis added). Speakers Bureau narratives are rhetoric we use to form for ourselves and our audiences who we are and, consequently, how we want to be perceived. They are constructions and presentations of identity. Disability theorist, Tobin Siebers, describes identities as “the theories that we use to fit into and travel through the social world” (287). In other words, identities are tools we use to interact with others. In Goffman’s terms, Bureau members use narratives to rhetorically “manage” our identities in the presence of audiences we assume contain mostly “normal” and some mentally disabled members. Gloria’s determination not to let others form who she is illustrates the “management” aspect of the speakers’ representations of their identities to external audiences.

We take on this identity management, the aforementioned task of “putting a face on mental illness,” with a specific purpose. Intent on fighting our own stigmatization, our goal in making rhetorical choices about the narratives we present—choices regarding content, language, style, etc.—is to garner “recognition” from the audience for our identities as mentally disabled people. Patchen Markell describes recognition as a concept often discussed as a solution to the identity-based oppression of marginalized groups. Recognition, he notes, is traditionally defined as giving respect to a group of people based on their true identity, based on who they *really are* (88-89) (emphasis added). By telling our stories of experience with mental disability, each of the study’s participants paints a picture in words of who she really is, a picture focused on the role of mental disability her life. We offer these pictures hoping that audiences will see that who we really are does not match the stigmatizing images of “the mentally ill” that circulate in the culture.

But for members of the Speakers Bureau, the question of identity, of who one really is, is not negotiated simply. This is the case because, for a mentally disabled person, the public representation of the self depends on what that person believes mental disability really is. My study revealed that five speakers, myself included, subscribe to one of two major models of mental disability, while Gloria subscribes to the other. Which model a speaker uses to explain his psychiatrically diagnosed condition—the traditional “medical model” or the alternative c/s/x model—makes a significant difference in how he speaks about himself to audiences. In the data I gathered, the depiction of who one really is depended partly on whether the mentally disabled rhetor believed mental disability is a brain-based illness that requires medical intervention (the medical model) or, instead, just another way of being on a spectrum of ways of being human (the c/s/x model).

In seeking to overcome the stigma the adheres to our psychiatric diagnoses, one of our primary jobs as rhetors is to bolster the damage done to our *ethos* by the labels we carry. When Jennell Johnson describes the damage done to the reputation of George McGovern's vice-presidential candidate, Terry Eagleton, after leaked reports of Eagleton's treatment for depression, she asks what accommodations audiences can make for "the bad man speaking poorly" (476). She uses the term *kakoethos* to describe the spoiled *ethos* Eagleton experienced once the public began to see him as a mentally disabled candidate rather than simply a candidate (Johnson 462). My observations of the Speakers Bureau reveal the terminology and rhetorical poses some speakers resort to in order to overcome the *kakoethos* that naturally dogs us as rhetors before we even open our mouths in classrooms. We turn to these means because we are aware of the danger Stephanie Kerschbaum warns of in her discussion of public disclosures of disability. We know that our credibility with audiences can often start out as spoiled because, as Kerschbaum notes, disability disclosures are often met with automatic assumptions that the disabled person is incompetent (69). As noted earlier, the means we use to overcome these aspersions of incompetence often depend on which model of mental disability we identify with and use in explanations of our lives.

The Medical Model and its Challengers

My first point of Speakers Bureau contact involved a meeting with Gloria. After describing the group and some of its history, she interviewed me to see if I would be a good fit for the Bureau. I had not expected an interview, having assumed that simply having a mental disability was qualification enough. My interview consisted primarily of Gloria asking me to tell my story briefly. I also answered questions such as “How do you define recovery?” At the time, I did not ask her what she or the group meant by “recovery.” Based on what I had been told by the two psychiatrists I have worked with over time, it has always been my understanding that people do not “recover” from mental illness. While remission, even very long periods of it, is possible with the right treatment, there is no such thing as “being cured” to the point where treatment—by which I mean the use of medications to right the chemical imbalance causing the illness—is no longer necessary.

The issue of medications turns out to be significant to my experience with the Speakers Bureau. The nature of my 29 years of mental illness has steeped me firmly in the medical model. According to this model, mental disorders are diseases of the brain and therefore require intervention through medication. I came to my strong belief in this model in a few ways, the greatest of which is its success in keeping me basically well over the decades. When I was first diagnosed with bipolar mood disorder, my psychiatrist started me on a course of medications that “did the trick” as far as I was concerned. They kept me above suicidal for the year it took me to crawl out of the depression that followed a six-week period of mania.

My second major episode of illness also followed the same course, about six weeks of mania, followed by a year-long depression. Again, the prescribed medications did not lift me out of the depression. Instead, they seemed to keep me just above suicidal for the year it took for my mood to stabilize. Some people would look at my initial illness history and say that it does not seem that the medications were that helpful, or even helpful at all. But even through the haze of depression, I had faith that they were keeping me out of the worst possible and most dangerous place—suicidality. Although I have been lucky enough never to get very seriously ill again, in the years that followed there have been small “blips” of depression and one of the less than fully manic condition known as “hypo-mania.” In each these cases, I believe, medication intervention definitely brought me back to full mental health.

Disability theorist, Lennard Davis, makes a strong case against the medical model, which he calls “this framing of sorrow and sadness as pathology” (60). He presents scientifically-based arguments against the contention that the standard form of anti-depressant medications—SSRIs (selective serotonin uptake inhibitors)— work to alleviate the symptoms of what psychiatrists call depression. His argument indicates he would consider my report of successful medical treatment a legitimate but uninformed opinion that ignores the lack of true scientific support for the usefulness of medications:

> Involved in the “works for me” approach are the many people who take SSRIs and respond with their own narratives. These personal narratives, in print and online, are very compelling, although they cut both ways. Some people report life-saving effects and relief from personal suffering from taking SSRIs. Other people report devastating “side” effects, including suicidal impulses and the actual suicides of relatives or friends. (Davis 57)

Three out of the six Speakers Bureau participants in my study present versions of the “works for me” argument regarding their own success with medications. Gloria, however, indicates to audiences that medications are not necessarily a cure-all, noting that even if they do eventually work, they may require patience from the person taking them.

In her classroom presentation, her interview, and her speech transcript self-analysis, Gloria identifies herself as a member of the Recovery Movement. In the Recovery model of mental disability, the person with the disability is primarily in control of their treatment. As Frederick Frese III et. al. put it: “The locus of control thus becomes less external. Mental health interventions are designed to be empowering, enabling the persons themselves to take responsibility for decisions about their lives" (1463). In contrast to this model, Frese et. al. present Munetz and Frese's description of the medical model:

> . . .the evidence-based, medical model has been highly paternalistic, emphasizing illness, weakness, and limitations rather than the potential for growth. . . the evidence-based medical model has been perceived as stamping out hope by implying that biology is destiny and emphasizing an external locus of control. . . some consumer advocates view the physician as a powerful and oppressive figure who 'at best is acting out of misguided beneficence' and at worst fosters 'helplessness and chronicity.' (qtd. in Frese et. al. 1463-64)

My personal experiences with psychiatry have not shown it to me in this light. But in saying this, I must acknowledge the moderate nature of my psychiatric condition. Not being severely disabled by my illness and having a doctor willing to work with me as a partner have both allowed me to be primarily in control of my treatment. I have never experienced what some other mentally ill people have—being forced to take medication and/or being committed to psychiatric hospitalization against my will.

The medical model, which does argue that chemical imbalances in the brain cause many mental disabilities and that some disabilities have a clear genetic component, began with the introduction of psychotropic medications in the 1950s. In the 1960s, the use of such medications increased, and they provided symptom relief for many people who had previously had no hope of such improvement. Stephen Hinshaw outlines the clinical significance of these results, the discovery of warranted genetic sources for several disabilities, and the ways in which neuroimaging has been used to illustrate significant physical differences in the brains of mentally disabled people. He states: "Such vivid portrayals of the neurobiological underpinnings of serious psychopathology make it hard to believe that mental illness is either imaginary or the product of weak will" (Hinshaw 85). At the same time, he does argue that attributing mental disability solely to biology or genetics fails to acknowledge the effect of environmental factors on the brain, an organ known for its plasticity. He supports what he identifies as the developmental psychopathology model (DP), which includes the role of biology and genetics but also takes environmental influences, including experience, into consideration when describing the origin of mental disability (Hinshaw 86).

Some powerful mental health advocacy groups, such as the National Alliance on Mental Illness (NAMI), have adopted the medical model in the hope that focusing on mental disability as a brain disorder will fight the societal tendency to blame mentally disabled people and their family members for their conditions (Hinshaw 85).Within this model, a person with a mental disability takes medication to manage symptoms—aberrant thoughts, emotions, and behaviors, ones which are found to be debilitating and which the people who experience them, and their psychiatrists, do not consider a part of "normal" existence.

The controversy over what constitutes "mental illness" continues, even as many people receive care based on the medical model. That controversy plays itself out in a much greater number of texts than can be covered in this exploration. I will limit this look to a brief description of three positions on mental disability: a critique of the medical model's central text, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the c/s/x model of mental disability, and a suggested "human rights approach" to mental disability that takes its cue from the larger field of disability studies. I examine the controversy because it directly influences some of the rhetorical choices the participants in my study make about how to represent themselves to audiences.

In *Making Us Crazy--DSM: The Psychiatric Bible and the Creation of Mental Disorders*, Herb Kutchins and Stuart Kirk take on all incarnations of the DSM, including the most recent two which are supposed to have made significant improvements. The DSM is a guide of symptoms and disorders that psychiatrists use as a diagnostic aid. Kutchins and Kirk argue that the diagnostic criteria for mental disorders include too many states and behaviors that could just as easily be classified as normal or non-disordered. They claim that the DSM uses the rhetoric of science, specifically claims for scientific validity (that the diagnoses arrived at using the criteria are accurate) and reliability (that all clinicians would arrive at the same diagnoses using the criteria) to cloak its arbitrariness and its susceptibility to the influence of advocacy groups and other powerful entities.

I find their argument reasonable but limited in that the only examples they provide of potentially non-disordered but still diagnosed conditions are on the fringes of present day psychiatric assessment and do not include the major mental disabilities, such as depression, bipolar mood disorder, and schizophrenia, whose impairing effects I find hard to consider “normal” or non-disordered. They do give historical examples that greatly support their case, which include the diagnosis of homosexuality as a psychiatric condition and the inclusion in the DSM of a diagnosis for women called “masochistic personality disorder.” Both diagnoses were removed, the first after an outcry from gay activists and the second after protests from feminist groups.

Another challenge to the medical model comes from the c/s/x community, also known as the Mad Pride movement. This group has its origins in the anti-psychiatry movement that started in the 1960s with support from writers including psychiatrists, Thomas Szasz, and R.D. Laing. These anti-psychiatrists argue, in varied ways, that mental disability is a myth, not a pathology but, rather, “a way of coping in a mad world” (Lewis 120). The Mad Pride movement considers what psychiatrists refer to as mental illness “mental difference.” It argues against the medical model’s emphasis on considering mental disability an individual defect, the psychiatric establishment’s primacy in deciding what treatment the mentally distressed individual needs, and what the movement considers an artificial distinction between “normal” and “abnormal” mental states (Lewis 116-17).

The Mad Pride movement originated in the negative experience its founders had within the psychiatric system. Its initial focus was a fight against involuntary commitment statutes and the reality that mentally disabled people can be legally forced to take medications (Mulvaney 594). Once highly radical in its challenge to the very definition of mental disability and the role of psychiatrists, Mad Pride has moderated its stance over time as its success with developing peer-run support services for people in mental distress (a term the movement prefers to the term “mentally ill”) has won it a seat at the mental health policy table. In the interests of coalition building, the movement moved away from Szasz’s black and white view of psychiatry towards the inclusion of “consumers,” people who still have issues with psychiatry but also choose to receive services from the psychiatric system (Lewis 121). As David Oaks, one of the leaders of the movement puts it: “We respect the right of people to choose the option of prescribed psychiatric drugs. Many of us have made this personal choice. . .However, choice in the mental health field is severely limited. One approach dominates and that is a belief in chemical imbalances, genetic determinism, and psychiatric drugs as the treatment of choice. Far too often this limited choice has been exceedingly harmful to both the body and the spirit” (qtd. in Lewis

124) In “A Mad Fight,” Bradley Lewis explains that beyond the political struggle, the c/s/x/ movement still carries on an epistemological struggle about what states of “severe mental and emotional crises” signify. The Adbusters editors’ statement with which he closes his article suggests that what the medical model would call “mental illnesses”—“our deep sorrow, our manic hope, or fierce anxiety, our imperfect rage,”—are, instead, natural reactions to a disordered and unjust world (qtd. in Lewis 128). This view clearly challenges my contention above that the effects or “symptoms” of major mental disabilities cannot be considered a part of normal living.

The claim that posits mental distress states as reactions to cultural factors such as isolation and materialism resonates with the views of those disability studies theorists and activists who argue for the social model of disability, the idea that disability is a social construction rather than a primarily material fact. The social model, Tom Shakespeare explains, claims that over and above physical impairment, disability results from structural and institutional forces that lead to the societal exclusion of disabled people (215). For example, a person who is blind has a clear physical impairment, but a lack of assistive devices, such as “talking” crosswalks in her town, is the external reality that disables her. Shakespeare provides a critique of this model which includes the contention that in arguing against the medical model of disability, the social model goes too far in suggesting that the disabled person’s impairment is “not a problem” (217-18).

Medical sociologist, Julie Mulvaney, also critiques what she calls the “social approach” to what she notes are the very real impairments that constitute mental disability. While she hails the way the conception of mental disability as a social construction challenges the traditional medical model of the body as the only source of illness, she criticizes sociologists’ avoidance of "the dilemmas of confronting the implications that may follow from an acknowledgement that some people experience severe pain and discomfort as a result of disorganized thinking, racing thoughts, fixed paranoid delusions, inability to control thought processes, or perceptions of external thought control. This makes their work increasingly irrelevant for many people experiencing serious mental distress." She argues that sociologists would do well to follow the lead of disability theorists who are working to re-inject concepts of impairment into the definition of disability (589). Helen Spandler and Jill Anderson call impairment "the elephant in the room," ignored in the work of some disability and "radical mental health activists" because it does not fit with the attribution of all disability to the effect of social forces such as discrimination (14).

In presenting a "human rights approach" to dealing with mental disability, psychiatrist Kenneth Burns also speaks to the need to go beyond the purely social model of disability, specifically when thinking about mental disability. He cites his support for a model that includes both biological and genetic causes for mental disability in interaction with environmental factors: "Innate or acquired genetic or biological factors associated with the origins of serious mental disabilities are not fixed impairments in the sense that blindness and spinal paralysis are. Rather, these factors exist as 'vulnerability factors'—rendering the individual susceptible to psychosocial and environmental factors within society." Burns points to increases in mental disabilities such as anxiety, depression, and substance abuse in relation to structural factors such as poverty, homelessness, and unemployment (22). He calls for actions to address these factors and concludes his piece with the contention that the medical establishment's research focus on stigma misses the real problem of discrimination (Burns 26-27). While I agree that addressing discrimination is crucial, I believe a continued focus on stigma is also necessary because stigma makes discrimination possible and probable.

The Challenge to the Medical Model Hits Home

A few weeks after our initial meeting, Gloria and I traveled together to an adjacent county for a workshop she had arranged for mentally disabled people who work as "peer supports." From a rhetorical standpoint, I was especially interested in the workshop as it focused on how to tell one's story in public presentations. I met the peer supports group and was introduced around as someone who was researching the Speakers Bureau. Meeting people, I felt initial discomfort because a few of the people at the meeting appeared visibly distressed in a way I have come to associate with a certain level of mental disability through my work experience as someone who provided support to mentally disabled people in low-income housing. My discomfort stemmed from a specific (and familiar) feeling of being not "as ill" as the other people in the room. What I experienced felt like a form of stigmatization, abhorrent, but still there—a desire to distance myself from identification with these more obvious presentations of mental disability.

I remember in particular a very nice woman seated next to me who repeatedly interrupted Gloria's presentation with breathless exclamations about how excited she was to be participating in the training. She said that she was excited about the opportunity to share her story so that people can see someone with a "scary diagnosis" (schizophrenia) who is still able to "be very functional and lead a normal life." I remember wondering how "normal" this person's life could be, given her behavior. At the same time as I felt deeply connected to her desire to send that message of normalcy, I wondered about the ways in which her self-presentation, especially her highly nervous affect, would reinforce certain stereotypes—such as the “scattered” nature of a mentally disabled person’s thought processes—when she told her story.

Gloria presented a text-version of a PowerPoint called “Crafting Your Story: Guidelines and Recommendations for Sharing Your Mental Health Experiences.” She offered advice about the steps to creating one’s story, with the following goals: to fight stigma, to educate, to help others come forward, to create trust. She also mentioned the concept of tailoring one’s message to various “power groups,” different sets of people who could affect life for mentally ill people, such as policymakers, landlords, and medical professionals. I learned much from the suggestions she made about narrating one’s mental health experiences, but here I want to note the things she said that gave me pause.

Under “Do’s, Don’ts and Be Carefuls” her PowerPoint stated: “Don’t overgeneralize medication, prayer, specific support groups, or anything else as a cure-all.” Gloria told the group to stress to audiences that whatever helped “helped for me.” She added that when talking to people about medication, we should remember that taking it is a personal choice, not the only way to approach mental disability. Although I am fully aware that medication does not always work for people in the ways that it has successfully worked for me, this caution about how to discuss medication made me uncomfortable. As a direct care worker serving people with mental disabilities, I had seen the highly negative effects of individual decisions to stop taking one’s medications. I was not familiar at the time with the arguments made by people within Mad studies who strenuously oppose the efforts by medical and social service systems to force mentally disabled people to take medications and undergo hospitalization against an individual’s will. I also was essentially unaware of the adverse experiences some people have had taking medications. For example, Irit Shimrat, a Canadian Mad studies scholar, writes in a book chapter entitled “The Tragic Farce of ‘Community Mental Health Care”:

> As I write this, a dear friend who was locked up on a suburban psych ward earlier this year is being coerced to attend her local Care Team. The Care Team injects her with an atypical neuroleptic that is already causing dystonic and cognitive difficulties, and tests her blood to ensure that she is maintaining what they call therapeutic levels of several other psychiatric drugs they make her take.
>
> Her outpatient committal order—euphemistically called ‘extended leave’ in British Columbia’s Mental Health Act—obliges her to subject herself to this ongoing damage and humiliation, on pain of reincarceration if she fails to comply. She and far too many others are receiving community mental health services because they have no choice (Fabris 2011).

Reading such a description, I have to admit that when I worked in direct service to people with mental disabilities, I was aware of what was locally known as an “assertive treatment order,” a legal requirement that someone take their psychiatrically-prescribed medications or face hospitalization [what Mad studies scholars would call “incarceration” (Burstow 83)]. At the time, I did not question the validity of these orders and certainly did not view them as the human rights violations Mad Pride activists and scholars consider them (Costa 206). I only saw them as necessary means to get people the medical treatment they needed in order to stop suffering from what the medical model calls the “symptoms” of mental illness. In her classroom presentations, Gloria refers instead to “what are known as symptoms” when she talks about her mental distress experiences, which she calls “states of distress.”

The next statement on Gloria's speakers training PowerPoint was the kicker, however: "Don't promote 'broken brain' theory.'" I raised my hand and asked what that caution meant. Gloria explained that speakers should not promote the theory that mental disabilities arise from chemical imbalances in the brain. She said she did not want to devalue one side of the debate about mental disability and its causes, but "these are human beings suffering." Gloria's affiliation with the Recovery Movement clearly places her on the c/s/x side of the debate. Addressing the workshop audience, she described power issues brought up by the primacy of the medical model, noting that she had been put in hospitals because of her condition and "treated as sick." She described the "sick role" as something that had been "put on me." She continued by saying that the issues of psychiatric labeling and medical opinions provide good opportunities for dialogue, arguing for a balance between respecting the experience of experts within the "system" and peoples' lived experience with mental disability. She brought up the idea that certain "states of being" can be considered life experiences rather than "symptoms," and noted that there are varying opinions as to what mental disability is: Is it a medical illness, or is it a "part of living?"

Regarding these statements, she told the group that they could mention how medications have helped them but should not say, "You must take your meds!" Some people physically cannot take them due to side effects, she noted, and some choose not to and find other ways to manage their "symptoms." She mentioned that one of the members of the Speakers Bureau has bipolar mood disorder and does not take medications. When this person speaks to groups, she makes it clear that this is her personal decision.

Gloria's commentary raised my hackles. I found myself wanting to argue forcefully against the idea that mental disability could be considered just another way of being. This idea rang false against my experience of mania and especially depression, where I found a depth of sadness and hopelessness unrelated to anything going on in my external reality. “Depression feels like an aberration,” I thought, “not a ‘part of living,’” a descriptor that seems to suggest that what I consider an illness is an acceptable state rather than one that needs medical intervention. I should note here I do not approach the topic neutrally. My father committed suicide after a long period of untreated depression.

I raised my concern about the advice to avoid “broken brain theory” with Gloria on the way home from the training described above. She explained her view of mental health as a set of behaviors that exist on a spectrum of “being human” Certain states, she said, are not symptoms of illness so much as “ways of being.” She added that this view of mental illness is the peer support model, the model associated with the above-noted movement that trains mentally disabled people to provide support services for other mentally disabled people. She also briefly described the “psychiatric survivor” movement noting that it has what she called the extreme view of mental illness. Mad scholar, Bonnie Burstow, refers more broadly to the antipsychiatry movement and argues, in the words of a Mad organization known as the Phoenix Rising Collective, that “psychiatric treatment is a form of *social control*” (84).

I told Gloria that my experiences of deep depression included a level of anguish and hopelessness that was incommensurate with anything going on in my life. I asked, “Doesn’t that suggest that the cause must be biological?” She turned to me and said, “The purists would say that you had not looked hard enough for a source for your sadness.” Slap! I politely expressed my dissatisfaction with this response, and we let the matter rest there. But inside I was seething, not at Gloria, who I had already come to like and respect, but at the “purists” who would dare lay their interpretation over my crystal-clear experience. (It has not escaped my notice that I am doing the same thing through my interpretation of their mental health experiences.) In an example of looking harder for non-psychiatric sources for one’s sadness, Jennifer Poole and Jennifer Ward describe what they call “psychiatric encroachment” when it comes dealing with individual experiences of grief after the death of a loved one: “It follows that the medicalization of grief has been on the rise, too, with more and more ‘types’ of grief making their way into the psychiatric manual known as the DSM. With inclusion come medical diagnoses and treatments, including ‘therapeutic’ pharmaceuticals meant to ease, numb, and control ‘symptoms’ of grief” (98). Poole and Ward challenge the medical model’s tendency to affix a clinical diagnosis to mood states.

Terminology and Identity/Seeking Rhetorical Distance

As my strong response to Gloria’s negation of “broken brain theory” indicates, I did not want that medical model challenged. Why? At that moment, I only knew I feared a challenge because I had thus far negotiated my sense of identity within the context of this model. I had viewed myself as a person *with* a mental illness, not a “mentally ill person.” The latter wording suggested to me that the illness formed the primary part of my identity, subsuming all other aspects of the roles through which I interact with others. As something wholly biological, however, I believed bipolar mood disorder did not affect my *true* identity in any way. The disease affected how I had to live my life, the precautions I had to take, the limits I had to be conscious of—but it did not have anything to do with who I really *am*. My sense of having a “true identity” is echoed by Hutchins and Kirk. They argue in the following way for the importance of their critique of the way the DSM is used to label certain mental states: "In short, diagnoses for physical ailments rarely have the social consequences that diagnoses for mental illnesses do. This is because how you think, feel, and behave is what you believe constitutes your "real" self: it is your essence as a human being" (262).

If one believes in the medical model, however, it is possible to distance oneself conceptually and rhetorically from one's psychiatric diagnosis. It can be considered something one "has" rather than something one "is." For example, Phil, the Speakers Bureau founder, once adamantly told me "I am not schizophrenic. I *have* schizophrenia." When he presents to high school audiences, he says, "I have a mental illness—paranoid schizophrenia." And each time I give a classroom presentation, I start out by saying "I have a bipolar mood disorder," rather than "I am bipolar." Identifying myself in this way is a conscious choice, one designed to put distance between my "real" self, my essence as a human being, and my psychiatric condition. Ultimately, both Phil and I suggest that our identities would remain unchanged today if our disabilities somehow suddenly disappeared. By verbally creating distance in the classroom between our selves and our psychiatric diagnoses, we attempt to counter the mark we bear because of those diagnoses.

In rhetorical terms, we try to add to our *ethos* as speakers by distancing ourselves from conditions we know much of the public tends to view as "bad." It is not that we *are* bipolar or paranoid schizophrenic, i.e. bad, people. We are simply people who *have* these conditions. They are a part of our lives, our wording argues, but they do not define who we are. One of the Bureau's speakers, Megan, makes this argument directly. She started the presentation I taped by saying, "I can tell you a little bit of my history, and I'll throw some diagnoses at you. *I hope that doesn't define me in your mind.* But I live with what's called Post Traumatic Stress Disorder." (emphasis added). Another speaker, Ben, tells students early in his presentation, "What I've got is called "schizoaffective disorder." Johnson underscores the need for such rhetorical distancing when she notes that Eagleton's detractors did not consider his *ethos* rehabilitated even when treatment had rid him of all symptoms of his mental disability. As she explains, "A diagnosis of mental illness, no matter how far in the past, no matter the severity of the condition, no matter the circumstances, is a permanent identity. One 'has,' or 'suffers from,' heart disease. One is perceived 'to be' mentally ill *even after successful treatment*" (Johnson 468). Speakers Bureau members face this exact challenge to our *ethos* even as we tell our audiences we have achieved wellness through the use of medications. The medical model's contention that one must take medication for the rest of one's life to maintain that wellness does not help us create an image of people free from the initial stigmatizing diagnosis.

I consider the described verbal distancing, the statement "I have X" vs. "I am X," a necessary rhetorical move on the part of Speakers Bureau members. We need to be perceived by audiences as Quintillian's "good man speaking well." We know stigma has likely marked us as "bad," in the views of a significant portion of our audience. Those of us who subscribe to the medical model of mental illness "come out swinging" in our presentations by using a seemingly small rhetorical choice designed to guide audience perceptions in our favor.

In contrast to the five other participants in my study, who all begin our presentations using such tropes of the medical model to describe ourselves, Gloria opens in the following way: "I'm here because I have a lot of experience with what is known as mental illness. I have a lot of experience dealing with the mental health system, and I have a lot of experience with pain and human conditions of distress." By mentioning having had painful and distressing experiences rather than giving the name of a specific illness, Gloria discloses more of her self than the other speakers do. She does not use clinical terminology that can put distance between life events and the person presenting them. Throughout her talk, she refers to "experiences" she has had in her life rather than to "symptoms" of her mental disability. She also argues that what the medical model would call her "illness" is, rather, an aspect of her individuality:

> There's no normal life. We're all individuals. I think that concept of being an individual and having differences, diversity in general, that we're all different in some aspect although there are many parts of us that make us human. . . There are many parts of us that make us different from each other. That's ok. We don't have to be the same. Diversity is beautiful and differences are beautiful. They don't always have to be medicated or diagnosed. I think sometimes that can be helpful. I've experienced ways in which it is not helpful, too.

By describing her diagnosed disability as an aspect of diversity rather than a defect, a veering from "normal," Gloria puts less distance between that diagnosis and her self than the other speakers do. In a second interview, she did mention that she does not go as far as to say, "I am schizophrenic" in classroom presentations, as she believes doing so will be too stigmatizing in front of relatively unsophisticated audiences. She reserves this assertion of identity for times when she is in the company of other people with the same disability, the "in-group" where such a reference feels safe because it will not be misinterpreted. She added that she will also say "I am schizophrenic" in conversations where she wants to invoke her own Mad Pride, such as at times when she feels threatened by doctors or nurses.

The idea that the mentally disabled speaker needs to rhetorically distance himself from his condition also meets a challenge when examined in light of certain disability studies discussions of identity. As Shakespeare explains, proponents of the social model of disability do not call themselves "disabled people" (rather than "people with disabilities") to suggest an "essence" of disability, as I fear the term "mentally ill person" would do. Rather, they do so to indicate that, while they have real impairments, they have only been *disabled* by the structures and exclusions imposed by an ableist society. For these advocates, "[l]ike gender, disability is a culturally and historically specific phenomenon, not a universal and unchanging essence" (Shakespeare 216). Seen in this light, the way I view my disability through the medical model's lens—as an individualized defect—does suggest it is part of my essence, part of who I am.

Siebers contributes to the view of disability identity as something other than an essence in his argument for the importance of identity politics for people with disabilities. He challenges the contention that politics based on identities that deal with pain and suffering should be considered narcissistic (286). He states instead that identity politics are the best way to fight injustice against minority groups and contribute their experiences to the construction of "progressive, democratic society" (Siebers 283). Rather than being pure essences that determine our individuality, he notes, "identity" refers to "the structure by which [a] person identifies and becomes identified with a set of social narratives, ideas, myths values, and types of knowledge of varying reliability, usefulness and verifiability. It represents the means by which a person, qua individual, comes to join a particular social body" (Siebers 283-84).

Siebers' description of identity as the intersection between an individual's consciousness and a set of cultural elements such as social narratives links to the rhetorical labor of the Speakers Bureau. Each speaker's presentation of their story of mental disability hinges on the intersection of personal disability experience with either the medical narrative of mental illness or the alternative c/s/x narrative of states of mental distress. Speakers Bureau members all use our rhetoric to fight back against the stigmatized cultural narrative of mental disability. By attempting to change the way our audiences perceive mentally disabled people, by selling them on alternative versions of what it means to have a mental disability, we try, through language, to change the way in which, as Siebers puts it, we join the social body from which our disabilities may have excluded us. But each of us make a choice regarding whether to speak of ourselves as "ill" or as experiencing a "different way of being human" on a spectrum of ways of being human.

Susan Gabel asserts her right to define herself in relationship to her disability rhetorically, as Bureau members do. She asserts her right to the claim "I am disabled" as it relates to her experience with depression. She refers to the medication she must take daily and the rest she has to get as indices of her disability. She needs both in order to function (Gabel 39). Gabel brushes aside the term "person with a disability" as one that makes it unclear whether or not the disability is part of the person's identity. Unlike the five speakers who subscribe to the medical model, she clearly sees her disability as part of her identity. She also rejects the designation "mentally ill," she notes, because she experiences her illness physically as well as mentally and because the illness only occurs intermittently. "Mentally ill," she argues, suggests a constant state of suffering. (Gabel 40). Primarily, she calls for what she calls a "body-centered interpretation of identity as an experience," explaining:

> In saying 'I am disabled', I am constructing my body through experience and I am interpreting my body and experience to my self and others in a certain way. Disabled-ness holds particular meaning for me and 'disability' refers to experiences of my body that contribute to the meanings I construct of the self. I may use other words to represent concepts that describe other meanings associated with my experiences, and those, too, will have value for me, but when I use 'disabled' to describe myself, I am valuing disability and the disabled parts of me. I am saying that experiences of disability are important in the struggle to know my self and to make sense of my body's experiences . . . I am making a place for my self in the world and in relation to other people. (Gabel 44)

Like Gabel, the Speakers Bureau rhetors interpret our experiences with mental disability to student audiences. We do so to win acceptance for people with these disorders in the larger culture of "normals." In this rhetorical struggle, how we describe our selves in relation to our conditions matters.

While it might seem like a fine point, I find Gabel's dismissal of the term "mentally ill" particularly helpful in terms of thinking of my own sense of identity as it relates to what I have not yet called my "disability." My refusal to identify as "mentally ill" derives from my fortunate health history. After two major episodes of illness in my early 20s, I have remained relatively healthy since, with only a few "dips" now and again. When I have experienced symptoms of my illness, I readily identified as sick. But in the intermittent years, feeling well has given me the ability to put at least some distance between myself and my diagnostic label. Reading Gabel's argument, however, I have to come to grips with the fact that my experiences, even down to having to take medication daily in order to maintain my emotional stability, do indicate the presence of disability. Like her, I require assistive measures in order to function well. And whereas she monitors her thought processes to determine if her illness is having an impact on others, I regularly monitor my mood to watch for telltale signs of a recurrence of illness that needs prompt (medical) attention (Gabel 39). So, following her lead, I will try on the phrase "I am disabled" as a way to speak about myself in public settings.

Rhetorical Poses in the Classroom

The decision to join the Speakers Bureau put my disability front and center. I had to reflect on it significantly in order to make my contribution to the group. My next encounter with a member of the Bureau came when I drove with Phil to tape his presentation at a local high school. As the only speaker that day, he had an entire hour to present. When we arrived at the school, Phil went up to the front desk and announced that we were there to speak in Ms. Henderson's class. I was already feeling self-conscious as a middle-aged person walking into a building full of high school students rushing up and down the halls. But when Phil announced us, I felt a different kind of self-consciousness. Specifically, I wondered if the woman working the front desk knew that we were the mentally disabled speakers. I tried to read her face to see if she was covering up any discomfort with politeness. This did not seem to be the case, but in retrospect I am struck by the way even the slightest possibility of stigma made me feel ill at ease.

After putting on visitor badges, Phil and I made our way to the classroom. The teacher introduced us and explained that I would be taping Phil's presentation for my research. Before he started speaking, Phil spent a while at the chalkboard writing down four phone numbers, hotlines for mental health crisis help. He began his presentation not by introducing himself but by explaining the numbers. Regarding the Psychiatric Emergency Services line, he said, "Say you're suicidal. We want to help you. They can talk you through your difficulty." His initial use of "we" made me wonder how he viewed his role as a member of the Speakers Bureau. Did he identify himself as part of the spectrum of support services available locally to people with mental disabilities? If so, Phil seemed to assume the rhetorical pose of "expert" right from the beginning of his speech.

I listened to his presentation carefully for assistance in considering how to develop my own. Only after describing the hotlines, the services they offered, and informational resources available through NAMI did Phil introduce himself by name. He immediately followed by saying that he had a mental illness, specifically paranoid schizophrenia. I had made the error of sitting behind the students for Phil's presentation, so I did not catch their reaction to his disclosure. I do remember wondering what they might be thinking as they listened to someone say he had one of the decidedly “scary” diagnoses. The public sphere representations of paranoid schizophrenia I have encountered are rarely kind and usually refer to the person’s potential for violence. Journalist Rob Wipond also notes the common media conflation of mental disability with violence and crime (254) The matter-of-fact way Phil named his illness impressed me. It reminded me that in certain moments of self-disclosure, if I am not particularly close to the person with whom I am speaking, I will omit the “bipolar” part of my diagnosis and just say I suffer from depression. After all, bipolar mood disorder, with its attached images of wild mood swings, also falls on the scary side of the diagnosis spectrum, although perhaps not as scary as paranoid schizophrenia.

Phil’s style of speaking was both teacherlike and methodical. He may have chosen this style to shore up his *ethos* by highlighting his competence to provide information about mental illness. Phil presented many statistics about the national rates of various mental illnesses and stopped intermittently to quiz the students, asking “Who here knows someone with a mental illness? Who here can name some of the major mental illnesses?” By speaking like an expert/teacher, he may have been seeking to distance the identity he was constructing for the students from the frightening images the words “paranoid schizophrenia” may have brought up for them. I connected his style of presentation with the goal he stated partway through his speech: “I want you to understand mental illness to the best of your ability.” Spandler and Anderson offer two definitions of “understanding” as it relates to mental disability: “comprehending the nature of madness or distress” and “sympathetic awareness, compassion and tolerance (of oneself and others)” (24). The first part of Phil’s speech seemed to aim for eliciting the former kind of understanding from its audience.

Unlike Gloria, whose speech mentions her participation in the Recovery Movement, Phil's presentation put him firmly in the medical model camp. He stated that he has made it his personal project to understand "the biological roots of mental illness" by doing Google searches related to neurobiology. He described the "symptoms" of his illness in clinical terms and only then followed up by giving brief examples of occurrences of those symptoms in his life. Phil's presentation did not contain any suggestion that there might be other ways of perceiving mental disability outside of the medical model. Strangely, this omission made me uncomfortable even though, only a few weeks earlier, I had struggled with Gloria's explanation of the "recovery" and "psychiatric survivor" models. Now, it struck me as limiting to present high school students with only one view of mental disability, albeit the dominant one, without at least mentioning that others do exist. As participants in psychology classes, these students had probably only encountered the medical model. I wondered about the consequences of lacking access to alternative conceptions of mental disability. If the alternative vision of the workings of mental disability proves, in the end, more powerful in the fight against stigma than the traditional one, would it not be important for students to have access to that vision?

Later in the week, as I prepared for my first presentation, the nervousness hit. While comfortable with self-disclosure to intimates, the idea of standing in front of a group of strangers, young people especially, and identifying myself as someone with a mental illness suddenly seemed daunting. I had planned my anecdotes carefully to convey the reality of my experience, but what would the students think of me after hearing them? And what did they think, what did they expect, before I even stepped in the room? Very conscious that the audience might be made up of people with preconceived notions—from media images, from textbooks, and possibly from personal experience with ill family or friends—I wondered what I could achieve in the space of 20 minutes to counteract all that conditioning. The question “What will they think of me?” certainly suggests the existence of shame, although I can say with confidence that I do not feel any shame about my illness, at least on a conscious level. Caring about the students’ opinion of me, though, does suggest that shame lurks somewhere, at least subconsciously.

The idea of shame accompanying a mental health diagnosis fits the medical model’s contention that mental illnesses are individually-based, medical defects. If I held to the c/s/x view of my condition, the action of disclosing my experience with “states of mental distress” could be a matter of pride, as it is for members of the Icarus Project, “a support network and education project by and for people who experience the world in ways that are often diagnosed as mental illness.” According to the project’s web page: “Sensitivities, visions, and inspirations are not necessarily symptoms of illness, they are gifts needing cultivation and care. When honored and nurtured, these gifts can lay the foundation for a wiser and more compassionate society.”

Coming from the medical model, which casts my “illness” as a defect in need of remediation, I felt no such sense of pride. Instead, I remember almost regretting the decision to participate in the Speakers Bureau’s regular exercises in self-disclosure. Feeling the moment approaching, I realized how much I enjoyed what PhebeAnn Wolframe calls “sane privilege,” the ability of sane people to behave in certain ways, such as “[showing] too much anxiety, or social awkwardness, or eccentricity” in a medical establishment without being subjected to a psychiatric evaluation the way a person with a mental health history would be (8). As someone who does not bear visible signs of being “different” from the norm, I, like the other study participants, have sane privilege. This privilege brings with it a great sense of safety. Even though I knew the Speakers Bureau involved minimal risk—it was unlikely I would see any of the students again—disclosure about a still-stigmatized condition felt dangerous.

Specifically, letting strangers know about my illness felt like a threat to my image of myself. I had spent almost 25 years without a severe episode of illness, almost 11 without a significant one, and about a year since what my husband and I call a "blip." I liked the distance I could at least attempt in my mind between my day-to-day experiences and the potential time bomb of my biological reality. Preparing to speak, I started to worry: What would it be like to talk about difficult experiences, regardless of how far in the past, to a classroom full of eyes and ears? If I shared the wrong detail, would I lose control of my self-image? Would the circulating stigma about mental disability adhere to me the minute I opened my mouth? Would discourse keep an uncomfortable reality constantly in the present? And would "talking about" lead to "re-living" in some way?

Driving to my first presentation, I experienced significant nervousness. As I entered the classroom, where I had been earlier in the day to tape another speaker, Ruth, I met friendly smiles from some of the girls in the class. The students' desks, arranged in a horseshoe shape, faced the front, where I perched on a small stool. As latecomers filed in, I found my hands shaking from a combination of nerves and strong coffee. I had forgotten to bring along the handkerchief I always keep around due to often sweaty hands, so my notes started to get wet. Nonetheless, I jumped in after pressing the button on the digital recorder and hearing the teacher say, "Go for it!"

I started off in a way designed to block the possibility that the audience might reduce my identity to my "defect." I stated my name and then said, "Just like you, I wear many hats. By this I mean I play many roles in my life. Right now, my primary role is that of a Ph.D. student. I'm also a teacher, a wife, a sister. But today I'm here speaking to you because I am a person with a mental illness—bipolar mood disorder." I then launched into a description of what mania and depression feel like. I realize now that I made confident, definitive statements about my illness such as "The hallmark of depression is an absolute lack of hope. You feel like there is no way the despair that you feel is ever going to end." I did the same when describing the highs of mania, even adding that the first time one experiences mania, it can almost be enjoyable because of the sensory enhancement and seemingly brilliant thinking it brings into one's life. I described the two poles of my illness as if the way I experienced them was the way that everyone who has my diagnosis experiences them. I believe this rhetorical choice comes from my attachment to the clinical model of mental illness—where symptoms seem to be described as standardized. I had heard enough descriptions of "racing and/or tangential thoughts, delusions of grandeur, enhanced perception of colors and sounds, etc." to be able to reproduce the language for the students.

As I continued to talk, describing my worst symptoms, my treatments, the healing process, the things that can help a person with a mental illness have a good quality of life, I found that my nervousness did not lessen. I did however experience a new sensation, the feeling of being an expert. The students seemed very attentive. I noticed no one yawning or talking to a classmate, so I chose to believe that they were paying relatively close attention. I started to feel like I had the ability to tell them what mental illness is *like*, while at the same time being aware of the huge amount of detail I had to leave out due to lack of time. I had the sensation of being the expert speaking the truth, not my truth but *the* truth about bipolar mood disorder. In retrospect, I believe this rhetorical pose allowed me the same kind of distance from my diagnosis that Phil may have been aiming for by staring off his presentation with a listing of mental health resources and statistics. Perhaps we felt the distance made possible by the expert pose aided our damaged *ethos*. Ben began his presentation with a brief history lesson of the ways in which mental illness has been conceptualized and treated over the centuries. While decidedly useful in orienting students, this choice of content also strikes me as an attempt by Ben, too, to bolster his *ethos* by establishing himself early on as an expert on mental disability.

Gloria did not position herself as an expert through her speeches. Instead, she spoke to the students in ways that indicate her stance as a rebel against the medical model. She spoke with excitement about the Recovery Movement, comparing it to other struggles for social justice:

> I consider myself a part of a movement known as the Recovery Movement. . . And the Recovery Movement says that despite these experiences being, um, treated as medical conditions, that there's a different way of looking at things. That opposed to labeling differences as disorders, people in the Recovery Movement look at mental health and health in general as part of a continuum, where people move along, everyone, whether you have a mental health diagnosis or not. Everyone kind of moves along this continuum, that parts of their life they feel better than other parts of their life. There's all sorts of reasons for moving back and forth on this continuum . . . To me it's a civil rights movement. I don't know if you guys are familiar. But people used to be diagnosed as homosexuals. And it was not doctors who sat around and decided that homosexuals aren't a different kind of people. It was a gay movement that came about``. They said we don't want to be diagnosed, we want to be accepted as we are. And they are still fighting but they are gaining rights at this point. So, I see this as a movement like that, and I hope that we'll continue to develop so that people will accept people that are maybe different. And that's not to say that I am against the medical

> movement or against medication or against any form of mental health treatment. It's just to say that people should have a *choice* about whether to take these medications of get these treatments. Because a lot of times, these things are forced on people. A lot of times they're seen as the only option and the only coping strategy. That I disagree with.

Gloria's rhetorical pose of rebel against the medical model that students have been studying may strengthen her *ethos* for some members of her audience, although others may find themselves wary of embracing a seemingly radical perspective.

At certain points of my talk, I did not feel the comfort of seeming like an expert. When I offered students examples of my aberrant behavior while ill, I felt the very uncomfortable sensation of having my skin peeled away from my body—of losing my protective coating, so to speak. I believed I had to tell the story of my psychotic break, even though it lasted only a day, because I wanted the students to understand how bad mental illness can be. Looking back, I also wonder if I was seeking a certain amount of mental illness "street cred" by describing that time I walked around town in my pajamas at 3 am, carrying a glass pop bottle to break and use as a weapon in case I was attacked. I told them how I got into the car of a man I didn't know who offered to help me out by giving me a ride. I told them how incredibly lucky I was that the man took me to a friend's house, as I had asked, rather than being someone who meant me harm.

Using the terms "psychosis" and "psychotic break" as well as "delusional thinking" felt extremely scary as I sat in front of the students because I could not read their minds to know how they might be shifting their opinion of me. Could my choice of anecdotes lead to the opinion: "Once a delusional thinker always a delusional thinker?" I did not know, and I found myself searching the faces in front of me for any clue of audience reaction. Only polite and attentive faces looked back, with the occasional, greatly appreciated, supportive smile.

That I cared about the students' opinion of me reveals my sense of the potential for them to make a leap between my diagnosis and a judgement of who I am as a person. Besides the "expert" rhetorical stance, I have noticed I aim for a chronologically distanced positioning from my illness as well. It is very important to me to stress to audiences that my two main experiences with mental illness occurred decades ago and that I have been essentially well since. Establishing this distance through the content of my speeches allows me to present myself in a way I feel is less open to stigma. I am aware that I invoke this distancing pose in this text as well with my explanations of not having had anything but the occasional "blip" of illness for years.

Sitting on my perch in front of the students on that first day, I felt like a bug brought in for inspection by a class that had recently studied the bodily workings of that bug in textbooks. Unlike a bug, however, I did have the use of words to try to describe my experience. During my time of speaking to classrooms, I have wondered what kinds of words, what combinations, what content, what styles of speaking will get the bug to seem fully human to its observers. I should stress that I felt human sitting up front that first day and on following ones. That was never in question. But I have wondered what I could say that would reveal me as *fully* human, as fully capable goods rather than damaged ones.

This chapter examines the rhetorical representation of identity as practiced by members of the Speakers Bureau and links that representation to where each rhetor stands with respect to two competing views of the nature of what is known as mental illness or mental disability. In terms of the phenomenon of narrating one's mental illness experience in public, examining my own experience has helped me discover the existence of a strong sense of self-stigma. I attribute this to the medical model's conceptualization of "mental illness" as a defect, even as I retain my belief in that model and depend on medication for maintenance of my psychiatric stability. For example, I wonder before and during each presentation "What will they think of me?" At the very beginning of each talk, before even mentioning illness, I make sure to mention that I am pursuing a Ph.D. I do so to counterbalance the presumption that a mentally ill person is incapable of a high level of achievement.

Before undertaking this study, I had not considered my illness a primary part of my identity. I had not expected to care deeply how anonymous groups of high school students might assess me as a person. I also did not expect that sharing the details of my story would begin to grow tiresome, even over the course of just four presentations. I found myself longing to get away from *that* picture of myself and back to the life I now lead. While exciting as something potentially useful in the fight against stigma, each speaking opportunity reminds me that, at least according to medical and public standards, I am "not normal," as a former co-worker once remarked when she said I should work in a flower shop rather than in the social work setting we shared.

Nonetheless, I find that after conducting my research and participating in the rhetorical work of the Speaker's Bureau, I have emerged with a greater acceptance of my identity as mentally disabled. As noted, I have tried on Gabel's statement "I am disabled," and have found that it fits comfortably. Yes, sharing the details of my disability on a regular basis reminds me that indeed, I am not "normal," or, to use a more accurate term, "neurotypical." But as I heard a Speakers Bureau member say recently, "Normal ain't nothing but a setting on the dryer!" Despite my growing comfort with my identity as someone with a mental disability, each classroom speaking opportunity with the Bureau still feels risky. In Chapter Three, I examine the risks Speakers Bureau members take by participating in what I call “deep disclosure” of our experiences with mental disability. I move from a discussion of those risks to an assessment of the benefits that deep disclosure can hold, in the right circumstances, for both mentally disabled rhetors and our audiences.

CHAPTER 3 DEEP DISCLOSURE, VULNERABILITY, AND RHETORICAL AGENCY

In Chapter Two, I explored the rhetorical means Speakers Bureau members use to represent the relationship between our personal identities and our mental disabilities. I argued that our self- representations depend on the model of mental disability to which a speaker subscribes. In an attempt to bolster an *ethos* which psychiatric diagnoses have damaged, each speaker uses the rhetorical moves I described to frame our individual classroom presentations. In this chapter, I turn to the "meat" of the presentations, the narration of "what it is like" to have a mental disability. These descriptions of the sometimes-disturbing symptoms or effects of mental disability have the potential to damage a speaker's *ethos.* Nonetheless, members of the Speakers Bureau rely on these narratives as our primary stigma-fighting tool. In this chapter, I argue that rather than having a counterproductive effect, disclosure of the troubling details of mental disability might influence speaker credibility in ways that lead to potentially generative vulnerabilities, ones that aid the fight against stigma in the classroom context.

In considering the Speakers Bureau's struggles with the issue of *ethos,* I find myself repeatedly drawn to the challenge posed by Prendergast's assessment of the mentally disabled person's basic lack of credibility in the eyes of the public--"If people think you're crazy, they don't listen to you" (57). For example, in terms of judgements passed by those in positions of authority, such as psychiatrists or court officials, she observes that the writing of schizophrenic people has no "transactional worth" (57). It is language that is not taken seriously outside of itself. To break through stigma and achieve the full dignity we seek, Speakers Bureau members need our audiences to listen to and take seriously what we have to say about ourselves and our place in the culture. Accordingly, we take rhetorical measures to construct the *ethos* Prendergast notes that our diagnoses deny us.

The cultural stigmatization of mental disability guarantees that the challenge to a speaker's credibility begins as soon as she reveals her condition, something each Bureau member does at the beginning of each classroom presentation. Like Prendergast, other scholars emphasize the risk to *ethos* inherent in the disclosure of what are described as "invisible disabilities" (Pilling 5). In Chapter One I described Johnson's assessment of the negative repercussions experienced by vice-presidential candidate Terry Eagleton when news of Eagleton's treatment for depression became public. Johnson uses the term *kakoethos* in referring to Eagleton's immediate loss of credibility in the public eye despite his disability being a thing of the past (468). Kimberly Myers expresses the need for caution in presenting information about chronic illnesses to strangers who do not already know one's professional and social competence, because negative judgements of one's ability in these arenas may follow (258). And Stephanie Kerschbaum presents the following important observation: "The reality is that disability to many still signals disqualification. Thus, because identity and agency are rhetorically constructed through mutual interaction and because many audiences still understand disability as incompetence, disclosures run the risk of undermining one's ethos" (69).

While these assessments of the vulnerability inherent in disability disclosure certainly ring true in a culture that stigmatizes disability to the extent that ours does, what I have not seen is discussion of the potentially positive impact of mental disability disclosure. Members of the Speakers Bureau all base our attempts to persuade audiences to accept us as equals on the sharing of specific details of our experiences with mental disability. We offer student audiences varying levels of what I call "deep disclosure," presentation of intimate details of the thoughts, emotions, and behaviors that mark what psychiatry would call our "episodes" of mental disability. As noted above, we take a significant risk in choosing this rhetorical tactic.

Illustrations of psychological breaks from what the dominant culture calls "reality" can affect an audience's perception of a speaker's ability to accurately depict his or her disability. And the presentation of the disturbing effects of those disabilities can turn at least some members of any audience off. By choosing deep disclosure, Speakers Bureau members make ourselves vulnerable to these outcomes. Nonetheless, we turn to deep disclosure seeking a specific payoff. As the speakers I worked with indicated in both interviews and rhetorical analyses of transcripts of their speeches, the goal is to get the audience to believe our individual depictions of how mental disability affects our lives. We want that belief to help audience members reach through the barrier thrown up by stigma and draw closer to us as human beings.

In what follows, I examine the work of two Speakers Bureau members, Phil and Ruth, chosen because their presentations offer listeners varying degrees of deep disclosure. By paying close attention to rhetorical choices these two speakers make, I seek to extend research that theorizes *ethos* in terms of vulnerability, thereby calling into question the idea that disability disclosure should always be thought of in terms of risk. Instead, I make the argument that through deep disclosure, a mentally ill speaker can add to rather than damage his *ethos*. Yes, deep disclosure does leave that *ethos* vulnerable to damage, but vulnerability can be something beneficial in instances when it moves the speaker closer to the audience's ability to embrace or reject his plea for acceptance. By understanding the benefits of deep disclosure in the fight against stigma, both rhetorical and disability studies can gain a needed weapon in the struggle to make the truths of some of the still marginalized members of our culture meaningful to those whom sociologist Irving Goffman long ago termed the "normals" (24). This possibility serves not only a goal of both disciplines but a crucial community need as well.

As rhetors operating under the constraints of stigma, Speakers Bureau members have a huge stake in Prendergast's assessment— "If people think you're crazy, they don't listen to you." We want audiences to listen to us *because* we are "crazy," crazy but also rhetorically attuned. By this I mean that while we all experience periods of disconnection from what the dominant culture would call "reality," periods of varying length, our experiences have also given us a strong awareness of the ways in which the stigma surrounding mental disability may have damaged our credibility. In what follows, I show both how we have internalized this awareness and how we attempt to bolster our credibility through the rhetorical stance of deep disclosure. Ours is a paradoxical task, however. At the same time as we need to persuade the audience that we are indeed "crazy," through credible narrative constructions of mentally disabled selves, we have to imbue those selves with the *ethos* or believability that can contradict the cultural notion that the crazy are not to be believed. Without this, our anti-stigma message will miss the mark.

The body of this chapter begins with an elaboration of three key concepts: *ethos*, deep disclosure, and vulnerability. I follow with description of how two speakers navigate the use of disclosure in their classroom presentations, emphasizing how one person makes no effort to shore up the credibility that deep disclosure can damage while the other does take steps to protect himself from that potential outcome. I follow this exploration of speaker vulnerability with one focused on ways in which the audiences of our presentations might find themselves vulnerable in ways both seemingly negative and potentially positive. Finally, I move to an explanation of how vulnerability on the part of both the speakers and their audience members, positively reimagined, can reap benefits in the form of lessening the perceptual distance between the two. Through my explanation of the workings of deep disclosure, I make the overarching argument that mentally disabled speakers should push for the greater vulnerability inherent in this technique because doing so creates an opportunity for at least some audience members to better understand and therefore more fully accept a stigmatized "other."

Throughout the essay, in discussing what I imagine might take place in the classrooms we enter, I offer images of symbolic, rhetorical movement. I describe Ruth and Phil as offering varying degrees of narrative disclosure in the hope that at least some in the audience may choose to "move closer to," or empathize with, them as human beings. In her discussion of narratives in political work, Francesca Poletta describes a legal theorist's explanation of the workings of empathy:

> . . . Henderson argues that effective narratives produce an empathetic understanding in their audiences. They make it possible for audiences to put themselves in the narrator's shoes and to understand her experience "phenomenologically," and in all its particularity. When that happens, Henderson goes on, it becomes impossible to stereotype the narrator or her experience. Instead, audiences find themselves obliged to think about the law not abstractly but in terms of its effects on real people. Empathetic narratives have the same effect on legal decision makers, Henderson argues, pushing them to jettison the stereotypes that inhibit just decisions. (126)

If we substitute "stigma" for "the law" above, and "those who stigmatize" for "legal decision makers," we can see how this description of the relationship between narrative and empathy applies equally to the anti-stigma work of the Speakers Bureau.

***Ethos*, Deep Disclosure, Vulnerability**

In keeping with our understanding that students may expect people with certain diagnoses to exhibit erratic speech or behavior, Bureau members are careful to speak calmly and coherently during our presentations. For example, I know that after I tell students I have a bipolar mood disorder, they may expect me to speak in the rapid-fire, highly tangential way associated with that diagnosis. Instead, I make sure my speech is measured and my presentation well-organized. Rather than being the “bad man speaking poorly” that Johnson says audiences need to learn how to accommodate in instances when the speaker has a disability such as mental disability, Speakers Bureau members work hard to come across as the “good man speaking well” (476).

At the same time as we convey this image, which in and of itself has stereotype-fighting power, we have to persuade our audiences that the person in front of them at times experiences a complete breakdown of the full rationality currently on display. Our madness has to be credible. We have to achieve this rhetorical effect because each of us seeks to convey the message: “I am a face of mental disability. I represent what mental disability looks like although I am not experiencing what are known as ‘symptoms’ right now.” We construct this message carefully through deep disclosure of the details, the emotions, thoughts, and behaviors we experience when we “experience an episode.”

As Gloria explains: “You have to tell them the things you go through. That’s what really captures audiences, when you’re really good at telling them what you go through . . . Invite them in and be gracious. Show them what is what. I’m speaking very symbolically here. Show them this is what depression is. This is what it looks like. This is what it smells like.” By saying one must be gracious, Gloria refers to the need to generously share what we have to give—the intimate details of difficult periods in our lives. We should invite the listener into our experiences by recreating them vividly, so the audience is “captured.” In other words, the speaker who excels at this kind of deep description hopes to get members of the audience to draw closer to the thoughts, emotions, and behaviors being described. If the audience cannot touch the speaker’s experience, so to speak, it might at least begin to imagine and therefore recognize a human reality different from its own.

As soon as a speaker has convinced audience members of the existence of her mental disability through deep disclosure, however, she runs into the problem described by Kerschbaum—many people still equate a disclosure of disability with incompetence. Disclosure of mental disability can make Speakers Bureau members vulnerable to a damaged *ethos* because our disabilities are thought to affect our connection to reality. Even though mental disabilities express themselves episodically, with sometimes very long periods of wellness in-between episodes, the myth of “Once mad, always mad” persists (Johnson 468). If successful in our efforts to represent ourselves as people who experience mental disability, Speakers Bureau members then face that possibility that audience members will doubt the accuracy of our careful attempts to represent the vicissitudes of our conditions through speech.

For example, autistic rhetorician, Melanie Yergeau, writes about the frustration of having non-autistic scholars conclude that autistic people cannot understand or accurately represent their own thinking. She explains, “[A]utistic people exemplify inherent unreliability. Whether in published autobiographies or in the blogosphere, autistic narratives are regarded as questionable (un)truths” (14). Kerschbaum also attests to the potential loss of credibility that can accompany a disclosure of disability (in her case, deafness) when she notes: “[I]t is only when I find my interlocutors willing to respond to me and *take seriously my version of things* that I can speak to them” (68) (emphasis added). As the discussion of Ruth and Phil’s presentations will show, a speaker can take steps to bolster this damaged credibility or simply count on the audience to take her seriously.

Of course, not all disclosures of disability, even those of mental disability, signal a damaged *ethos* to audiences. Peter Wayne Moe examines a speech given by actor, Michael J. Fox, to members of Congress. Fox gave the speech while not taking his Parkinson's medications and so "performed" his neurological disability for the audience. Moe argues that Fox's visible, physical symptoms helped to establish his *ethos* as a representative of people with Parkinson's disease. By putting his body on display, he got the audience to consider which of his personas should be considered the "normal" one, a level of message control deeper than that usually afforded to disabled people and one Moe attributes to the credibility Fox gained as a speaker inhabiting the physical effects of his disability (355).

It is also possible that being the people who live the realities students have been studying in their psychology classes may grant Speakers Bureau members *extra* credibility rather than decreasing it. As Gloria puts it: "We're in a unique position. Only we can teach it from our angle. I mean, it's one thing for a teacher to get up there and say, 'This is what mental illness is.' This is *us* saying who we are . . . taking control of the message we send about ourselves. I think a lot of teachers might teach it as 'these poor people' or 'these horrific enigmas' you know, to society. But we're putting a face on it. We're saying, 'No, this is who we are. We are just like you, or we're not much different from you.'" In noting that speakers take control of the message we send about ourselves, Gloria assumes a credible speaker *ethos* that will guarantee the positive reception of that message.

Ruth's Rhetoric—Seeking "connection" Through Deep Disclosure

During one of Ruth's presentations, a student asks if people ever imply that she is "stupid," referring angrily to the "Why doesn't she just eat?" comments he hears about an anorexic friend. When she responds by commiserating with the student's frustration at such unsympathetic remarks, Ruth illustrates an internalized sense of the damaged *ethos* that can accompany disclosures of mental disability. She expresses her frustration at not being believed: “People don’t . . . If they have never experienced it, they don’t get the legitimacy part of it.” Her entire presentation, with its detailed description of the thoughts, emotions, and behaviors that accompany her disability, clearly seeks to establish the legitimacy of bipolar mood disorder. Describing others’ responses to her experience of not being able to get out of bed when she was depressed, Ruth explains: “Cause it looks like you have a choice. It looks to people like you are being lazy. And people will say ‘Why don’t you just go back to work?’ or ‘Why don’t you go for a walk? Why don’t you get a dog?’ You know? ‘Why don’t you go to funny movies?’”

In her analysis of a transcript of her speech, Ruth circles this section and writes: “I say this to fight stigma about mental illness, the unfairness of not being understood. I feel angry when I say this, resentful. I think the audience sees how this has happened to them, how they’ve been the person in desperate trouble or the person not accepting someone else’s truth.” The key phrase here is “not accepting someone else’s truth.” Ruth comes to her speaking engagements with this bitter experience of not being considered credible when she tries to tell others about her experience of mental disability.

In the classroom, Ruth offers the audience deep disclosure about her experiences with mental disability. Ruth’s description of being suicidal is one example of the rhetorical invitation that group leader, Gloria, encourages speakers to provide:

> When I’ve been suicidal, when I was most dangerous to myself, I wasn’t emotional, I wasn’t ‘Oh I want to die!’ I was very calm. I was in a problem-solving mode . . . just kind of like—what comes to mind is you know you’re going to have a test on Friday, and yeah, you make a plan. You’re either gonna wait ‘til the last possible minute, or

> you're gonna do a little bit each day to get ready for the test. Well, I was in this do a little bit every day to get ready for the test kind of plan. When you're suicidal, they always ask, 'Have you thought about how you'd do it?' Well, I thought about how I would do it. Then they ask, 'Do you have the means to do it? Do you have the gun?' And I had the means to do it.

By providing vivid and detailed description of her internal thought process during her time of depression, Ruth tries to make the audience a part of that process. Her rhetoric seeks to invite them in, especially through the surprising analogy between preparing for a test, something any student can imagine, and preparing to commit suicide. She offers play-by-play details in an attempt to give the listener necessary proof that she has experienced depression and that depression is something real.

Ruth's experiences with disclosure about the nature of her disability have shown her the risk inherent in this move. She chooses to deal with the ever-present vulnerability to a damaged *ethos* by leaning into that vulnerability. She does this by insisting on speaking extemporaneously during each classroom presentation, unlike some other speakers, who carry notes or talk primarily from a memorized script. Asked about this rhetorical choice, she explains that speaking off the cuff allows her to be "present" in the room, a term that translates to "vulnerable" as she describes why she avoids "canned" speeches:

> It is tempting**.** I can see why people do it . . . If I did it, my feelings would be less. I wouldn't be feeling my feelings while I was giving it if I was doing it the same way every time. And why is that? Because then it would be just like something . . . It would feel to me that it was just something that I read, that I read in a book, and I'm telling them what I read, instead of, like when I do it, I can recall. I can recall how

> bad it was or what it felt like to suddenly have it lift and all that. And I think that might be why. It's just being genuine. I'd rather.

Being genuine or authentic, according to Ruth, involves feeling the emotions associated with what one is narrating, i.e., making oneself emotionally vulnerable in the act of speaking, vulnerable to re-living the experience being narrated. In an interview, she suggested that feeling the emotion of what one recounts, at the moment of recounting it, gives one's words greater connection to the reality they describe and thus a greater ability to reach, or persuade, the audience.

In this way, Ruth does not put up any rhetorical barriers between the way she narrates her experience and herself as a person. She does not make attempts to shore up the credibility that her clear depiction of herself as mentally disabled might damage. Instead, she deals with the vulnerability inherent in deep disclosure by embracing it in the hope that doing so will get students to, to use her word, "connect" with her as a human being. She seeks the trust of the audience by portraying herself as extremely honest. With a laugh she asks, "What's the point of leaving anything out?" Ruth's reliance on the audience's willingness to accept her level of disclosure without the provision of any rhetorical means of bolstering her credibility does leave her open to the possibility that some members of that audience will reject her self-representation. Some could side instead with the cultural stereotypes that suggest depressed people are "fakers," the very notion Ruth has spent time trying to debunk.

Phil's Rhetoric-Seeking "Understanding" Through Holding Back

Only part of Phil's presentation consists of what I am calling deep disclosure. Unlike Ruth, he does attempt to navigate the tension between the need for deep disclosure and the need to be found credible as a speaker. He does this to achieve a goal he mentions in his interview and his rhetorical self-analysis—getting the students in the audience to “understand” mental disability. In other words, he wants audiences to know how mental disability works. In the first part of his presentation, he gets around the audience’s potential expectation that he is disconnected from reality by aligning himself with medical science, an entity considered highly credible by the general public when it comes to discussions of mental disability, even as strong opposition to the workings of the psychiatric establishment exists (Price 10-12, 33-37). The beginning section of Phil’s speech contains no direct description of the emotions related to his experience of paranoid schizophrenia. Rather, it centers on the medical model of mental disability and details the biological origins and treatment of what he presents as brain diseases. He offers information about the origin, workings, and treatment of his own disability, stressing that mental disability has a biological origin, that schizophrenia results from low dopamine levels, and that his schizophrenia has been effectively treated with a particular medication.

Through this linkage to the language of psychiatry, Phil portrays himself as a person living a reality that science clearly understands. The contention that science can explain mental disability carries with it the somewhat comforting sense that things are under control, that there are answers. By presenting his reality within the context of science, Phil attempts to present that reality as valid, explicable, and therefore acceptable. In this part of his speech he distances himself from deep disclosure, presenting mental disability as a monolithic, comprehensible entity rather than an individual experience.

The fact-based, unemotional rhetoric Phil uses in the beginning of his speech implies internalized knowledge of the public perception of schizophrenic people as irrational and incoherent. Beyond the desire to inform, I believe his reliance on psychiatric explanation, presented in a teacherlike fashion, reflects a desire to combat possible negative perceptions about how a schizophrenic person speaks and behaves. In response to the interview question, “Do you think the Speakers Bureau speeches affect the stigma that surrounds mental disability in any way?” Phil responds: “By giving students an understanding of what mental illness is about. I would also hope that they would have a clinical view of mental illness. Asked “Why a clinical view?” he responds that he seeks to impart “. . . almost a scientific view and a medical view. If they [have] that, I think they’ll be more fair to those that have mental illness.” Phil’s clear, unequivocal style of presentation contradicts any unfair expectations an audience may have of encountering the “word salad” or “verbal diarrhea” attributed to speakers with schizophrenia (Walters 86). By structuring his speech in the logical fashion listeners expect from rational speakers, he seeks to give his words transactional worth. Presented through the persona of scientific “expert,” his rhetoric initially seeks to get the audience to understand and accept Phil’s conception of how mental disability works.

As his speech progresses, Phil does move from a scientific discussion of mental disability into a description of his own experience with paranoid schizophrenia. In the following passage, he discloses details many people would find highly embarrassing to reveal:

> Delusions are one of the symptoms of schizophrenia. You may ask “What’s a delusion?” If I say a delusion I have . . . The delusion says, ‘They’re monitoring everything you think, do, and say.’ Well what am I supposed to do with that? What I do is, I put it in a box. It’s a therapeutic device. It’s when I can’t figure out the delusion. Sometimes someone may have a delusion about a satellite beaming down on you and monitoring your brain . . . If I don’t want to think about it anymore, I put it in a box.

By being willing to disclose these potentially embarrassing details, Phil presents his experiences as credible representations of mental disability. He offers the audience further engaging description when he describes his experience with hallucinations of various types: “Sometimes I tell myself everything I see is a hallucination. But what do you do about that if you think you have a hallucination? I always tell my symptoms, I say, ‘I want to see what is there. I want to hear what is there. I don’t want to have a hallucination!’” Here he speaks about his symptoms as entities outside of himself, as things he can fight by “telling” them he does not want to experience them. He rhetorically reaches out to the audience to get them to take on his quandary, asking “What am I supposed to do with that?” about delusions and “What do you do about that?” regarding hallucinations. Although deep disclosure does not constitute his entire presentation, as it does Ruth’s, Phil does use it in instances such as these. In doing so, he takes the chance that students in the audience will reject him as corresponding too closely to stereotypes of schizophrenic people that correlate the presence of delusions and hallucinations with danger to others. This despite his careful attempts to construct his *ethos* on the basis of the science surrounding mental disability.

The possibility of rejection by the audience is one that Speakers Bureau members constantly face as part of the act of representing our realities to the students we address. What drives us, I believe, in the hope that some of these students will respond to our disclosures with a corresponding vulnerability or openness. We hope they will grant us the credibility we require to give our self-representations the power to persuade.

Deep Disclosure and Audience Vulnerability

In providing deep disclosure, Speakers Bureau rhetors create vulnerabilities not just for ourselves but for our audiences as well. Some of these vulnerabilities involve exposure and can be experienced as threatening. They must be considered in any attempt to assess the value of deep disclosure. But some can be experienced by audience members as openings leading to positive rhetorical outcomes such as a greater connection with oneself and between self and other. The possibility of such outcomes indicates the value of accepting the risk to speaker *ethos* that deep disclosure necessitates. In his meditation on vulnerability and rhetoric, Richard Marback makes a useful comparison between empathy and vulnerability as they apply to audiences for another's rhetoric. Empathy involves an openness to the influence of the other but includes the possibility of controlling one's response so as not to risk one's own integrity. Vulnerability, however, involves greater risk, a risk to our sense of self, i.e. our integrity, or our own views. As Marback puts it: "To be vulnerable is to be exposed to forces beyond our control, forces that have the potential to disrupt who we are" (6-7). He does not consider vulnerability a necessarily negative thing, however, pointing out that certain vulnerabilities that involve positive actions can be considered "expressions of integrity" (7). The Speakers Bureau student audiences may find themselves made vulnerable by the deep disclosures of the person at the front of the room and this vulnerability can take either a threatening or an inviting form, depending on the ways in which the listeners respond to what they are hearing. Some of those responses may be automatic and others may depend on listener choice.

Trauma is one potential, automatic response that can affect students if they themselves have experience with a mental disability or know friends or family members who do. Hearing about the difficult experiences of people with the same conditions as they have or know of in loved ones can cause fear and hopelessness in listeners despite the Speakers Bureau's charge to present our stories in an ultimately hopeful light. Fear may also result from getting the information that many mental disabilities strike people in their teens and early twenties, a point that Phil stresses in the information portion of his presentations. In her discussion of "trigger warnings," instructor statements to students that some course materials might generate negative emotions and even traumatic flashbacks, Alison Kafer refers specifically to the effects of disability disclosure in the classroom. She notes that these disclosures “often will involve histories of trauma.” “Given such histories,” she asks, “what are the effects on, and what are our obligations to, the people we disclose to in our classrooms, our conference rooms, our conversations” (4)? At a training for potential new speakers, Gloria stressed the importance of caution when considering what kinds of details to disclose to impressionable, young minds.

Seeing seemingly rational people talking about their experiences with mental disability may also provide a challenge to audience members’ senses of self. If they perceive themselves as “normal,” the speaker presentations might threaten the inviolate nature of that perception. For students without mental disabilities, choosing to draw closer to the often-disturbing details of a speaker’s experience requires them to adopt a vulnerable stance in the rhetorical situation. Accepting the visibly rational speakers’ narrated realities means students have to acknowledge that mental disability might affect them someday. As Sander Gilman describes it:

> The banality of real mental illness comes into conflict with our need to have the mad be identifiable, different from ourselves. Our shock is always that they are really just like us. This moment, when we say, ‘they are really just like us’ is most upsetting. Then we no longer know where lies the line that divides our normal, reliable world, a world that minimizes our fears, from that world in which lurks the fearful, the terrifying, the aggressive. We want—no, we need—the ‘mad’ to be different . . . (13)

Madeline Burghardt also notes this potential source of vulnerability for the students by referencing M. Shildrick’s contention that “the vulnerability evoked when in close contact with disability is threatening, not because of profound difference, but rather because of proximity”

(560). In other words, attempting to understand the experiences of the speakers requires many of the students in the audience to admit to similarities between themselves and the people they might prefer to think of as a comfortably distanced "them."

The potential for vulnerability that audiences experience as inviting also exists each time a Speakers Bureau member makes a presentation. It is true that faced with deep disclosure about another person's mental health struggles, audience members can choose to move away, symbolically, by considering the disclosed details further support for stigma: "See, this person is very strange and truly has nothing in common with me as a human being!" Bureau members run this risk every time we narrate our non-normative experiences. As Kerschbaum explains, disability disclosures are not one-way streets. The audience for the disclosure must accept the rhetor's constructed disability identity for the disclosure to succeed (62). The audience has this power in the rhetorical situation.

But audiences have another choice. They can make themselves vulnerable to the influence of the mentally disabled speaker in a welcoming way, risking their sense of self by opening themselves up to the possibility of broadening that sense. If an audience member allows the speaker to move towards him or herself through deep disclosure, that person makes possible a challenge to the integrity of something he or she holds dear. What the Bureau members' intimate revelations challenge, I suggest, is the neurotypical students' faith in the idea of normalcy. To maintain her sense of self, a student approaching the speakers' revelations with good intentions would need to expand her idea of what it means to be human. She would have to accept people who experience strange emotions, thoughts, and behaviors into the fold of what it means to be "us." The audience member can respond to the Speakers Bureau member's willingness to make themselves vulnerable through deep disclosure by moving towards that speaker in terms of a new perception of mental disability as, for lack of a better term, a natural part of human experience.

Agency Through Vulnerability

"If people think you're crazy, they don't listen to you." Speakers Bureau members openly disclose, to varying degrees, the details of our madness and intend that people will listen to us. Not only that they will listen to us but that they will accept our message of inclusion. In order to show ourselves as credibly mentally disabled, members of the Speakers Bureau make ourselves vulnerable through deep disclosure. The vulnerability thus created—vulnerability to the charge that as mentally disabled people we are not capable of accurate self-representation—is worth the risk. Through that same deep disclosure, we give our audiences the opportunity to respond to us with a productive vulnerability of their own. By making ourselves vulnerable to our student audiences in rhetorical situations that encourage them to also make themselves vulnerable, the Speakers Bureau participates in scenes with the potential for rhetorical agency.

Carolyn Miller calls on us to consider rhetorical agency a "kinetic energy," one that is owned neither by the speaker or the audience but by the speaking (or writing) event (147). For my purposes, the most important part of Miller's discussion is her argument that this kinetic energy between speaker and audience can only exist if both the speaker and the audience members attribute agency to each other (150). As she explains, "Rather than having to having to posit an agent function existing in a totally abstract space, we can position it within the habitual or imposed patterns of attributions that rhetor or audience is prepared to make. The agent function, then, would be simply an indication of the ability or willingness of participants to attribute a particular form of agency" (Miller 151). In the classrooms where Speakers Bureau members appear, the assumption of rhetorical positions of vulnerability plays a role in these attributions of agency.

By assuming the vulnerable rhetorical stance that comes with the provision of deep disclosure, members of the Speakers Bureau grant to the students in our audiences the power to reject the life narrations put before them. They can hear our deep disclosures and choose to find us repulsive. We hope, however, that the detailed descriptions we offer will instead make it enticing for audience members to draw closer to the realities being described. And by assuming a vulnerable rhetorical stance, the audience members, in turn, grant to the speakers the power to affect the audience's perceptions of people with mental disabilities either positively or negatively. By granting the speakers credibility, they make themselves open to the construction of identities that might seem disturbing, especially when that openness includes the acknowledgement of the fact that mental disability can touch their own lives in some fashion. They open themselves up to believing in the existence and acceptability of realities they cannot completely understand. In the context of the Speakers Bureau's attempts to fight stigma through narratives of self-disclosure, the speaker and the audience member's willingness to take a vulnerable stance—to grant potentially change-producing agency to the other—can be seen as something necessary to rhetorical success.

The success of a given speaker's classroom presentation depends, I believe, on the extent to which we are willing to deeply disclose potentially embarrassing details about our experiences, making ourselves vulnerable to the audience members' judgement. How close are we willing to move towards the audience's ability to embrace or reject us? Ruth is willing to move very close, Phil less so. A highly vulnerable stance on the speaker's part may open up the possibility that at least some audience members will respond with a corresponding act of vulnerability. Responding to the speaker's openness, some students might find themselves willing to try to imagine experiencing the thoughts, emotions, and behaviors depicted through speech. In this way, the students may attribute to the speaker the capacity to change their perceptions about mental disability. Moving closer through the act of attempting to understand at least something of the speaker's described reality could help the audience to see Speakers Bureau members as part of "us" rather than as part of "them." In the classroom, an agentive rhetorical effect might be achieved, not through the actions of one person or group but through the interaction of elements, what Marilyn Cooper calls the "dance of perturbation and response as agents interact" (qtd. in Kerschbaum 64). When Speakers Bureau members speak through the vulnerable stance that makes our individual realities more palpable to people who, for the most part, do not know them, we open up possibilities for a commensurate and co-occurring "return of serve"—the acceptance of life truths that need to be heeded in order for the public to better recognize all of its citizens.

CHAPTER 4 CONSIDERING DISCLOSURE IN ONE'S OWN CLASSROOM

As described in Chapter Three, members of the Speakers Bureau rely on the rhetorical tactic of deep disclosure to move the stigma-fighting effort forward. We make ourselves and our audience members vulnerable in the hope that this vulnerability will prove productive, drawing both speaker and listener closer to the other in understanding. In this chapter, I move away from the Speakers Bureau, undoing what I did in previous chapters by introducing and interrogating a situation in which the vulnerability engendered by deep disclosure may not have productive results. I do so to argue that the context of deep disclosure matters and to explore how it matters. I make the claim that it is possible, in some contexts, to fight stigma without engaging in public disclosure of one's mental disability.

Deep disclosure in the Speakers Bureau context comes with risks that each speaker accepts—the risks of being considered incompetent, not credible, and simply not fully human. But there is safety as well in the relative anonymity of this organization's work. Because we do not have an ongoing relationship with the young people we address, their influence on our lives is limited. When we enter high school and college psychology classrooms, we do not have an identity outside of "the mentally ill person who is here to talk about what living with mental illness is like." Even when we reveal other aspects of our identities to encourage the students to think of us as complete human beings, the students continue to exist for us as pure audience. We enter their classrooms as strangers, disclose troubling aspects of our lives to try to persuade them not to stigmatize people with mental disabilities, and leave as strangers. Interaction ends there.

In other contexts, such as employment situations, members of the Speakers Bureau are not strangers and thus do have to consider the possible risks inherent in disability disclosure. For example, when I enter my own undergraduate writing classrooms, I have the identity of "teacher," one that my students become familiar with as the semester progresses. As a writing teacher, I choose not to make even a limited disclosure of my mental disability to students. While deep disclosure serves my stigma-fighting goal as a Speakers Bureau member, I keep the mentally disabled aspect of my identity separate from my overt teacher identity. I see the latter as composed of a set of functions I perform in and outside the classroom. As long as my state of mental health allows me to perform those functions well, I see no reason to risk having my workplace competence called into question by a psychiatric diagnosis. A few semesters ago, a classroom incident that stigmatized mental disability challenged this decision to keep my condition hidden. The incident left me both eager to let students see my "mark" and frightened of doing so. This chapter explores ways in which instances of ableism in the classroom are fraught for mentally disabled teachers. In it, I ask which positionality—mentally disabled person or neutral instructor—might better serve a teacher's goal of addressing such ableist incidents productively.

In what follows, I describe what took place in the classroom that day and interrogate the pedagogical implications of my immediate reaction—the overwhelming desire to disclose my bipolar mood disorder. I explore what is at stake for mentally disabled teachers and students when the realities of mental disability stigma and pedagogy intersect. I examine how such teachers can get students to engage the issue of mental disability when it arises in the classroom, engage it in a way that involves accepting the idea of mental difference rather than rejecting it. By asking "What could I have done?" about the stigmatizing incident, I seek to contribute to the ongoing discussion about the advisability and potential of teacher disclosures of mental disability. As in the previous three chapters, I continue to use the term "mental disability" to refer to what psychiatry refers to as "mental illness." I use the former term in keeping with the disability studies contention that psychiatrically diagnosed conditions, while impairing, are not medical defects.

Like the mostly high school aged students the Speakers Bureau addresses, college students are young enough to be still forming their attitudes towards people with mental disabilities. Thus, responding pedagogically to instances of mental disability stigma in the classroom matters. As Caroline Mann and Melissa Himelein observe about typically popular college psychology classes:

> There are few places in society where we have access to such a wide and captive audience, where a non-intrusive stigma intervention could be implemented with little extra effort or cost. To wait and attempt to reach these young adults after their attitudes have solidified and they have scattered throughout the workforce would be a major undertaking, with diminishing chances of success. (549)

The stigmatizing incident in my classroom, which I describe below, involved a highly diverse set of students. They were united, however, in amusement at one student's comment about bipolar mood disorder. My questions about how a mentally disabled teacher might respond to such ableist incidents have everything to do with Mann and Himelein's description of the classroom as a "captive audience." I seek to understand how to make the most productive use of this captivity in which teachers play a significant role.

Frozen by Laughter

Like any instructor, I build a classroom persona as each semester of teaching progresses. Part of the construction of my persona involves decisions about what details to reveal to students. A few semesters ago, I found myself teaching an ambitious, enthusiastic, intelligent group of young adults in a service learning class our university calls Writing and Community. Based on the urban justice issues discussed in class, it made sense, at one point in the semester, to tell the students about my background as a housing/homelessness activist. I enjoyed their amused reactions to my revelation that I had been arrested “not once, not twice, but *three times*!” for civil disobedience. I felt comfortable making this disclosure because my “criminal record” is a matter of pride for me rather than a matter of shame.

What I chose not to disclose to that class was the mental disability aspect of my identity. While unashamed of my condition, I nonetheless feared the public shaming, the stigma, that can attend its disclosure. I did not want my students to consider me dangerous, irrational, or incapable of performing my duties in any way: “She’s crazy, and she’s grading our papers?!” If I am honest, I can say I chose to enjoy the privileged position of relative respect and human dignity that “passing” as neurotypical allowed me in the classroom (Wolframe 3).

Despite my regular participation in the activities of the Speakers Bureau, I was completely unprepared for the day the topic of mental disability arose in my own classroom. I had just finished describing a colleague who experimentally alternated teacher personas from semester to semester. One semester, he would approach his class in a very friendly fashion. The next semester, he would come in with a much tougher stance. Hearing this, a student, Avi, responded with “Sounds like he’s got bipolar mood disorder!” The entire class burst out laughing. Mortified, I desperately wanted to say something to counter the swirling derision. Instead, I found myself frozen and smiling along. I felt outnumbered and powerless in the face of their obvious amusement at the thought of my disability. Their reaction and its seeming universality stripped me of my rhetorical agency. I did not feel capable of saying anything that would affect the situation. At that moment, I did not have rhetoric that would transform the derision into respect or at least empathy.

Here was an opportune moment to address stigma, it seemed, if I could just harness its potential in the right pedagogical way. I forced down my immediate impulse—to give the class pause by coming out the them about my own disability. I wanted to beat back the stigma but found my tools limited. All I felt I had was disclosure—the ability to say, "Hey, please don't laugh. I have a bipolar mood disorder, and it's not something to laugh about!" This would have silenced the class, certainly, and would have shamed Avi. But these were not my goals. I wanted to *permanently* end the stigma so clearly on display. Standing in front of the class as they laughed, I found my mind a blank. I also encountered a sense of shame, knowing I was letting my sisters and brothers in mental disability down by smiling along at bipolar mood disorder posited as a joke.

Despite the overwhelming desire to disclose, I froze in class that day due to the emotions and potential consequences the very thought of such an action brought to the fore. Listening to the students' laughter, I felt extremely vulnerable and let that sensation keep me silent. I did not feel comfortable leaning into my vulnerability in the way I describe Ruth doing through deep disclosure in Chapter Three. I did not feel ready to embody the subject of the students' laughter. In the classrooms Speakers Bureau members enter, stigma exists as a potential. We know the students live in a culture saturated with images that denigrate us, but we do not usually encounter direct instances of stigma. In contrast, Avi brought stigma into the writing classroom that day in a concrete way. Rhetorically, this intrusion required me to "think on my feet" as a rhetor rather than presenting prepared material the way I was used to doing as part of the Bureau. I found myself unable to do so.

As noted, members of the Speakers Bureau risk rejection by people they most likely will never encounter again. If I revealed my mental disability to my class in response to Avi's comment, I risked rejection by people with whom I had an ongoing, working relationship. Disclosure could strip me of the respect and concurrent authority I believed I needed to carry out the functions of my job.

My newfound sense of vulnerability created a problem in the classroom because it stood in the way of my belief, as a teacher, that I needed to make use of the teaching moment the stigmatizing comment had created. As an anti-stigma advocate, I heard an equally strong inner voice saying, “Do something!” Among my students, there must have been at least a few, if not more, who had experience with mental disability or knew people who did. They, at the very least, could have used a discussion of mental disability that did not involve mockery. Despite feeling vulnerable, I knew it was my duty as a teacher committed to socially relevant education to decide how to proceed.

What I Had to Lose

One emotion silenced me in the classroom that day—fear. I felt fear at the thought of disclosing a highly-stigmatized aspect of my identity. I did not want to begin wondering what 22 sets of eyes might now see as they looked at me. It believed it important for my *ethos* that my students see me as capable, a quality that culturally circulating stereotypes of mental disability negate. As the teacher, I was used to having significant credibility in the classroom setting. Disclosure of mental disability could eradicate that *ethos*. Worse still, it could leave me with the *kakoethos*, or “bad state” Johnson describes in her discussion of Senator Terry Eagleton (462). In a class focused on rhetoric, a teacher with *kakoethos* would be open to insinuations about her ability to pass unaffected judgment on student writing and student performance in general. Standing in front of my laughing students, I did not relish revealing my position as someone whose rationality would be brought into question by *kakoethos*, not when rationality is the unspoken “minimum qualification” of the instructor’s job.

I know that the symptoms of a mental disability such as mine only occur episodically, that to be “mentally ill” does not mean that one is experiencing symptoms at all times. Only during an “episode,” to use psychiatric parlance, is lack of rationality even an issue. But my students, steeped in cultural stigma as I assumed them to be, may not hold this view. They may see the situation as “Once mentally disabled, always mentally disabled.” I found myself wondering if disclosure would make my students scrutinize my every move, especially because bipolar mood disorder remains a highly-stigmatized disorder as compared to, for example, depression. The wild “highs” the public associates with the former disability make it easier to mock. I have a hard time imagining a classroom laughing at the mention of depression as a condition on its own.

I feared losing authority if my students knew I had a disability that from time to time could affect my ability to think, feel, and behave rationally. I wanted to maintain my authority to set the parameters of a class, to keep discussion moving along, to evaluate student work, etc. These endeavors require that students have faith that you, the teacher, know what you are doing and are capable of doing it. In a way, the expectation of pervasive teacher authority is an ableist paradigm, one that does not account for instructors who may not always be able to meet the standard. For example, students expect their teachers to have their thoughts, emotions, and behaviors under control at all times. The possibility of my students losing faith in my ability to perform in the expected way was terrifying. While the institution grants the teacher her authority, the doubt of students can take it away.

When I thought later about my students laughing at the mention of bipolar mood disorder, I wished I could, through disclosure, get them to put aside their clear stigmatization of people with mental disabilities and replace it with the gifts they had in their power, as an audience, to bestow on me—the attributions of respect and dignity that all stigmatized people seek. In saying this, I clearly give all the power in the rhetorical situation to my students. This is what stigma can feel like. Fighting it verbally can involve a stance of supplication, at least when using the narrative disclosure tactics of the Speakers Bureau: "Please return us our dignity as fellow human beings!" Standing frozen at the front of the class, however, I felt distinctly vulnerable to the possibility that I might speak out, might tell a story that "put *my* face on mental illness," and still not receive the respect I craved for the newly revealed aspect of my identity.

During a later discussion of my dilemma, a colleague asked bluntly, "Why disclose?" I responded that to do so would be to seize a potentially powerful teaching moment, one which would give my students an opportunity to engage directly with a stigmatized "other." Identifying myself as that "other" could have opened the chance for me to de-stigmatize not just my own mental disability but such disabilities in general. Eager to enact that kind of a perceptual shift whenever and wherever possible, I came away from the incident wondering how I could respond to a similar incident of stigma: What kind of commentary, what rhetoric, could have turned the laughter into a transformative discussion of mental disability? This question has broader implications for other mentally disabled teachers who grapple with the issue of disability disclosure in the classroom. My scholarship is a small attempt to add to this discussion, with the understanding that the pedagogical fight against stigma can, student by student, lead to a more progressive and inclusive citizenry.

An Initial Pedagogical Response

After the incident mentioned above, I set to work coming up with a proper pedagogical response—an answer to “What should I have done so as not to lose a powerful teaching moment?” I made a one-day lesson plan because I knew I could not spare more time for the stigma issue in a tightly scheduled, service learning focused writing class. The Speakers Bureau’s method of fighting stigma through narrative disclosure drove my thoughts, as did my belief that any classroom intervention would have to involve significant student discussion of the stigma that attends psychiatric diagnoses. As disabled college instructor, Deshae E. Lott, observes: “Although on one level student silence regarding another’s disability may suggest an embracing of the Other, on another level I know that to truly embrace alternatives and differences requires carefully considering them and grappling with the interplay of embedded cultural constraints” (149). Like Lott, I wanted my students to struggle, to think about and write about what influences in their lives led them to the perception of mental disability that made them burst out laughing at the very mention of it. Like Lott, I wanted to encourage students to examine why the “other” has been excluded in the community and seek out ways to change that exclusion (151). What follows is my initial thinking and lesson plan for a class session in which I would “set things right.”:

“After reflection, I believe an instructor can destigmatize mental disability in the classroom by laying herself open to the very vulnerabilities an initial disability disclosure would bring to the fore. By risking through disclosure what there is to lose—specifically, classroom authority and the pose of overriding rationality—an instructor with a mental disability can create the chance to win a small victory for herself and her mentally disabled compatriots as well as offering at least some of her students the benefits of a broadened definition of “us.”

As a start, on the day in question, I could have leaned into my sense of being vulnerable to a loss of classroom authority by accepting, if not even welcoming, that loss. First, I would have to make my disclosure immediately after the laughter died down. With the benefit of hindsight, I imagine saying something like the following: 'This is hard to talk about, but I need to say something because I really like this class, and I respect you as people. I need to say that because these things are true, it troubles me to hear you laughing at the idea of bipolar disorder. It troubles me because I have that condition. I belong to a group of people that goes around to local schools and colleges talking about our experiences with mental disability. We do this to fight the stigma that exists around these conditions. Now I'm faced with an example of that stigma right here in our class, and I'd like us to talk about mental disability for a bit—not to embarrass you for making a comment or for having laughed at it but to see if we can figure out this stigma thing together. I've been impressed with the way you guys have discussed other social issues, so I'd like us to tackle this one, to see where we can get in our understanding of it. And right up front, I want you to know that I won't be judging you based on anything you say. That's just something you'll have to take my word for! So please feel free to be honest in your comments during the discussion I would like us to have.'

Next, I would ask students to write for a while about their connection to the issue of mental disability. I would do this knowing that it would be likely that some students may have a mentally disabled friend of family member or may be struggling with such an issue themselves. Although my disclosure may make them feel comfortable to do so, I would not expect or even encourage anyone to "come out." Rather, I would ask people write about the sources of their perceptions of mental disability including any media sources they cared to name. By using writing as a starting point, I would hope to help students lessen the natural vulnerability they *might feel addressing such a topic—one that is socially stigmatized and one to which their instructor has a strong, personal connection. Next, I would ask those students who felt comfortable doing so to share their writing, to which the rest of the class could respond.*

The key here is that my narrative would be just one of several possible ones, rather than being the focal point of attention. Several members of the class would provide their own link to the issue. Ideally, I would save my speaking for last. To achieve true dialogue on such a sensitive topic, especially after a pedagogical intervention enacted by the instructor, students would need to feel comfortable joining the conversation from whatever standpoint they had at the moment. One of the most interesting moments of my experience with the Speakers Bureau came when I asked a gathered group of students what they had expected when they heard that people with mental disabilities were coming to speak to them. One young man said, "I expected you to be drooling and wheeled in in a wheelchair." This comment was followed by further explanations that the images they had of mentally disabled people came from asylum scenes in the movies and on television. If some of my students mentioned similar sources for their impressions of mental disability, while others might at least know people with such disabilities, I can envision a spirited discussion of stigma ensuing.

When it came to my time to speak, I would offer the students an abbreviated version of the presentation I give in psychology classes, to give them a glimpse of one person's experience with mental disability. Doing this would require me to make myself vulnerable to the fear of being judged as irrational based on even brief descriptions of the two poles of my disability—mania and depression.

The steps of the lesson plan I propose for use in a classroom where the subject of mental disability 'pops up' unexpectedly begin with the first act—teacher disclosure. I see the disclosure *as useful because it would give students an opportunity to question the "other" and to see a "face of mental disability" that does not match stereotypes they may hold. Each step that follows —the writing and the unfolding of the ensuing discussion—is based on keeping both the teacher and each student open to the vulnerabilities they face as members of a dialogue. The students will individually decide whether to embrace those vulnerabilities by entering the discussion in certain ways. Their participation is not something the teacher can guarantee or control. All she can do is set things in motion through her initial disclosure of a stigmatized identity. It would not be the teacher's job to "win" the affirmation of her audience. In fact, she would cease to view the class as an audience at all. Instead, the entire group would make themselves individually vulnerable to negative outcomes in the search for a positive, stigma-reducing, positive one. All involved would encounter the possibility of transformation. Students might know a transformation of previously stigmatizing perceptions of mentally disabled people, and the teacher may find herself transformed in the act of listening to her students to learn what they can teach her about the origins and workings of stigma.*

Consider that day in the classroom. What if, after my initial disclosure statement, I had set up a classroom writing and discussion session as described here? What if I had let go of the rhetorical stance of disabuse— "No. You are wrong, and I am going to show you why!"—and offered the option of "Let's approach this topic of mental disability and stigma together to try to understand it better"? I would be putting my students in a vulnerable position in that they might worry how honest they could be about some of their opinions about mentally disabled people if they were negative ones. Some might also be encouraged to risk coming out about their own mental disability. Others might experience the discomfort of hearing that mental disability can affect anyone and that it often hits people in their early 20's.

Meanwhile, I, too, would experience a host of risks. What if the lesson plan met with silence despite its best efforts to generate discussion? What if this golden opportunity to fight stigma did not pan out, dissolving instead into chaos and washing down the tubes, leaving me exposed in front of my class? What if the students did not understand or empathize with mental disability, despite my best efforts at inclusive discussion? I feel comfortable engaging these risks for the potential pedagogical and stigma-fighting benefits offered by a lesson based on teacher disclosure of disability and the embrace of mutual vulnerabilities in the classroom. By putting the teacher and her students on the same rhetorical footing, a footing dependent on vulnerability, such a plan can make truly productive dialogue possible."

The lesson plan above represents my earnest desire to react constructively to an instance of stigma in my classroom. To interrogate this plan, I turn now to scholarship on both disability disclosure in the classroom and the role of teacher identity. The work of some scholars suggests that by making personal disclosure the first part of my lesson plan, I could unintentionally lessen the chances of enacting a successful stigma-fighting intervention in the classroom. Brenda Brueggemann and Debra Moddelmog discuss risks present for the teacher who undertakes disclosure of a hidden element of his or her identity. For both authors, the decision to come out to their literature classes—Brueggemann as hard of hearing and Moddelmog as lesbian—involved serious concerns:

> Even our recognition that naming our identities will improve the functioning of our classes . . . . is not enough to eliminate our discomfort and worry about how the information will be received, processed, and returned. Brenda worries that students might read her disability identity with pity or might question her intellectual ability or authority because of their perception of missing 'faculties';

> Debra is concerned that students might react to her lesbian identity with vitriolic or even violent homophobia. Moreover, the act of naming our invisible and supposedly private identities may be taken as an attempt to turn the classroom away from knowledge and toward intimacy, which can be troubling for both our students and ourselves, since we have been conditioned to see the classroom as only an intellectual space. (314-15)

While I do understand the authors' worry about bringing what students may consider the "private business" of the teacher into the public space of the classroom, I do not see intimate revelations and the pursuit of knowledge as necessarily dichotomous undertakings. If I simply started talking about my mental disability in class one day, not connecting this disclosure to any incident or other topic relevant to the class, I would certainly expect my students to scratch their heads. Like Hilary Selznick, I would wonder if my disability disclosure in the classroom might leave students feeling I was oversharing (10). Lott's memory, from her student years, of the resentment peers felt towards instructors who seemed to disclose excessively would also give me pause. Students viewed such teachers as egotistical and resented being treated as a captive audience (143). I would not expect a charge of narcissism from students in the classroom context I imagine, however, where I would carefully frame my personal disclosure as the jumping off point for helping students explore the concept of mental disability and the stigma that accompanies it. I would hope that their recent participation in a stigmatizing classroom incident would make the pedagogical need for this exploration clear. True, students may feel like "captives" to such a lesson plan, but such a feeling can exist regarding the introduction in the classroom of any topic that makes students uncomfortable. This feeling of discomfort when faced with a newly disclosed identity, an "other" in the classroom, can be harnessed productively if instructors are open to beginning discussion where students are regarding an uncomfortable topic, rather than where we might like them to be.

My suggested lesson plan does ask for a relatively immediate, high level of student comfort with a very difficult topic, a level of comfort and familiarity I now realize I would need much longer than one class period to establish. Jonathan Cheu describes a class he taught at Ohio State University called “Cultures and Literatures of Disability.” As a visibly disabled teacher, (Cheu uses a wheelchair), he was dismayed one day when faced with student silence regarding one of the class texts. He observes that students had three reasons for silence concerning disability: “not being disabled or not knowing anyone disabled, never having been asked to consider disability, and disability being a ‘personal issue’ no one talked about . . . . And, because they were not themselves ‘disabled,’ they felt they had no authority to speak, write, or say anything about disability. It was the classic “us/them” binary at work” (Bruegemann et. al. 388). Cheu explains that once he got the students to start talking, their questions were very basic. For example, instead of addressing the theory and “hot-button issues” he wanted to discuss, the class wanted to know if they should hold the door open for people in wheelchairs.

Cheu realized that he had to start the classroom discussion from the students’ entry point into the issue of disability. He observes, “And although [answering their basic questions] perhaps, unwittingly, set me up as some ‘paragon of disability,’ it also, I think, created a common vocabulary and validated their experiences and discomfort. It created for us a place to speak” (Bruegemann et. al. 389). Cheu’s desire to start discussion at the point of disability theory and hot-button issues echoes the intentions of my initial lesson plan. While this plan speaks of encouraging students to enter the discussion from “whatever standpoint they [hold] at the moment,” it still functions as *my* plan in that it approaches the topic of mental disability by going straight to the theory *I* want to talk about—the construction of stigma. It does so without accounting for the probability that mental disability, in and of itself, is a topic about which young adults might only be beginning to think. They may have questions and concerns much more basic than “How does our society construct stigma?” My lesson plan does not take the potential for student discomfort with mental disability into account. Just as Cheu finds the careful creation of “a place to speak” necessary in the classroom before his students could write with depth and passion about disability, I would have to spend many class periods with my students to arrive at a place where we could delve comfortably into the topic of mental disability stigma. In a writing class not focused on disability, students would probably find themselves at a loss in the face of a teacher’s disclosure of mental disability because they would lack the conceptual tools a disability-based course would give them to approach the topic with.

The teachers mentioned above all manage to disclose their disabilities in the classroom and conduct engaged classroom discussions about issues related to disability because they teach semester-long classes focused on the topic. Getting to a point of comfortable, or uncomfortable but functional, classroom discussion about such a fraught issue takes time. As Brueggemann and Moddelmog explain:

> In the classroom, we head toward the continual rather than the momentary, turning the naming of our identities from a onetime confession into a process linked to a theory about identity. From this perspective, our coming out is not so much a functional disclosure as a strategic performance. We subsequently situate our *named* identities as *claimed* identities and explore the relationships, both oppressive and enabling, between what has been named (a positioning of identity as absolute) and what has been claimed (a positioning of identity as contingent).

> Thus, the moment of coming out turns into a movement, a bidirectional process of communication in which we and our students must do more than simply encounter a “secret”: we and they must examine it. That examination is sometimes comforting, sometimes discomforting, and sometimes both at once. (315)

A single class period would not give my class enough time to do much more than encounter my “secret” briefly. A productive examination of it, one that could *eventually* get to the issue of stigma and its workings, would require sustained focus. A productive examination of mental disability could also open the way, as Brueggemann and Moddelmog suggest, for a larger classroom discussion of identity. This might help students engage with the concept of otherness, something that could forestall future instances of stigma in my classroom and others.

Besides its limit in scope, my plan also naively assumes that my students and I need to somehow achieve equal power in the classroom for them to feel comfortable enough to openly discuss their true perceptions about mental disability and mentally disabled people. Such equality would be impossible and, I now believe, unnecessary for us to attain. Even though my disclosure could have the immediate effect of making students doubt my competence as a teacher, I would still possess significant authority in terms of being the one with the power to grade their performance as students. Karen Kopelson cites Cheryl Johnson and Shirley Logan’s experiences as teachers marked by difference, noting, “both Logan and Johnson warn that, in a mostly white classroom, the mere presence of a woman of color ‘at the front of the room’ often ‘is read as a signal that now oral and written expressions of ideas may need to be suppressed lest they offend the person who will evaluate them’” (126). At first glance, this warning would seem to put a damper on my lesson plan. After all, how effective would my students find assurances that I would not judge them for their views about mental disability when I had just revealed myself as mentally disabled and had indicated being upset enough by their show of stigma to make stigma the topic of class discussion in the first place? How willing would they be to air negative perceptions shaped by stigma, the very airing necessary to fuel a productive discussion?

I understand Kopelson's assessment that the very identity of a teacher with a non-dominant identity might silence the free expression of students who belong to the dominant group. However, I believe she puts too much emphasis on visible elements of identity, such as race, when a teacher's classroom *ethos,* her students' trust in her, is something built over time, something dependent on elements beyond identity markers. I build this trust with students through our discourse and growing rapport as a semester progresses, through fairness in classroom conduct and grading, and through maintaining a sense of humor in the classroom. While I cannot in any way guarantee that my students would respond to my suggested lesson plan by overcoming the natural fear of offending me, my instinct regarding our nurtured relationship as interlocuters suggests that they might do so, especially if I demonstrate my openness to questions about my disability in the way that Cheu does about his.

Beyond fear, Kopelson also points to resistance as a reason students may not respond positively to my attempts to get them to write about and discuss their relationships to mental disability, including their connections to stigma. She speaks of the risk run by composition teachers whose very identity—as women, as people of color, as gay or lesbian—causes student resistance to their attempts to address issues of difference in the classroom (121). The students resist such discussions because they view these teachers as too personally invested in the subject matter at hand (126). They suspect a political agenda woven into classroom instruction. This possibility of student resistance to discussions facilitated by teachers with visible or stated identities that differ from the white, heterosexual, male, able norm has me thinking about the resistance my initial lesson plan to combat stigma might encounter *because* it starts off with my disclosure of mental disability. Students may see me as an "other" to resist rather than an "other" they want to engage. They may resent being made to discuss a topic in which the teacher has so obvious a stake.

Again though, I feel that Kopelson exaggerates the possibility of such student resistance or at least neglects to factor in the relationship of trust an instructor can build in the classroom by truly illustrating her respect for *all* the kinds of students present, including those who may initially resist discussing difference. My stake in the topic of mental disability stigma would be clear, yes, but students would have had experience in my class with discussing issues in which some class members had more of a stake than others. If trust in the teacher's respect of diverse opinions is present, her stake need not loom larger than that of others. Also, the topic at hand, mental disability, is one that crosses all other identity lines. People of all races, classes, sexualities, genders, abilities, etc. face mental disability or know people who do. This fact might motivate class discussion by generating a unified interest in the topic, one that might overcome any resistance that might exist.

Overcoming Student Resistance—The Value of Choosing Not to Disclose

I developed my one-class lesson plan in the hope of using my personal disclosure of mental disability to stimulate lively classroom discussion of how and why people with psychiatric diagnoses experience stigma in our culture. Considering the need for a much longer period of classroom intervention to adequately address the topic, as well as the possibility that disclosure on the teacher's part might lead students to resist discussion in the ways Kopelson suggests, I now believe a disclosure of disability, as part of a one-class lesson, would not adequately serve the purpose of pedagogically taking on the stigma circulating in the classroom of a mentally disabled instructor. Nonetheless, I consider finding a way to do so part of my duty as an anti-stigma advocate, one whose identity as a teacher affords her unique opportunities to reach a key "audience" in the struggle. A teacher's disclosure of disability might prove intrusive and counterproductive to discussion, but what might happen as the result of a classroom intervention that did not involve such a disclosure?

Let us assume the initial lesson plan I proposed would indeed to fail to produce productive discussion that would lessen the stigma that swirls around mental disability. What if I, or any other mentally disabled teacher, have not developed the level of trust with our students that we think we have, and they resist discussion of a fraught topic? Given this possibility, I turn to another option for action for mentally disabled teachers who find themselves confronted with an instance of stigma in their writing classrooms. Specifically, I seek a way to lessen the possibility of resistance to instructor attempts to encourage students to address their own biases.

Kopelson makes a controversial and intriguing suggestion as to how teachers with clearly "different" identities can lessen student resistance to the discussion of such differences in the classroom, resistance she believes impedes learning. She argues that teachers who occupy visible minority positions in the classroom need to adopt poses of neutrality as instructors, poses that emphasize the traditional "teacher in control" dynamic, thus de-emphasizing the teacher's identity:

> . . . if students are indeed shutting down in the face of teaching practices perceived as "heavy handed" and "coercive," we may need to develop a different pedagogical focus than today's often explicit and emphatic focus on difference; we may need to 'look at strategies that preclude long term antagonism' but that

> still allow and encourage students to engage critically with sociopolitical issues. (121)

By adopting a pose more distanced from their own identities, Kopelson notes, teachers with visibly different identities can "increase students' critical involvement with difficult issues by decreasing their preoccupation with the teacher's identity position" (126). While it makes sense that less emphasis on a teacher's identity position might increase student willingness to engage in discussion of issues related to that identity, Kopelson here assumes that teachers with visible identity positions always behave antagonistically towards students who might disagree with them in classroom discussions. She also assumes that a teacher who engages her identity position in the classroom somehow has less authority in the eyes of the students. This could be the case if students view identity as equivalent to bias but would not be true if students are sophisticated enough to differentiate between the two.

In my writing classes, I do not have a "visibly different" identity position like the ones to which Kopelson refers. My long-term wellness allows me to "pass" as neurotypical. Kopelson's advocacy of teaching through a "performance of "neutrality" suggests to me a valid reason for teachers with mental disabilities who can do so to keep our positionality as mentally disabled hidden. From this stance, we could engage students in a discussion of their views on mental disability while avoiding the possibility of resistance a personal disclosure might engender. When Avi said, "Sounds like he's got bipolar mood disorder," I froze because I did not want to lose my authority as a teacher. The neutral performance Kopelson suggests relies on that authority distracting attention away from the teacher's position on the issue at hand. The advice to assume a neutral position assumes that students might not grant authority to an instructor they consider biased. Citing Kenneth Burke, Kopelson calls performances of neutrality in the classroom useful “rhetoric on the edge of cunning” (130). She considers such cunning practical rather than unethical, a masquerade designed to engage students rather than a selling-out of one’s identity. With student engagement with the issue of stigma as the overriding goal, I am willing to agree that to dissemble about one’s mental disability identity, in this instance, is indeed not to sell out.

As indicated by my wording at the beginning of the original lesson plan I developed—regarding using disclosure to “win a small victory for [myself] and [my] mentally disabled compatriots”—I felt guilt for not immediately letting my students know my direct relationship to the source of their amusement. This sense of guilt relates to my conviction that individual mental disability disclosure, in any context, is an act of courage, undertaken in solidarity with, and thus in support of, the many people who stay hidden due to the stigma that adheres to psychiatric diagnoses. When the ableist incident occurred in my classroom, my instincts as an activist said that to remain silent when an opportunity for action arises is a sign of cowardice. While these are deeper issues worth exploring more closely, for my purposes in this chapter, I stick to a consideration of individual disability disclosure as it intersects with the needs of pedagogy. Having done so, I see the pedagogical potential of holding back on disclosure in the classroom when such “inaction” can still serve the goal of fighting stigma.

A Pedagogical Response Reconsidered

If a mentally disabled teacher chooses not to come out about her disability because her role as the person at the front of the classroom may stymie the value of that choice, how can the “other” speak to that teacher’s writing students when they most need to listen? Kopelson captures the tricky dynamics of a classroom attempting to deal with issues of difference when she observes:

> What Brodkey seven years ago called ‘the endless spectacles of the terror of difference’ are only becoming more spectacularly terrifying, and students’ frequent embodiment of this terror and their resistance to its interrogation demand our continued and continually inventive pedagogical attentions and *interventions*. Certainly, no one knows this more or more acutely than those of us who stand before our students as the very subjects/objects of their terror every day. However, many of us who are thus positioned have also come to know that the representation of our true selves and /or our insurgent politics is both not enough and at times is counterproductive. (140)

My students’ laughter at the thought of bipolar mood disorder certainly indicated a resistance to the very thought of mental difference and could easily have also hidden the kind of terror of difference Kopelson cites. As an alternative lesson plan, I encourage other mentally disabled teachers to lessen and educate that terror by bringing it face to face with people who can tell students about the experience of mental disability while not coming from a position of power in the classroom. I suggest inviting members of a Speakers Bureau, or, ideally, members of a group of mentally disabled students from campus, to class to interact with students. A teacher can locate a Speakers Bureau by contacting the local county’s Community Mental Health organization to see if they sponsor a set of speakers. Local mental health support groups composed solely of people who have mental disabilities may also have members who participate in advocacy through public speaking.

I say invited speakers should interact with rather than simply speak to students because I would want the Speakers Bureau members I know to assume a more participatory role than we do in our usual classroom presentations. In the presentations I observed, the speakers seemed in many respects to function the way I often felt I was functioning, as a bug brought in for inspection by students who had studied the workings of that bug in their textbooks. Presenters take questions after their speeches, but the Q and A does not take the form of a dialogue. I only experienced dialogue with students during the Q and A period noted in my initial lesson plan, when I asked the students what they expected when they heard that mentally disabled people were coming to their class to speak.

Wanting dialogue between my students and the presenters, I suggest preparing the invited Speakers Bureau members to facilitate interaction. For my class, I would ask them to come in with the following set of questions, adapted from a list I used to generate discussion in a stigma-fighting workshop I organized for the Bureau:

1. How do you think the public views mental disability? To what do you attribute this view or these views?
2. How do you think the public views people with mental disabilities? To what do you attribute this view or these views?
3. Have you or someone you know ever experienced stigma due to mental disability?
4. If you are willing, please describe that experience or those experiences.
5. How do you want people to perceive you as a person?
6. Do you think people with mental disabilities and those without them are the same, essentially? If so, why so? If not, why not?
7. How do you relate, personally, to the term “normal” as it operates in our culture?

8. Are there things about mental disability or stigma that you feel you have learned today that you did not know before? If so, can you describe what you have learned?
9. Are there things about mental disability or stigma that you feel you do not yet understand and would like to learn? If so, what are some of these things?
10. What additional questions can you come up with together, to ask each other?

I suggest the following set-up in the classroom: Presenters sit with small groups of students. If enough presenters are available, a one-to-one student to presenter ratio would be ideal. Presenters should take about 15 minutes to narrate their mental disability experience to their group of students. Afterwards, the speakers and the students can work together to respond to the list of questions, with both the speakers and the students making contributions to the responses and taking notes on them. The instructor collects each group's responses at the end of the class and distills them into a document he can share with both students and the presenters who attended the class.

I base this class design partly on Mann and Himelein's research, which they subtitle "an intervention to reduce mental illness stigma in the classroom" (545). The researchers compared a psychology classroom intervention based on the first-person narratives of mentally disabled people with a more traditional approach in which students learned about mental disability through more distanced, third-person explanations focused on medical diagnoses. Their conclusion—that the introduction of first-person narratives into the classroom led to stigma reduction while education without the narratives did not—supports the Speakers Bureau's use of narrative as a stigma fighting rhetorical method. What truly intrigued me, however, was the following finding: "Contact is most effective when there is 'equal status' between individuals with mental illness and participants, as in the case of students speaking with other students or two persons cooperating on a task" (546). The Speakers Bureau's "person/bug in front of the classroom" rhetorical stance does not create an atmosphere of equal status between the speaker and the listening students. By having students in our classes working in small groups with a speaker on the task of exploring mental illness and stigma together, as equals outside of the power dynamic the teacher's involvement would impose, we might create a rhetorical situation in which the students and the speakers can learn from each other. By speaking and working together across difference, they can begin to break down the barriers caused by stigma. I suggest proposing the exercise to a Speakers Bureau or other group of presenters as an opportunity to both fight stigma and hone their rhetoric. By working together with students, they might gain a deeper understanding of the ways the young minds in their audiences approach both the topic and nature of their presentations.

It is important that the people who come to speak to students about mental disability are, indeed, people who have lived the experience of mental disability. An instructor might be tempted to invite a psychiatrist or psychiatric social worker into the classroom to talk about what these professionals would call "mental illnesses." Doing so would be counter-intuitive to the effort to have students hear *from* "the other" rather than *about* her. The face that the latter would put on mental disability would, by definition, be the face of medical diagnosis, suggestions of how the mentally disabled person fits various categories of symptoms rather than the presentation of this kind of individual as a whole, human being.

I suggest introducing the exercise to students as soon as possible after a stigmatizing incident. With the Writing and Community class in question, I would do so in the following way: "Because I like you so much as a class and have been impressed with the open-minded way you have approached issues of cultural difference before—such as when we have discussed homelessness, religious differences, single motherhood, etc.—it surprised me the other day when everybody seemed to crack up when it was suggested that my colleague who behaved in different ways at the start of each semester had bipolar mood disorder. The laughter reminded me how much stigma is still attached to diagnoses of mental disability. I worried about that because I'm sure at least some of you know people who deal with mental disability and possibly some of you deal with it yourselves. So, in keeping with our class focus on listening to and trying to understand people different from ourselves, I want to break into our syllabus and explore the topic of mental disability together, And I thought, 'What better way to start talking then to bring in some experts, people who live the reality daily?'"

During the next class period, some anti-stigma advocates who are part of a local group called the Speakers Bureau will come in to engage you in discussion. First, they will talk about their experiences with mental disability, and then you will get together with them in teams to explore the issue further. Their goal as an organization is to lessen the stigma that exists around psychiatric diagnoses. I'm hoping you can assist them in that task by working together to answer the following questions. (At this point, I would hand out the list given to the Speakers Bureau members). We only have one class period, so it will just be a start, but what I hope we can do is raise some productive questions about mental disability and stigma."

Because the lesson plan described above exists as a response to a single incident in the classroom, it will be especially important not to single out the student who made the troubling comment. I believe the best way to do this is to explain to the class that while the comment itself was a point of concern, it was the class reaction, the laughter, that made mental disability stigma something I wanted to bring to their attention. Saying this might take at least some of the attention off the student who made the comment and require the class to think instead about their reaction to it. I also suggest presenting students with a mini-lecture about instances of mental disability stereotypes as they exist in popular culture. Doing so might help them see that they are not "guilty" of some huge wrongdoing but rather have imbibed the stigma that saturates their environment. Lessening potential guilt on their part for having participated in laughing at mental disability may lower any resistance to talking about the topic that might linger.

How does this alternative lesson plan address or fail to address the shame I felt when I froze in the classroom, shame engendered by the knowledge that I failed to immediately defend my compatriots in mental disability? While the decision not to disclose to a class in need of a stigma-fighting intervention may seem like a cowardly one, I believe a teacher's duty to provide a productive experience for students, the drive to "keep students open, keep students learning, keep students open *to* learning, so they many engage with rather than shut out difference" supersedes my desire to manifest a basic "I am one of them, too!" kind of solidarity with fellow mentally disabled people (Kopelson 135). But if my lesson plan can indeed help students broaden their definition of "us" to include people with mental disability, it enacts a different but also significant kind of solidarity, a solidarity of effect.

Within the Speakers Bureau, I can enact my identity as an advocate. Within the classroom, I can and will advocate for mentally disabled people, but must do so within my identity as a teacher. Within the classroom, I owe that identity my primary responsibility. By creating a lesson plan that can keep my students, and those of other mentally disabled teachers, open to difference in a way we might not be able to if "out" about our disabilities, I have attempted to address the dilemma Avi's comment raises in a way useful to both pedagogy and advocacy. The lesson plan I suggest involves students and community-based anti-stigma advocates working together to understand stigma in classrooms that do not have disability as a semester-long focus. Although brief, this plan can encourage students to engage with the topic of mental disability in an open way.

By proposing a lesson plan that intervenes when ableism occurs in the classroom, a plan that does not include a mentally disabled instructor's disclosure of her own disability, I make a claim about identity. As was implied at the beginning of this chapter, I claim that mentally disabled people who can pass can treat our disabilities as irrelevant in certain contexts. As long as we are "well," we can hide the stigmatized aspects of our identities. But incidents like the one that occurred in my classroom indicate that no context is safe from the stigma that attends mental disability. Because this is so, I believe mentally disabled teachers who can pass have a responsibility to consider how we will respond to incidents of stigma in the classroom *before* they occur. I have here offered one suggestion of a way to proceed. It is quite possible that other instructors may choose to greet classroom ableism head on through deep disclosure even in classes that do not focus on disability. And they may meet with great, stigma-fighting success. Ultimately, what is necessary is putting students in touch with deep disclosure of some sort. Whether it comes from the the instructor, or, as I have argued, through encounters with mentally disabled members of the community, such exposure can, I hope, begin to replace the laughter engendered by the very thought of mental disability with respect.

CHAPTER 5 CONCLUSIONS AND CONCERNS MOVING FORWARD

As both a student of rhetoric and a mentally disabled person, I find myself intrigued by the Speakers Bureau because it regularly seeks to attain what Prendergast says mentally disabled people lack, “rhetoricability” or rhetorical agency (56). Like anyone else, people with publicly revealed psychiatric diagnoses are free to speak and write. No one will listen to us, however, Prendergast argues, because “normal” people see the communications of “crazy” people through the lens of stigma. Because they consider us irrational by definition, those who hear what we have to say dismiss our communications as meaningless (57). Because we bear what Goffman calls “spoiled identities,” members of the Speakers Bureau face rhetorical impasses when we enter classrooms intent on persuading young audiences to let go of negative perceptions about mental disability (19). Stigma paints us as incompetent people *and* incompetent rhetors. I joined the organization to understand, through participation and observation, how its members wield language in pursuit of the rhetorical agency necessary to get around these impasses. In what follows, I describe how the participants in my study approach this challenge, provide further analysis of the different messages sent to audiences by speakers who adhere to the two competing models of mental disability, and present plans for future research suggested by this study.

For a basic definition of “rhetorical agency” I have relied on Campbell, who describes it as “the capacity to act, that is, to have the competence to speak or write in a way that will be recognized or heeded by others in one’s community” (3). I am drawn to Campbell’s definition by her choice of the word “heeded,” a verb that connotes the active, change-producing audience uptake of a speaker’s message. My study set out to explore the rhetorical moves Speakers Bureau members engage in to try to get our audiences to “heed,” i.e. to agree with our message, through the haze of mental disability stigma that circulates in the culture. Based on the Bureau's mission statement, this message translates to: "Ignore the stereotypes fed to you by mass media. *We* represent what it means to be mentally ill. And because we can provide living proof that people with mental illnesses have hope and do recover, you should not stigmatize us or discriminate against us."

The second half of Campbell's basic definition of rhetorical agency pertains here. She notes that the ability to speak in a way that will be heeded "permits entry into ongoing cultural conversations and is the *sine qua non* of public participation, much less resistance as a counter-public" (3) The Speakers Bureau strives to resist as a counter-public by circulating its texts, or speeches, in opposition to the dominant public "conversation" regarding what it means to be mentally disabled (Warner 119). Conscious of the ways in which we are stigmatized before even entering a classroom, Bureau speakers are careful in the way we employ our rhetoric of resistance. I define rhetoric here as the purposeful use of language to persuade an audience to think differently about a given reality. Through our personal narratives—our stories of "This is what it is/was like for me"—we offer audiences an alternative way to view the reality of mental disability, one that does not match the dominant narrative peopled with stereotypes. These stereotypes suggest that mentally disabled people are dangerous, incompetent, lazy, and disingenuous about their suffering, to name but a few public perceptions. As Gloria exclaims about the work of the Speakers Bureau, "This is *us* saying who we are!" an assertion that implies long experience with being described and categorized by outsiders.

Edmund Husserl, considered the father of phenomenology, believes only normal people, rather than those he describes as "anormals" can be involved in the struggle to influence the perception of reality. As "anormal," Husserl scholar, Dan Zahavi, gives the example of the infant, the blind man, and the schizophrenic (135). As Zahavi notes, the motivation of science, for Husserl, is the fact that people don't experience the world in the same way. These disagreements, he points out, drive the search for what Zahavi calls "irrelative knowledge" (135). The irony here is that the Speakers Bureau, made up of only "anormals," would by Husserl's reckoning not be allowed to do the very thing it exists to do—present its members' sometimes different experiences of reality. They would be kept out of the debate Husserl believes can do two things: either provide a more comprehensive picture of the world by incorporating differing perspectives or determine a version of reality that would have validity for everyone (everyone rational, that is) (Zahavi 135). Through their rhetoric, the "anormal" members of the Speakers Bureau attempt to truly do the former in the face of societal pressures that push for the latter at the expense of the marginalized, "irrational" voices of mentally disabled people.

In the classrooms where these voices choose to speak, rhetorical choices involve the management of risk. Even as each Speakers Bureau member enters the classroom fully prepared to disclose her disability and describe the unpleasant details of its manifestation in her life, two risk-related questions remain: To what extent should a speaker link her identity to the diagnosis she names for the students, and how much disclosure is too much disclosure? As my study indicates, individual speakers make rhetorical choices that tell the audience the extent to which the speaker identifies with his or her mental disability. Some attempt to distance themselves from the negative images attached to their diagnosis by claiming to "have" a "mental illness" rather than "being" a manifestation of that illness. (I say, "I have a bipolar mood disorder," rather than "I am bipolar.") And some adopt rhetorical stances, such as the pose of expert concerning mental disability, in a possible attempt to draw audience attention away from negative images that equate such disability with incompetence. (Phil begins his presentations with a list of figures about the percentages of people in the country who have various mental disabilities. He also quizzes students, like a teacher, regarding what they know about his own disability, paranoid schizophrenia.)

Speakers also make risk management decisions when it comes to decisions about levels of disclosure. The disclosure of too much disturbing detail about a speaker's disability experiences may lead members of the student audience to increase rather than decrease their negative perceptions of mentally disabled people. At the same time, a speaker must provide enough detail to convince listeners that the person in front of them truly is disabled and thus has the authority to represent the reality of living with a psychiatrically diagnosed condition. All members of the Speakers Bureau do take the risk of offering audiences various levels of what I have called "deep disclosure" to provide listeners with a genuine sense of the emotions, thoughts, and behaviors mental disability can involve. As noted, this is part of the organization's determination to present what they want audiences to see as the true "face of mental illness."

Although Phil mentions wanting students to "understand" psychiatric conditions, and Ruth notes her desire to "connect" with her audiences, none of the study participants directly mentions using their narrative disclosures to generate empathy. Nonetheless, I believe this goal, as much as the desire to disprove stereotypes, underlies the willingness of Bureau members to take the huge risk of deep disclosure. We are generous with our details of the experience of mental disability. We "invite them in and [are] gracious" to use Gloria's words, in an attempt to get audience members to come as close as possible to emotions, thoughts, and behaviors that can definitely seem frightening. Our disclosures indicate great trust in the ability of audience members to change their own perspectives about the people who share these details, thereby encouraging audience recognition of the humanness behind the narratives.

In a comment that could easily refer to the rhetorical efforts of the Speakers Bureau, blind poet, Emily K. Michael, describes the relationship between empathy and the fear of difference that can generate stigma:

> I think the difference between fear/pity and empathy is a willingness to be vulnerable, which may seem counter-intuitive. When someone is afraid of disability, and I represent that disability, they're going to try to get away from me as fast as possible. If they can't get away, they're going to try and control the situation. . .Pity is another form of taking control. If a person pities me, they don't have to be on my level. They can look down on my life and call this superiority 'compassion.' Empathy is the willingness to *go there* with someone. It's the willingness to say, 'This scares the crap out of me, but I'm going to sit here and let you tell me what it's really like. . .even if that reality is just as scary as I thought it would be.' When someone is empathetic, they aren't trying to talk over me or silence me. They're not afraid to stand next to me and ask questions. (4).

The deep disclosure of Speakers Bureau narratives gives our audiences an opportunity to be go to some difficult and disturbing places with us. The risk we take in doing this—the risk that the identities we put forth will be rejected—is balanced against the possibility that some listeners might make themselves vulnerable to changing the way they see mentally disabled people.

In Chapter Two I ask, "what [could I] say that would reveal me as *fully* human, as fully capable goods rather than damaged ones [?]" I also mention feeling during presentations like a bug on display for inspection by the students. But in these instances, the bug does get a chance to speak for itself. The encounter is fraught both with peril, as noted by my discussion of the risks of disclosure, and potential. The bug's rhetoric has much work to do in the space of just 20 minutes. My study reveals that Speakers Bureau members rely as much on the nature of the delivery of their presentations to do this work as they do on the message itself. Knowing that our diagnoses stigmatize us, we all strive to be the "good man speaking well" by presenting in ways that belie student expectations that mentally disabled people cannot speak clearly, coherently, and calmly. As instructed, we dress neatly, to counter any expectations of dishevelment or poor hygiene. As embodied rhetoric, this contrast between the speakers expected and the speakers who show up seems as important to the Bureau's stereotype displacement work as the individual narratives. Because my study was not an empirical one, I cannot assume that such displacement occurs, of course. I refer here only to our rhetorical aims.

Although all members of my study use their personal narratives to represent "the face of mental illness," they disagree as to the nature of what they are representing. Two competing models of mental disability are at play in the Speakers Bureau's work: Are psychiatrically diagnosed conditions "illnesses," signs of "broken brains" in need of medication? Or are such conditions "states of mental distress," not medical defects but merely alternative ways of being human? As discussed in Chapter Two, I found that the model of mental disability a speaker adheres to affects the way he speaks about himself to persuade students against stigma. The medical model allows the speaker to verbally distance himself, his "true identity" as Hutchins and Kirk would call it, from what is seen as an illness like any other (262). He "has" schizophrenia just as he might "have" diabetes. The former should not characterize him as "bad" in the eyes of the audience any more than the latter would. Meanwhile, the speaker who sees her times of "mental distress" as part of being human refers to them as simply a part of her identity, something that makes her a proudly diverse individual. Both models of mental disability allow a speaker to cast themselves in the kind of positive light that might challenge stigmatizing perceptions.

The effect of the two competing models extends beyond wording choices to the very message promoted by the speakers' presentations as well. Bureau members who derive our rhetoric from the medical model, the "broken brain" theory Gloria cautions against, imply through our reference to illness that we are, indeed, "broken." In our presentations, we talk about and describe the effects of chemical imbalances. Then we stress that through medication, these imbalances can be corrected. In effect, we can be "fixed." As I read it, we present the following argument against stigmatizing mentally disabled people: *Because* we can be fixed, you should not consider us less than you. Through medical intervention, we can function normally again, with the occasional set-back. Yes, when we are ill, we are different from you, but we can get help and change to fit into your world, into your definition of "normal." By this we mean we can again be the kind of human beings you would consider "capable." We can have jobs, maintain marriages, go to school, work for organizations such as the Speakers Bureau. You should accept us because with help, we can be mostly just like you." This claim to having the ability to recover, to be mostly just like those members of the audience who are neurotypical, plays a crucial role in the rhetoric of all but one of the Bureau members who participated in my study.

As the final part of my research, I produced and facilitated a collaborative, stigma-fighting workshop with ten members of the organization. Only two workshop participants had taken part in my in-depth study. On the day of the event, the gathered participants responded to and discussed a set of questions designed to elicit their opinions about the origins and workings of stigma as well as information about the specific rhetorical techniques they used in their classroom presentations. All the participants mentioned that their narratives include details designed to persuade students that the person at the front of the room is “no different than anybody else.” In response to the question “How do you want audiences to perceive you and how do you achieve this effect in your speeches?” one young man said: “I would say as a capable, functioning individual with hopes and dreams just like everyone else. . .at the end of my presentation, I talk about my current life situation. I tell them what I’m involved in, school, work, married life, just like anyone else, and that I hope to graduate from college with a Bachelor’s degree someday and maybe do public speaking as a profession.” Another participant said he tries through his presentations to get audiences to see “. . .that people can have hope, that you can work, can go to school, that you can still have strong ties with your families and friends. . . I just want to be seen as a regular person who is battling through something difficult but not immovable.”

In contrast to the “broken but fixable” narrative, Gloria, who speaks within the context of the consumer/survivor/ex-patient (c/s/x) model, presents herself not as occasionally defective but as “diverse.” She states that she does not need to be fixed and should be accepted, with all the states of mental distress psychological diversity can imply. Her description of the Recovery movement, which falls under the c/s/x/ movement label, illustrates this alternative message about mental disability:

> You would never get two people telling you the same thing, but the medical model says you have to get fixed by medicine and the Recovery model says we all go through ups and downs in life and we deal with extreme distress, extreme sadness, happiness, alternative states of being, you know, but we get through these things. We sort it out for ourselves. We find out what it is to be human. This is what makes us humans. We’re not all the same, like little bar code labels of

> people, you know? And that we're detailed organisms that have hopes, fears, things like that. And the medical model, to me, seems to say a little bit more that you're programmed to be this way. You're programmed to be happy but not too happy, sad sometimes, but not too sad. But if you get a little out of sorts, then we'll give you some medicine and bring you back to baseline. But everyone's baseline is different, you know.

Note how she skillfully replaces the term "normal" with "human" to broaden the set of "being states" she wants her audience to accept. From her positioning within the Recovery movement, the mentally disabled person is truly no different, essentially, from the neurotypical one.

The two competing models of mental illness require different levels of participation from rhetors and audiences involved in the stigma fighting endeavor. This occurs because the model one adheres to affects the relationship of the speaker to the stigma she is trying to fight. By representing ourselves as essentially different from our audiences, the medical model speakers take on the stigma that circulates in the culture. We say to audiences, in effect, "Here are our glaring differences. We are going to explain ourselves to you in the hope that you will empathize with us and also see that we can be made well, or normal, again." Gloria does not do this. She rejects the stigma by arguing for a new way of perceiving mental disability altogether. She rejects the idea of normalcy. Speakers who stick to the rhetoric and rhetorical stances of the medical model take stigma, and the responsibility for mitigating its effects, primarily on ourselves. We attempt, through deep and (we hope) moving disclosure, to convince neurotypical members of our audiences to accept us into the fold. Audience members do have work to do in achieving this effect, as argued in Chapter Three, but mentally disabled rhetors' self-representation as "just like you" makes the job easier. Gloria's position puts greater responsibility for dealing with stigma on the audience. Its members are asked to expand their view of who should be considered fully human, rather than passing simply passing judgement, no matter how benign, on speakers who work to prove their worth through public speech.

Despite the above assessment, I do not argue for one or the other model of mental disability as the more effective lens through which to filter rhetoric designed to fight stigma. During this study, I have found it very tempting to try and adjudicate between the two models, to suggest that speaking from one or the other might prove the better way to encourage the public to perceive mentally disabled people differently. Such adjudication is not possible, however, because convincing a mentally disabled speaker to switch models is highly unlikely, even if one was proven more successful at reducing stigma. My secondary research and interaction with study participants, as well as my own experience, suggests that a person who believes in the medical model will not suddenly decide to embrace a Mad identity. They will not easily be persuaded that what they have experienced as "symptoms"— the highs of mania, the voices heard in schizophrenia, the catatonia of PTSD—represents just a "different way of being human" rather than a medical illness. Nor do I envision a person who proudly claims an alternative kind of human experience easily deciding that they are "sick" after all. Also, adjudication between the models has little value as far as stigma fighting is concerned because whether one views one's disability as a medical defect or a different way of being human, the public views it as a significant difference. Those who live with the impairments concurrent with mental disability face stigma due to that public's fear of and distaste for this difference.

In my time with the Speakers Bureau, I have come to respect the work they do greatly. Taking this work on myself, albeit not as frequently as I could have, gave me a strong sense of how difficult it is to, in Michael's term, "go there" and ask audiences to follow you in the hope of increasing understanding and changing minds. During the study, I in some ways learned the most from Gloria, the person whose views about mental disability directly challenged my own. I find myself wishing I could view what for me is a frustrating illness instead as a point of diversity and pride. I understand completely the emphasis other members of the Speakers Bureau put on the idea that as people, we can be “fixed.” and share the desire to be seen as “normal” by the rest of the world. In future research, however, I intend to examine the potential danger in the value that mental disability anti-stigma groups such as the Speakers Bureau put on public perceptions of normalcy.

I want to explore what advocacy and activist roles can be or have been made available to the many mentally disabled people who cannot regularly achieve a status close to normalcy, people whose conditions debilitate them to the point that they would not be able to make fully coherent speeches to classrooms of psychology students. More to the point, I want to investigate the repercussions of marginalizing these voices in advocacy settings.

I mention this because Gloria explained to me early in my research that the Speakers Bureau has a vetting process for potential speakers. She said that although “everyone can have an impact, we wouldn’t just put anyone in front of any class.” She noted that decisions about who should speak are tricky with mental illness. Some people, she said, would be more easily misunderstood based on hygiene problems or cognitive deficiencies. “In front of some audiences” she told me, “it’s more important to say, ‘We’re just like everyone else.’ Speakers who come across as more impaired or more disheveled, we’d be more cautious about where to put them, so as not to reinforce stereotypes. . . Mental illness stereotypes are big, and powerful, and strong, for example the disheveled schizophrenic with a cap and a big coat.” At the time

Gloria told me this, I let it slide because I was focused on the rhetorical work of my already determined set of study participants. But the vetting issue did stick in my craw.

As my research continued, I wondered how complete a picture of the reality of mental disability our group of speakers was offering to students. The disheveled and more highly impaired people—the ones not represented by our small group of presentably dressed, well-spoken Bureau members, whom Goffman would call "heroes of adjustment,"—are the very people who often face the highest levels of stigma and therefore discrimination and poverty in the community (25). How might the exclusion of these voices affect our group's capacity to really fight stigma at its roots? The situation reminds me of the boy in high school who made racist jokes about African-American people while sitting right next to me (Indian-American) and my Filipino-American friend, Tricia. I once asked him how he could do that, given that Tricia and I were people of color, too. His response? "Oh, you guys are ok 'cause you're doctors and lawyers, and things."

After completing this first portion of my research, questions that I want to pursue in future research remain: When "putting a face on mental illness," what face should we be turning to? What harm might we be doing by excluding the most troubled faces? To what extent have we truly addressed the stigma surrounding mental illness if the people representing their experiences with mental illness are, in terms of the capacity to represent themselves through speech, "doctors and lawyers and things"? Will our words help remove stigma from people like ourselves, those who have sane privilege and can "pass," while doing little to alleviate the stigma experienced by people who more closely match the cultural stereotypes of what it means to be mentally ill?

As they will not get chosen to join the Speakers Bureau, at least to speak to audiences of high school and college students, where will more severely disabled people have their chance to speak and share their experience with general audiences who might indeed respond by letting go of the stigma that separates the two groups? While I do understand the hesitancy to put such speakers in front of the public, thereby risking the reinforcement of stereotypes, my initial experience with the Bureau suggests to me that such occasions must occur. If only the people whose bearing and rhetorical techniques suggest a "good" character or *ethos* get the chance to represent "the mentally ill"—which is what the individual members of the Speakers Bureau are doing—to what extent are we truly fighting the most intransigent stigma? Johnson argues that audiences should make accommodations for "the bad man speaking poorly" (476). I want to investigate the stigma-fighting potential of this proposal.

In relation to this question of *who*, my research raised a concern with the content of the Speakers Bureau presentations I studied, a question of *what*. The rhetoric of most of my study participants, my own included, might be seen by some, albeit quite disparagingly, as a "song and dance" in which the speaker tells the audience, "See, I was crazy, but I've taken medication, and I'm better now. So, you don't have to worry about me, and you don't have to address any of the larger issues of oppression, discrimination, and potential human rights violations that come with mental disability. You don't have to worry about all those people you see talking to themselves, or sleeping on benches, or locked up in solitary confinement. Everything is all right. *We* represent mental disability, mental disability contained in this relatively nice, relatively safe picture."

As all but one of my participants speak from within the medical model and recovery, I do wonder what political issues pertinent to mental disability remain obscured by this rhetorical choice. For example, Lewiecki-Wilson, suggests that even when people with mental disabilities are allowed to participate in the public sphere as equal humans, they can find themselves "being *pushed* toward the argument, ‘we just want to be treated like everyone else’ thereby diluting the transformative potential of their participation in the public forum” (159). Lewiecki-Wilson’s contention makes me wonder about the demands of people with mental disabilities that extend beyond the potentially limited request to be publicly perceived as normal. As my research continues, I hope to explore what key issues might be kept from the public eye by what activist and Mad scholar, V. Armstrong, refers to as “sanitized” anti-stigma campaigns and Brigit McWade et. al. call “individualized and neatly packaged tales of recovery that are sometimes promoted at the expense of stories of oppression, marginalization, and collective activism” (McWade et. al. 307-08).

In noting these research interests, I do not intend in any way to denigrate the work of the Speakers Bureau, a group I respect for its members’ courageous, generous, and unflagging commitment to promoting public understanding of mental disability by making their stories public. I know that no one group can do everything there is to do in the large-scale effort needed to address the stigma faced by people with mental disabilities. Rather, it is my exposure to the Speakers Bureau’s powerful work that has inspired me to ask questions about how the fight against stigma can take place on an even wider playing field than the one to which its members generously granted me access.

APPENDIX A (Individual Interview Questions)

Individual Participant Interview (90 minutes)

1. Tell me about a time you were speaking with the Speakers Bureau that really stands out for you in some way.
2. How do you feel when you are up in front of a classroom talking about your experiences with mental illness?
3. How do you decide what aspects of your experience to include in your presentations and what to leave out?
4. How do you judge how students are responding to your presentations?
5. Why did you join the Speakers Bureau?
6. What is your current mental health diagnosis?
7. In what ways has that diagnosis manifested itself in your life?
8. Do you have periods when you are completely well?
9. How have other people (outside your Speakers Bureau activities) responded to your illness?
10. Tell me about a moment when you disclosed to somebody that wasn't during a Speakers Bureau event.
11. Has presenting at Speakers Bureau events changed how you speak about yourself?
12. What are the other scenes in which you speak about your illness?
13. Can you think of a time or times when others reacted to you talking about your illness in surprising or noteworthy ways?
14. How is talking about your illness at Speakers Bureau events different from other scenes where you speak about it?
15. Think 15 years down the road. What would you like the Speakers Bureau to have achieved?

APPENDIX B (Speakers Bureau Collaborative Workshop Questions)

Questionnaire for the Speakers Bureau Stigma Fighting Workshop

Directions: Please answer the following questions on a separate sheet of paper, numbering each question as you go. Do not put your name on your answer sheet. Please use as much room as you need to answer each question to your satisfaction. There are no right or wrong answers, of course, just the hope that you will be inspired to provide the insights you have about stigma! Thank you in advance, and see you at the workshop ☺

1. How do you think the general public views mental illness?
    a. To what do you attribute this view or these views?
2. How do you think the general public views mentally ill people?
    a. To what do you attribute this view or these views?
3. Have you experienced stigma due to your mental illness?
    a. If you are willing, please describe that experience or those experiences.
4. Do you see your speeches as an attempt to combat stigma?
    a. If so, what particular aspects of what you say and/or how you say it do you use to try and achieve this effect?
5. How do you want audiences to perceive you as a person?
    a. What do you do in your speeches to try and achieve this effect?
6. Making the assumption that many of the people in the audience do not have mental illnesses: Do you want them to consider you the same as them, essentially?
    a. If so, why so?
    b. If not, why not?
7. How do you relate, personally, to the term "normal" as it operates in our culture?
8. Are there things about how to fight stigma that you feel you have learned through your participation with the Speakers Bureau, things you did not know before you joined?
    a. If so, can you describe what you have learned?
9. Are there things about how to fight stigma that you feel you do not yet understand and would like to learn?
    a. If so, what are some of these things?
10. Additional thoughts?

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ABSTRACT

THIS IS *US* SAYING WHO WE ARE: SPEAKING THE RHETORIC OF MENTAL DISABILITY

by

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People with mental disabilities, or what are sometimes referred to as “mental illnesses,” face stigma when they interact with the public. To fight this stigma, the members of a small, grassroots, advocacy organization known as the Speakers Bureau travel to high school and college classrooms narrating their experiences with mental disability. They do so to replace culturally circulating stereotypes regarding such disability with more accurate and positive images. This dissertation is an auto-ethnographic exploration of the rhetoric of the Speakers Bureau. Through rhetorical analysis of members’ classroom speeches, interviews with each speaker, and the speaker’s self- assessment of their own rhetorical motivations, it identifies the moves one group of mentally disabled speakers makes to circumvent the impasses that stigma puts in their way of their efforts to persuade audiences to let go of negative perceptions of people who bear psychiatric diagnoses. The study of the Speaker’s Bureau’s rhetoric involved six participants including the author. It led to the following conclusions: First, the way in which a mentally disabled speaker represents her identity to audiences depends on which model of mental disability she accepts—the “medical model,” which posits mental disability as an illness

that medication can successfully address, or the "consumer/survivor/ex-patient" model, which considers mental disability not a defect but simply an alternative way of being human. Second, the speakers' attempts to persuade rely on "deep disclosure" of the disturbing nature of their experiences with mental disability. Deep disclosure makes the speakers vulnerable to rejection by the audience, but may also open the possibility for a reciprocal vulnerability in members of the audience, vulnerability to the idea that mental disability can affect them and vulnerability to a change in the audience member's faith in the idea of normalcy. Through these vulnerabilities, the speaker and the audience member grant each other agency. The speaker grants the audience the agency to accept or reject him, and the audience member grants the speaker the agency to truly change the audience member's perception of mentally disabled people. Through these mutual acknowledgments of agency, the agentive potential of each speech comes into being.

AUTOBIOGRAPHICAL STATEMENT

N. Renuka Uthappa was born in Detroit, Michigan in 1967. She received her B.A. from the University of Michigan and her M.A. from Eastern Michigan University. She spent a decade as a housing/homelessness activist with the Ann Arbor Homeless Action Committee. The work of this non-violent, direct action group involved rhetoric in its written, spoken, and embodied forms (such as demonstrations, building occupations, and guerrilla theater). Hearing about the advocacy work of the Speakers Bureau offered a welcome opportunity to join another group of people who harness rhetoric in the service of social justice, this time in the attempt to counteract the mental disability stigma that leads to discrimination and other indignities.

Renuka's own mental disability, diagnosed when she was twenty, is a moderate one. As one of the lucky ones who have experienced decades of wellness, she has enjoyed opportunities often denied to people with more severe conditions— such as maintaining a marriage, pursuing higher education, and pursuing a career. Her time working as a direct care provider for people with severe mental disabilities gave her an appreciation for their daily heroism and a concern for the societal barriers in the way of their full participation in the community. She hopes to continue to be a part of the fight to eliminate these barriers in solidarity with her sisters and brothers in mental disability and our allies.