55. In his account in 1849 of the escape of William Box Brown, the abolitionist Charles Stearns compared Brown's escape to the Crafts', noting that William and Ellen's use of public transportation was extremely risky. Unlike Brown, however, "They had the benefit of their eyes and ears," even as Ellen feigned deafness and helplessness: Stearns, *Narrative of Henry Box Brown*, vii.

56. William Craft, *Running a Thousand Miles for Freedom; or, the Escape of William and Ellen Craft from Slavery* (London: William Tweedie, 1860), 34–35, 51–52.

57. See Lindon Barrett, "Hand-Writing: Legibility and the White Body in *Running a Thousand Miles for Freedom*," *American Literature* 69 (June 1997): 319, 322, 330–332; Sterling Lecatur Bland, *Voices of the Fugitives: Runaway Slave Stories and Their Fictions of Self-Creation* (Westport, Conn.: Greenwood Press, 2000), 8, 22, 141, 156; Michael A. Chaney, *Fugitive Vision: Slave Image and Black Identity in Antebellum Narrative* (Bloomington: Indiana University Press, 2007), 80–82, 97; Jennifer Fleischner, *Mastering Slavery: Memory, Family, and Identity in Women's Slave Narratives* (New York: New York University Press, 1996), 35; Susan Gubar, *Racechanges: White Skin, Black Face in American Culture* (New York: Oxford University Press, 2000), 13; Charles J. Heglar, *Rethinking the Slave Narrative: Slave Marriage and the Narratives of Henry Bibb and William and Ellen Craft* (Westport, Conn.: Greenwood Press, 2001), 81–86; Barbara McCaskill, "'Yours Very Truly': Ellen Craft—The Fugitive as Text and Artifact," *African American Review* 28 (Winter 1994): 510–511; Ellen M. Weinauer, "'A Most Respectable Looking Gentleman': Passing, Possession, and Transgression in *Running a Thousand Miles for Freedom*," in *Passing and the Fictions of Identity*, ed. Elaine K. Ginsberg (Durham, N.C.: Duke University Press, 1996), 38–39, 44–45.

58. Ellen Samuels, "'A Complication of Complaints': Untangling Disability, Race, and Gender in William and Ellen Craft's *Running a Thousand Miles for Freedom*," *MELUS* 31 (Fall 2006): 16.

59. Interview of William and Ellen Craft, originally published in *Chambers' Edinburgh Journal* 15, series 2 (March 15, 1861), in Blassingame, *Slave Testimony*, 270–271. See also Samuels, "A Complication of Complaints," 17.

60. Craft, *Running a Thousand Miles*, 44.

61. Ibid., 71–73; interview of William and Ellen Craft, in Blassingame, *Slave Testimony*, 272–273.

62. Craft, *Running a Thousand Miles*, 35–36.

63. Ibid., 79, 81.

64. Thomas Wallace Knox, *Underground; or, Life Below the Surface* (Hartford, Conn.: J. B. Burr, 1876), 433.

65. Ibid., 434.

66. Samuels, "A Complication of Complaints," 28–29.

67. Ibid., 20–22.

68. Ira Berlin, *Generations of Captivity: A History of African-American Slaves* (Cambridge, Mass.: Harvard University Press, 2003), 3.

6 Passing as Sane, or How to Get People to Sit Next to You on the Bus

PETA COX

FOR THE PAST FIVE YEARS, I have been taking public transport in Sydney, Australia. I ride on buses, trains, and the occasional ferry.[1] My experiences have prompted me to develop the following rules for appearing sane on public transport:

1. Do not talk to yourself. This includes not mumbling obscenities under your breath about the late arrival of the train or bus or about the incompetence of the driver. It does not include pretending to talk on a mobile phone that then rings. For this you will be deemed a jerk, not mad.[2]
2. Avoid eye movements that are too fast or too slow. Do not stare at a person, although staring at the ground or toward the middle distance is fine. Try not to show your agitation by looking repeatedly around the vehicle. If you are concerned about someone or something coming into the vehicle, look up from your book or focus point every ten seconds, fix your eyes in the middle distance, and scan, using your peripheral vision.
3. Do not wring your hands or self-soothe. Keep your hands still, though not rigid. Playing a game on your mobile, with the sound off to indicate an awareness of other passengers, is a good middle-ground activity.
4. If you must avoid touching poles, seats, and other surfaces that could transmit germs, make this avoidance appear casual.

Where possible, remain seated until the vehicle has stopped so you do not need to grab anything for balance. If you *have* to stand in a vehicle, do not cover your hands with the sleeve of your jacket; rather, lean against a wall or balance pole with a part of your body already covered by clothing.

5. Do not attempt to converse with others. Asking questions that require one-word answers is OK ("Do you know what this stop is?" "Can you tell me the time?"), as are rhetorical questions ("Bloody hot day today, eh?").
6. Observe the dress code. Try to look unremarkable—avoid wearing five different shades of pink or a wizard outfit. A clean appearance always helps.[3]

As these examples highlight, passing as sane occurs when a person who is experiencing psychological distress or non-normative emotional states or cognition manages to avoid displaying these states in the presence of others. "Passing" therefore occurs when others do not perceive the person as distressed.[4] Passing is particularly important for people diagnosed with a mental illness, because the costs of not passing can be quite high—including, in some instances, nonconsensual treatment and involuntary hospitalization.[5]

This chapter uses feminist accounts of performativity to examine the complex relationships among acts of passing, experiences of embodiment, and identification as a person with a mental illness. Theories of performativity destabilize the distinction between "being" and "acting" and, in so doing, help us understand the experience of passing as sane as a complex undertaking that can either increase or decrease an individual's distress.

Passing as sane often depends on a person's embodiment, specifically how an individual's body is held, placed, and experienced by that individual, as well as how others interpret this embodiment. Popular understandings of embodiment routinely position it either as a meaningless but unavoidable result of having a body or as an expression of personality. Scholars who use the concept of performativity dispute these understandings of embodiment and assert that certain repeated actions become culturally significant because they *give the sense*, both to the individual and to observers, that the individual is a particular type of person.

Although some feminist accounts position passing as a legitimate aspect of subjectivity, passing is more routinely considered a negative pursuit, the unfortunate result of personal shame and social stigma. For example, Tobin Siebers positions passing as a negative action in which, at times, people are "locked in the closet." While this is true in some circumstances, it is equally true that some people find it comforting to be able to lock the door and protect themselves from the outside world.[6] Thus, a deeper understanding of passing as sane leads us to understand such strategic actions in less absolute moral terms and acknowledge that the actions are legitimate choices regarding when and where attributes or identities are on display.

To understand what it means to pass as sane, a definition of sanity is required. The definition is culturally represented as the normalized and nearly invisible opposite of mental illness.[7] Yet while mental illness may be entrenched in the cultural imaginary, defining it remains extremely difficult. The emotional and cognitive states and behaviors that are understood as "sick" vary significantly over time and place.[8] Such changes reflect the morals and norms of a particular period and location. For instance, the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was, in large part, a response to activism by gay and lesbian people as part of the gay pride movement in the 1970s.[9] Throughout most of the twentieth century, the moral and social norms regarding sexual orientation supported understanding homosexuality as a sickness. Similarly, over the past two millennia, understandings of extreme sadness have included various explanations, such as an imbalance in the humors, a vice, a sin, a type of pathological mourning, and a chemical imbalance in the brain.[10] Each explanation made sense and was consistent with explanatory and moral frameworks of the period when it was used.

These examples demonstrate how cultural norms both create and restrict definitions of mental illness. However, this insight does not negate the lived experience of distress; it simply acknowledges that this lived experience is influenced by the available explanatory discourses.[11] Emily Martin's definition of manic depression demonstrates this social constructionist perspective:

Will I be claiming that manic depression is not "real"? Not at all. I will claim that the reality of manic depression lies in more

than whatever biological traits may accompany it. The "reality" of manic depression lies in the cultural contexts that give particular meanings to its oscillations and multiplicities. Will I be claiming that people living under the description of manic depression do not need treatment? Not at all. I will claim that whatever suffering attends the condition should be treated by any means possible. But I will also say that manic depression is culturally inflected: its "irrational" heights and depths are entwined in the present-day cultural imagination.[12]

Performativity theorists extend social constructionism and argue that our sense of self is a construct created through repeated and ritualized action. Judith Butler argues that rather than *being* a gender, we continuously *enact* a gender, and through this we construct a sense of a gendered core that is both continuous and immovable. For Butler there is no self, no "doer behind the deed"; instead, the stylized repetition of gendered acts gives the impression that there is such a core. Butler notes that there are limits to the types of selves that can be constructed through performativity, as it is a "compulsory repetition of prior and subjectivating norms, ones which cannot be thrown off at will, but which work, animate, and constrain the gendered subject."[13]

Similar to the deliberate act of passing, in which a person seeks a particular type of reaction from others, gender performativity occurs through relation: "One does not 'do' one's gender alone. One is always 'doing' with or for another, even if that other is only imaginary."[14] However, most theorists agree that there is a categorical distinction between choosing to act in a particular way and repeated enactments of social norms that create a particular sense of self. Butler makes this distinction plain when she states:

> *In no sense can it be concluded that the part of gender that is performed is the truth of gender; performance as bounded "act" is distinguished from performativity insofar as the latter consists in a reiteration of norms which precede, constrain, and exceed the performer and in that sense cannot be taken as the fabrication of the performer's "will" or "choice." . . . The reduction of performativity to performance would be a mistake.*[15]

This differentiation means that many gender studies scholars consider arguments that merge gender performance and gender performativity

suspect or inaccurate. However, as discussed later, separating performance and performativity is less useful when dealing with passing as sane, since the experiences of managing emotional distress often disrupt a distinction between deliberate and ritualized presentations of self.

Another key aspect of performativity theory is that there is no original gender or gendered relationship that is "copied" by non-normative others (e.g., butch lesbians, drag queens, femme gay men). Rather, all genders are enactments.[16] Thus, the concept of performativity implies that all behavior is a type of performance or enactment.

Thinking of mental illness as performative means that every person, regardless of the perceived "reality" of that individual's mental state, passes as sane or insane. In other words, every action is a construction of self that gives the perception of an internal sane or insane self.

While theories of performativity are useful as a starting point in examining passing as sane, there are fundamental differences between gender and mental illness that limit the applicability of this theory. The link between deliberate performance and successful enactment of selfhood for gendered presentation differs from that for mental health. In the case of masculinity, men who feel they are *acting* masculine often report that they feel they are failing at *being* masculine; thus, deliberately "walking like a man" may feel like a less successful enactment of masculinity than if such actions were to "come naturally."[17] By contrast, the *acting* of mental health, even when a person experiences that acting as a false presentation, is an aspect of *being* "mentally healthy." Western culture understands the "ability to continue acting 'normal'" as part of the definition, and the experience, of good mental health.

To demonstrate the relationship between acting "normal," passing as sane, and *experiencing* oneself as sane, imagine two people diagnosed with depression. Both report feeling the same level of sadness and despair. Yet one goes to work and the other takes the day off. Is it still reasonable to say that these two individuals are equally unwell? Similarly, imagine the person who hears voices but does not yell back at them in the street, or the person who has a panic attack but does not run down the road yelling that the world is ending. Is this performance, this enactment for self and audience of a lack of distress, not actually the same as *having* less distress? Thus, in both the commonsense and the medical understanding of these experiences, how one reacts to physical and emotional manifestations of distress (i.e., symptoms) may be understood as a symptom in and of itself.

Similarly, both laypeople and professionals interpret an individual's long-term reactions to symptoms as indicators of how "mentally ill" that person is. Such assessments are not based on what a person thinks or feels. Rather, these assessments focus on what one does, and does not do, with one's body. For example, some ways of coping with emotional distress are deemed indicators of mental illness (excessive use of alcohol, self-harm, engagement in crime, forced vomiting, and suicidal ideation and behavior are, respectively, part of the DSM-IV-TR criteria for alcohol dependence, borderline personality disorder, conduct disorder, bulimia, and depression).[18] A person who engages in particular embodied practices may be classified as mentally ill or may be deemed *more severely* mentally ill. In comparison, a person who takes medication, goes to a psychiatrist, stays at a hospital, does exercise, and practices meditation is typically considered *less* mentally ill.[19] It is thus not solely a person's symptoms or internal state but, rather, that individual's embodied responses to the symptoms that determine how "mentally ill" the person is deemed to be.

Mainstream interventions for affective disorders such as desensitization also focus on reactions to symptoms, with the goal of allowing the individual to pass as non-symptomatic. Some psychologists use desensitization to treat anxiety and phobias. Desensitization involves graded exposure: controlled engagement with the phobic object or situation, increasing in intensity over time.[20] For example, L. J. Gilroy and colleagues' system for graded exposure to a spider involves individuals' relating to a live spider enclosed in a container placed on a table. Step one is to enter the room; step four is to touch the container in which the spider is enclosed; and the final step involves holding the spider with both hands.[21] At each stage, the person feels afraid but proceeds with the required action. In other words, the person acts "normal" (performs "normally").

Mainstream therapies such as desensitization and cognitive-behavioral therapy are often coupled with skills training. While the aim of such training is to enable people to function better in their day-to-day lives, the training also teaches individuals how to pass as sane. Skills learned might include breathing techniques and ways to remain calm and continue to function in distressing situations. In these instances, the practitioner assesses as less impaired the client who can *act* in ways that *appear* normal—the client who does not, for example, obviously hyperventilate or run out of a confined place. In other words, practitioners routinely assess impairment as reduced when the client can pass as sane. However, clients are likely to think of themselves as "cured" of their anxiety only when they are not experiencing symptoms. Thus, for many practitioners and their clients, "cure" occurs when the deliberate *performance* of being OK can routinely be used as a mechanism to stop distressing emotional or embodied states. Unlike gender performativity, in which embodiment, subjectivity, ritual, and performance are typically considered part of a singular lived experience, the performativity of mental health may involve more stratification. Specifically, the deliberate *performance* of being OK may at times be either enmeshed within or very distinct from the subjective embodiment of being OK or asymptomatic. Or to put this in colloquial self-help terms, both mindfulness and desensitization are therapies based on "fake it 'til you make it."[22]

This use of performance to preempt performativity also occurs in more everyday situations. For some people, being told by friends or family members, "You are not going to get upset," will stop them from becoming more distressed. In these instances, the first few minutes of trying not to be upset may involve some form of quivering-lip, teary-eyed pretending. However, when this type of intervention is successful, a few minutes later the lips stop quivering, the eyes dry, and the pretense is no longer needed, because the person really *is* OK. In other words, the emotional spiral is abated by an approximation of the embodiment of OK-ness. What has been a solely physical shift (stopping crying) becomes a psychological one (a lack of distress). Thus, the performance has become performativity.

The ability to fake it 'til you make it, or pass as sane, relies heavily on knowing what behaviors signify mental health in a particular community. Expectations of sane behavior vary across communities and identities; most people's expectation of the "sane" behavior of a middle-aged white woman differs from their expectation of the "sane" behavior of a teenage African American male.[23] In fact, the ability to pass as sane does not depend on a singular set of criteria for sanity. Rather, passing as sane requires that a person refrain from breaking the social norms regarding other aspects of that individual's identity; one's sanity falls into question if one does not act appropriately for one's gender, race, class, sexuality, religion, and so on.[24] In the Australian context, the identity-dependent nature of passing as sane is apparent when we examine published accounts of the different coping behaviors of men and women with depression. Whereas women describe managing their

symptoms by taking bubble baths, reading quietly, cooking, receiving affirmation from a lover, and looking after their children, men report that they manage their symptoms by drinking with "mates" or by themselves, joking, distancing themselves from family and friends, and damaging property.[25] In these instances, adherence to gender norms (women doing womanly things and men doing manly things) is a key aspect of being understood as sane. Had these people deviated from conservative gender norms—if the men had enjoyed bubble baths or the women had damaged property—it is likely that they would have been perceived as more mentally ill than they would have been had they remained appropriately gendered. Passing as sane depends on a wide range of social markers, such as race, gender, class, and sexuality.

WHILE PASSING may be therapeutically useful as a mechanism for encouraging individuals to fake it 'til they make it, for many people passing as sane remains a deliberate and strategic performance that is morally devalued because it is considered a signifier of shame. As the social scientist Kenneth Paterson notes, the person who feels that it is necessary to "wear a mask" to continue relationships with friends and family may also feel that this behavior requires universal rejection of the person's "true" self.[26]

This understanding of passing appears to be centered on a belief that the need to pass is, in itself, an indication that a person is experiencing a mental illness. For instance, on an Australian Internet forum about experiences of depression, an anonymous participant writes: "For what feels like forever I have been pretending that I'm ok. I go through everyday with a fake smile just biding my time until I can go home and curl up in a ball and sleep."[27] In this instance, the "fakeness" of the coping is presented by the author as evidence of being unwell. Ironically, a person may interpret the very actions that promote the appearance of sanity as evidence of *in*sanity, so passing behaviors may augment rather than diminish distress. In these circumstances—when it remains a continuous, and self-conscious, "acting"—passing as sane is likely to be experienced as a destructive or negative behavior.

For people diagnosed with a mental illness, masquerading as insane may have a variety of benefits. Siebers uses the term "masquerade" to describe the act of exhibiting an impairment or implying that one has a different form of disability. He argues, "The masquerade represents an alternative method of managing social stigma through disguise, one relying not on the imitation of a dominant social role but on the assumption of an identity marked as stigmatized, marginal, or inferior."[28] In line with Siebers's understanding of "masquerade," passing as insane or intentionally exhibiting insane behavior may grant access to services that passing as sane would not. As a participant in Paterson's study of Australians living with depression notes, "I wouldn't have bothered applying [for federal aid] if I wasn't just continuing weeping from the eyes, and just completely dysfunctional. . . . I wouldn't have been able to get the appointment. What's the point? They're not going to believe me."[29] This example depicts a participant who felt compelled to exhibit mental illness, or masquerade as insane, when applying for mental-health–related support from the government.

For some, passing as insane provides a valuable sense of community and enjoyment, as is the case with the members of a bipolar support group that the anthropologist Emily Martin observed:

> The next moment, a man who had come to meetings week after week, but who always sat quietly, saying nothing, with a gloomy expression and dejected appearance said, "I don't usually say anything at all, I have been silent here for weeks and weeks, but tonight I realize I can't hold it all in. I have to let it out." Then, he launched into a string of shockingly barbed and funny jokes. Startled, everyone looked around the table hesitantly. Smiles bloomed as a rapid "eye flash"—eye contact that moved rapidly around the group—signalled the start of a hilarious session of joke telling that took up the entire rest of the two-hour meeting.[30]

Martin describes the support group as engaging in what Siebers defines as masquerade. Specifically, the group members exaggerate their manic symptoms deliberately as part of their social interaction.[31] This example counters the characterization of passing as always the shameful or undesired behavior described earlier in the chapter, as the group members appear to enjoy their exaggerated interactions. Moreover, passing as (in)sane has a surprisingly strong link to pleasure; passing as sane often helps to reduce distress, while passing as insane, at least in some instances, can be both amusing and joyful.

Both passing as sane and passing as insane are cultural and reflexive practices. Passing as sane (or insane) is a constant enactment of self that depends on knowing social norms of sanity and a range of other social identities, such as gender, sexuality, class, and race. Passing as sane plays on the edge between acting and being, which is also the edge between performance and performativity. At times, people diagnosed with a mental illness can use the tension between acting and being as a way to manage their symptoms or to maintain social engagement despite their distress. However, at other times, such passing may exacerbate distress. At its most extreme, passing as (in)sane may collapse the division between acting and being, so that what was once a deliberate act becomes a ritualized construction of self. In this way, the experiences of those with mental illness suggest a merging between performance and performativity that offers us new insight into passing and other issues of identity presentation.

Notes

1. Although I am based in Australia, my research and observations are relevant to the American context because modern beliefs about insanity in Western countries such as Australia and the United States have a close link to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and the mainstream use of psychopharmacology, which is heavily promoted within the United States. See Catherine Coleborne and Dolly MacKinnon, *Madness in Australia: Histories, Heritage and Asylum* (Brisbane, Australia: University of Queensland Press, 2003); Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Sickness* (St. Louis, Mo.: Mosby, 1980); Peter Kramer, *Listening to Prozac* (New York: Penguin, 1993); Adam Phillips, *Going Sane* (New York: Penguin, 2005).

2. See also Margaret Price, *Mad at School: Rhetorics of Mental Disability and Academic Life* (Ann Arbor: University of Michigan Press, 2011).

3. This set of "rules" is specific to mental illness. No other illnesses and conditions will have their own sets of behaviors that, in public places, are understood to be indicative of "sickness." For an extended discussion of disability in public, see Susan Marie Schweik, *The Ugly Laws: Disability in Public* (New York: New York University Press, 2009).

4. I use the terms "sane" and "insane" because they are meaningful social and moral categories in modern Western culture. This does not suggest that I support the negative stereotypes often associated with these terms.

5. For a social constructionist definition of mental illness, see Juliet Foster, *Journeys through Mental Illness: Client Experiences and Understandings of Mental Distress* (Basingstoke, U.K.: Palgrave Macmillan, 2007); David Healy, *Mania: A Short History of Bipolar Disorder* (Baltimore: Johns Hopkins University Press, 2008); David Pilgrim and Richard Bentall, "The Medicalisation of Misery: A Critical Realist Analysis of the Concept of Depression," *Journal of Mental Health* 8 (1999): 261–274.

6. Tobin Siebers, "Disability as Masquerade," *Literature and Medicine* 23 (Spring 2004): 19.

7. Phillips, *Going Sane.*

8. Robert Daly, "Before Depression: The Medieval Vice of Acedia," *Psychiatry* 70, no. 1 (2007): 30; Emily Martin, *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton, N.J.: Princeton University Press, 2007); Healy, *Mania.*

9. Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (New York: Basic Books, 1981); Robert Spitzer, "The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues," *American Journal of Psychiatry* 138 (1981): 210–215; Ronald Bayer and Robert Spitzer, "Edited Correspondence on the Status of Homosexuality in DSM-III," *Journal of the History of the Behavioral Sciences* 18, no. 1 (1982): 32–52; Gerald Davison, "Politics, Ethics, and Therapy for Homosexuality," *American Behavioral Scientist* 25, no. 4 (1982): 423–434; Richard Friedman and Jennifer Downey, "Psychoanalysis and the Model of Homosexuality as Psychopathology: A Historical Overview," *American Journal of Psychoanalysis* 58, no. 3 (1998): 249–270; Gary Greenberg, "Right Answers, Wrong Reasons: Revisiting the Deletion of Homosexuality from the DSM," *Review of General Psychology* 1, no. 3 (1997): 256–270; Charles Silverstein, "The Implications of Removing Homosexuality from the DSM as a Mental Disorder," *Archives of Sexual Behavior* 38, no. 2 (2009): 161–163.

10. Daly, "Before Depression," 30; Martin, *Bipolar Expeditions,* 16–28; Healy, *Mania,* 1–51.

11. Marino Perez-Alvarez, Louis Sass, and José Garcia-Montes, "More Aristotle, Less DSM: The Ontology of Mental Disorders in Constructivist Perspective," *Philosophy, Psychiatry, and Psychology* 15, no. 3 (2009): 212.

12. Martin, *Bipolar Expeditions,* 29.

13. Judith Butler, "Critically Queer," *GLQ: A Journal of Lesbian and Gay Studies* 1, no. 1 (1993): 22; Edwina Barvosa-Carter, "Strange Tempest: Agency, Poststructuralism, and the Shape of Feminist Politics to Come," in *Butler Matters: Judith Butler's Impact on Feminist and Queer Studies,* ed. Margaret Sönser Breen and Warren J. Blumefeld (London: Ashgate Publishing, 2005), 176; Judith Butler, *Gender Trouble* (New York: Routledge, 1990); Butler, "Critically Queer," 22.

14. Judith Butler, *Undoing Gender* (New York: Routledge, 2004), 1.

15. Butler, "Critically Queer," 24; italics in the original.

16. Butler, *Undoing Gender,* 209.

17. R. W. Connell, *Gender* (Cambridge: Polity Press, 2002).

18. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR,* 4th ed. (Washington, D.C.: American Psychiatric Association, 2000).

19. Ironically, in these examples, it is behavior indicating that a person believes he or she has a mental illness that positions that person as *less* severely mentally ill, because such behavior positions the individual as being rational and responsible (i.e., the person is taking responsibility for his or her own health and minimizing any self-inflicted harm and/or harm to others)—characteristics that in Western culture are not associated with severe mental illness.

20. M. Gelder, I. Marks, and H. Wolff, "Desensitization and Psychotherapy in the Treatment of Phobic States: A Controlled Inquiry," *British Journal of Psychiatry* 113 (1967): 53–73; Jeffrey Bedell, Robert Archer, and Michael Rosmann, "Relaxation Therapy, Desensitization, and the Treatment of Anxiety-Based Disorders," *Journal of Clinical Psychology* 35, no. 4 (2006): 840–843.

21. Lisa J. Gilroy, Kenneth C. Kirkby, Brett A. Daniels, Ross G. Menzies, and Iain M. Montgomery, "Controlled Comparison of Computer-Aided Vicarious Exposure versus Live Exposure in the Treatment of Spider Phobia," *Behavior Therapy* 31, no. 4 (2000): 733–744.

22. See, e.g., Katie Evans, *Understanding Depression and Addiction Pamphlet* (Center City, Minn.: Hazelden Publishing, 2003).

23. See Peter Sedgwick, *Psycho Politics: Laing, Foucault, Goffman, Szasz, and the Future of Mass Psychiatry* (New York: Harper and Row, 1982), 45.

24. See Barvosa-Carter, "Strange Tempest," 179.

25. Tessa Wigney, Kerrie Eyers, and Gordon Parker, *Journeys with the Black Dog: Inspirational Stories of Bringing Depression to Heel* (Sydney: Allen and Unwin Academic, 2008), 47, 247; Penelope Rowe and Jessica Rowe, *The Best of Times, the Worst of Times: Our Family's Journey with Bipolar* (Sydney: Allen and Unwin, 2005), 38, 46; Craig Hamilton, *Broken Open* (Sydney: Bantam, 2004), 56, 123.

26. Kenneth Paterson, "Living with Depression: Resisting Labels and Constructing Pathways to Empowerment" (Ph.D. diss., University of Queensland, Brisbane, Australia, 2009), 82.

27. "Blue Board," Centre for Mental Health Research, Australian National University, available online at http://www.blueboard.anu.edu.au (accessed June 1, 2011).

28. Siebers, "Disability as Masquerade," 5.

29. Paterson, "Living with Depression," 102.

30. Martin, *Bipolar Expeditions*, 75.

31. Ibid., 75–76.

7

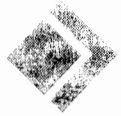
Athlete First

A Note on Passing, Disability, and Sport

MICHAEL A. REMBIS

FOR SOME DISABLED PEOPLE, being viewed as an athlete first is the ultimate compliment, and the ultimate goal. Deborah, for example, likes to think of herself as a "sports . . . person—*not* as a woman—and *not* as disabled." She adds, "It's *very* hard work, but I like to feel strong and powerful and that's how I win gold medals—in the same way able-bodied people do."[1] The Major League Baseball (MLB) pitcher Jim Abbott reportedly once said, "I never told myself that I wanted to be the next Pete Gray [a physically impaired outfielder who played one season in 1945]. I always said I wanted to be the next Nolan Ryan."[2] This revelation compelled one baseball historian to explain that Abbott's comment was not meant as an insult to Gray but was a statement of Abbott's desire to be seen as a "ballplayer—not a 'one-armed' ballplayer."[3] While on the surface these admissions may seem innocuous or even empowering, a testament to ideas of "inclusion" and "normalization," I argue that they are a powerful and, in some cases, physically and psychically debilitating form of passing.[4]

"Athlete First" is the title of a recent monograph on the history of the Paralympics (Steve Bailey, *Athlete First: A History of the Paralympic Movement* [Hoboken, N.J.: John Wiley and Sons, 2008]). My subtitle is (I hope) an obvious play on Erving Goffman's universally influential study *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon and Schuster, 1963).



Disability *and* Passing

Blurring the Lines of Identity

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