

Chapter 11

“I Don’t Ask God to Move the Mountain, Just Give Me the Strength to Climb It”: Disability Stories of Southern Rural African American Women

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Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and
no man could head me! And ain’t I a woman? *Sojourner Truth*, December 1851

Introduction

Sojourner Truth, abolitionist, preacher, and advocate of women’s rights, is emblematic of the history of oppression that American Black women have faced throughout the brutal exploitation of their (re)productive labor over the last three centuries, as well as the strategies of resilience and resistance employed by Black women in facing these oppressions (Mullings 2006). Truth also represents the gendered expectations of Black women, many of whom are responsible for their family’s economic health, the health of their households, and for the community’s wellbeing—often at the expense of their own health and personal wellbeing.

Historically, Black women have been “triply” oppressed (King 1988). In the dominant U.S. society, images that reflect gender oppression as well as racial oppression have been cast against them over time. Additionally, Black American women have also been oppressed as second-class workers. Truth’s 1851 speech, delivered at the Women’s Convention in Akron, Ohio, responded to new mid-nineteenth century attitudes constructed around the idea of the innate superiority of men over women. The cult of domesticity held that a woman’s place should be in the home and that the ideal woman was dainty and frail, centering her sole attention on rearing her children and managing the household. Within this cult, then, women were relegated to the private (domestic) sphere, making them economically dependent on their husbands working in the public sphere: “...the domestic code controlled women's behavior by threatening those who deviated from it with the loss of their feminine identity.”

The cult of domesticity held that a woman’s place should be in the home and that the ideal woman was dainty and frail; this new age woman should center her sole attention on rearing her children and managing and maintaining the household for the benefit of her husband. Within the cult of domesticity, women were relegated to the private (domestic) sphere, making them economically dependent on their husbands working in the public sphere: “...the domestic code controlled women's behavior by threatening those who deviated from it with the loss of their feminine identity” (Glenn, 1991, p. 265). However, these standards did not apply to Black women. Due to their enslavement and subsequent forced labor as sharecroppers and subsistence/agricultural workers, Black women were not afforded the opportunity to work solely inside the home. Not only could they not wholly participate in the domestic sphere, but the very labor that subsumed much of their time denied them ready access to maternal and reproductive roles within their own families. Thus, subverting a constructed dichotomy between public

and private, in which men's labor in the public sphere is positioned as more valuable than women's work in the private sphere, Truth points out the ironies of working hard in the public sphere, like a man, while still being denied this new label of womanhood.

Evelyn Nakano Glenn (1991) writes of a "myth of female disability" resulting from this cult of domesticity. "Real" women, as defined by their proper behavior within this cult, were not able to perform certain tasks relegated to the public sphere. White women were thus constructed as disabled in terms of their ability to compete with White male standards of ability, standards that were measured by White male participation in the public sphere. Accordingly, male standards included leadership within the household and community, and importantly, the male role in acquiring cash and capital in a burgeoning capitalist economy. For a woman to be disabled in this way, interestingly, gave her the full status of womanhood in a paradigm built on women as central to the domestic sphere and "unable" in the public sphere, outside the home. On the other hand, using this same logic, Black women were constructed as "able" in the public sphere, while at the same time *disabled* women, in terms of their *inability* to compete in a cult of domesticity.

While continually working in the public sector, whether in nineteenth century women's houses as maids and servants, or in the twentieth century as they moved into jobs in the service sector as food service and health care workers, Black women's jobs often centered on their ability to fulfill reproductive functions. Thus, they were subject to a cruel twist of fate: they were not allowed to participate in the ideals of the cult of domesticity that centered upon one's reproductive capabilities in the private sphere—within their *own* home—while they worked in the public sphere in low-end, low-paid jobs in the homes and later businesses of others as caretakers (Collins 1984, Glenn 1991). At the same time, however, Black women also took on a "second shift," as they were often conceived of as the center of their own communities, working to uphold "the race" by taking care of their own children, others' children, the sick, and other community members in need (Hochschild 1990, Glenn 1991).

From a postcolonial standpoint, the need to create a caste of people who are "disabled" in some way by their "otherness" is a part of a capitalist system based on the exploitation of the surplus (outsider, extra, "othered") laborers (Dossa 2005; Kliever & Fitzgerald 2001; Lacom 2002). Though disabled in terms of access to power within dominant society, this "othered" caste is at the same time exploited for any productive value contained within their bodies. Thus, while judged as non-valuable according to their "othered" bodies, they are only deemed as valuable in terms of the *contributions* their bodies can make to the profit economy. Poor Black women are said to be treated like "mules" in low level and low wage service-sector jobs where they do not make enough money to adequately support their families (Collins 2000; Hurston [1937]1998). These literally back breaking jobs, which may be linked to back problems, arthritis, and carpal tunnel syndrome, among other work-related ailments, are some of the only available in a draconian state system pitting women as mothers against the need to fulfill particular job requirements in order to receive state welfare benefits. Generally speaking, the field of Postcolonial Studies centers on the interactions of European nations and the societies they colonized in the modern world. Subsumed in this study is the discourse on race and gender oppression in the capitalist world system. However, this discourse fails to engage an analysis of disability and the ways that disability, as a label and marker of the "other," is used to control individuals and groups thought not to conform to hegemonic standards (Garland-Thompson 2002).

This article looks at the socially constructed meanings of disability for seven Southern, rural African-American women. I focus on both the social location of the individual participants providing their narratives, as well as the discursive context in which their disabilities are constituted. Stories related to social location focus on poverty, race, and gender as intersecting sites for constructing identities related to disability. A social location framework looks at the ways that differential access to power in the dominant system structures one's experiences, while also noting that social locations are not static and shift according to context. Social locations are presented identities, constructed in response to oppressions (Grenier 2005). Thus, in this paper I focus on the ways that participants frame their disability narratives and situate themselves with particular identities in relation to structural oppressions (such as low-wage work, poverty, gendered expectations, and racism).

As Amanda Grenier (2005) cogently points out, merely conducting a structural analysis and looking at the oppression faced by participants overlooks the participants' own activity in making meaning of their experiences, activity that often denies, subverts, or strategically employs oppression in identity construction. Inspired by her call to go beyond a biomedical or functional approach to disabilities, which sees disabilities as firmly rooted in the body, I take a more social constructionist perspective to determine how both context and social location affect the meanings of disabilities. In this study, I consider both social location *and* discursive context as central to participant constructions of disability.

In her paper on older women's experiences of disability, Grenier (2005) analyzes participants' stories according to their contextual location (i.e. whether participants focus on the home or the bus as a site for constructing identities, some of which are related to disabled identities). Here, I take an alternative meaning of "context" into account, focusing on the *discursive* context of participant narratives used to situate themselves as disabled (or not). First, I focus on two discursive contexts of storytelling, beginning by focusing on a biomedical discourse, which participants readily take up to situate themselves and others with disabled identities. I then look at how participants take up an Afrocentric discourse to situate themselves as disabled women. This discourse includes their inability to mother children, their perceived selfishness, and their dependence on others. I conclude by drawing linkages between a postcolonial perspective on disability or one that allows an outsider-within identity and one in which one participant is able to transcend an oppressed/disabled identity (Lacom 2002; Mattis 2002), and the two other discursive frameworks. Both biomedical and Afrocentric discursive frameworks are equally as consequential in situating women as normal or able in their broadly conceived communities.

Methods

The participant narratives in this study come from a larger study conducted on the growing-up stories of rural African American women. The purpose of this larger study was to better understand the gender socialization process of Black women living in the rural Southern United States. A narrative approach to gender socialization was taken to allow the participants themselves to construct their own meanings of gender socialization, rather than setting their accounts against a human development scale and seeing where participants' experiences "measured up," so to speak, against a normative life plan as written by predominantly white, male social theorists (i.e. Erickson 1968; Freud 1964;

Kohlberg 1969). Participants used the social circumstances of their lives, or their social locations, to make sense of what they have experienced through time. Social circumstances, such as living in a rural area and being African American, female, poor, and/or a drug user, are just a few of the narrative resources that the participants used to give substantiation to their growing up stories.

Theoretical Orientation

A social constructionist perspective informs both my larger project on gender socialization and this paper. In their classic book, *The Social Construction of Reality* (1966), Peter Berger and Thomas Luckmann write that reality is socially constituted: “This proposition asserts that social reality is not a social fact in its own right, but is something produced and communicated, its meaning derived in and through these systems of communication” (McCarthy 1996, p. 20). Thus, a social constructionist perspective sees meaning as constructed, rather than as an eternal truth to be mined and discovered by the researcher if she digs hard enough to find it.

In this paper, I take up the “what” and “how” questions central to a social constructionist perspective (Holstein & Gubrium 2000)—I focus on the participants’ activity, in asking *what* resources participants use to interpret their experiences and *how* these resources are used to make sense of their experiences. Discursive contexts, thus, are implicated as narrative resources in participant stories on disability. I also take a social location approach to participant stories, in that my analysis of participant narratives is also sensitive to circumstance—circumstances informed by the intersection of race, class, and gender, as well as more broadly conceived from a postcolonial standpoint, by dominant discourses out there dictating what is and what is not conceived as “normal.” While participants all share the social circumstances of being rural African-American women living in the South, their situated realities differ in terms of socio-economic status, drug use history, social support networks, religiosity, family background, social problems background, and a myriad of other circumstances. As a feminist anthropologist, I am interested in examining how social circumstances mediate the stories told by participants, the “hows” of participants’ meaning constructions; how the resources for their interpretations, are located in their lived historical, cultural, and social circumstances.

Setting and Participants

Port Charles is a relatively poor rural community located in North Florida with a significant population of African Americans. I selected Port Charles as the site of my larger study on gender socialization because of my familiarity with this town. I got to know several of its community members after assisting in a separate research project conducted within the same vicinity. Statistics covering the entire population of Port Charles show that 23.2% of the people live below the poverty level; compared to 14.4% statewide in Florida; with a median household income of \$25,347 and 8.6% of individuals aged twenty-five or older unemployed (U.S. Census 2000). A significant minority of the population (31.8%) in Port Charles is Black, with the majority being White, Non-Hispanic (62.6%). The industries that provide employment in Port Charles are education, health care, and social services (26.9%); public administration (19.9%); and retail trade (14.0%) (U.S. Census 2000). Many of the jobs within the educational,

health care, and social services sectors are associated with two state-run institutions: a prison located on the outskirts of town and a mental hospital located in a nearby town. In terms of educational level, for a population twenty-five years and over, 72.7% have a high school education or higher, while only 9.8% hold a bachelor's degree or higher, and an even fewer 5.0% hold a graduate or professional degree (U.S. Census 2000).

As part of my larger study, I conducted semi-structured interviews with 20 rural Southern African American women between the ages of 18 and 65. Participants were chosen using a modified snowball-sampling technique (Bernard 2000). For this paper, I chose to focus on the narratives of seven of these 20 women, as these seven participants reflect the narrative breadth of representations of disability from within my larger sample. Representation, here, refers to the discursive realm of disabilities (Garland-Thomson 2002). My goal is to focus on the diversity of representations on disability present in participant narratives to highlight varying experiences with disability expressed by the participants (Grenier 2005). In other words, my goal is not to gather a sample representation of all disabled rural African American women from this community, but to get at the array of ways that disability is represented in participant stories.

Biomedical Perspectives on Disability

13.4 million working age adults are currently medically diagnosed with disabilities. Of that number, 2.4 million (18%) are African American. African American women comprise over 54% of African Americans diagnosed with disabilities and two-thirds of African Americans diagnosed with physical disabilities (Nabors and Pettee 2003, p. 334). Black women are reported as having the second highest rate of disability (21.7%), next to Native American women (21.8%) (Beatty 2003, p. 227). Statistics related to arthritis, which is the leading cause of physical disability listed by the participants in this study, as well as the leading cause of disability in the U.S., show that among the 42 million Americans affected by arthritis, most of those affected are women with low incomes (Feldman & Tegart 2003). Disability is thus linked to structural inequities, such as poverty and race, in their relation to the unequal distribution of social and economic resources. Structural inequities come into play, as a background context for disability, as well as a continuing context throughout disability—as individuals with medically diagnosed disabilities may be unable to work, receiving only a small sum of money from the government as a “benefit” of disability (Groe 1999). Black women receiving welfare benefits are also often constructed as lazy within a political economy centering on productive use value (Seccombe, James & Walters 1998).

The traditional biomedical discourse on disability medicalizes disability; the intervention takes place at the individual level and the treatment or intervention of physiological or mental “problems” affects the individual's body or mind. This approach sees disability as rooted in the individual body and the disabled individual constructed as not normal, not able, or as malfunctioning in some way. Thus, the primary focus of the biomedical treatment plan is on fixing the person rather than changing the environment. Biomedical models of disability ignore social and cultural dimensions of disability and often these omissions lead to a person being labeled as disabled by society (Feldman & Tegart 2003; Stienstra 2002). They establish a dominant societal norm usually referred to as a young and white Christian heterosexual male. This hegemonic conception of bodily norm is also seen as tall and thin, middle-upper class, and importantly, perceived as able bodied. Utilizing this norm, the social and cultural perception or construction of disability

is often overlooked; biomedical models label those who deviate from this dominant societal norm as “other” (Lorde 1984). These conceptions of normality often preclude many individuals and groups in our society from achieving what can be termed as an “able” bodied status (Garland-Thomson 2002; Lorde 1984). Statistics on disability, such as those listed previously, assume that one can measure rates of disability; they assume a common definition of disability as one related to functional inability.

Congruent with the biomedical definition of disability as rooted in individual malfunction, is a common belief that women with disabilities do not contribute to social/economic life and that they are a drain on the state’s resources (Asch 2001). “Cultural stereotypes imagine disabled women as asexual, unfit to reproduce, overly dependent, unattractive—as generally removed from the sphere of true womanhood and feminine beauty” (Garland-Thomson 2002, p. 17). A social constructionist critique of biomedical models of disability suggests that the most important criteria of being labeled as disabled is not the actual functional workings of the individual body, so much as it is the perception or being seen by others as an “impaired woman” (Asch 2001; Groce 1999). Impairment is thus socially constructed and is imbricated in an individual’s inability to succeed in a dominant society—it is written upon a particular normative construction of valued personhood. In terms of value, poor “racialized” women with disabilities are constructed as having little value within a wage economy (Dossa 2005). A social constructionist perspective on disability, however, does not imply that the medicalized characteristics of disability are not real (Asch 2001). Rather, it puts forth that these characteristics influence an individual’s experiences, in terms of her social location within the context of hegemonic bodily norms.

Participants represented in this paper situated themselves, or were labeled by others, as biomedically disabled—either physically or mentally. Physical disability was generally derived from work related activities. Work, then, often figured as the discursive context for situating oneself or another with a biomedically diagnosed physical disability. In terms of work, many of the participants in my larger study on gender socialization had worked, or were currently working, as health care aides in nursing homes and other assisted-living facilities. Taking care of others in these settings, participants described work-related activities as especially strenuous; they described the lifting and carrying they performed to help their clients function in daily life. Ironically, by helping others to function, the participants’ own bodies were said to malfunction. For these participants, a typical work-life trajectory goes from being a self-sufficient caretaker of others, to being disabled due to this caretaking, to receiving or depending on caretaking for oneself. Three participant narratives are particularly evocative of the pain and resulting disability suffered while at work.

Priscilla, a 27-year old woman at the time of the interview, said that she did not work because she had suffered a back injury while working at a nearby nursing home. Still awaiting a settlement from this injury, Priscilla spent much of her time at home, living at her mother’s house and taking care of her younger daughter. She was also an admitted drug user. When asked about her job history, Priscilla situated herself as a “disabled” woman who suffered two slipped discs while trying to lift an older woman out of her wheelchair at the nursing home: “I hurt myself when I was working at Walton Manor. Tried to transfer a patient from a wheelchair to bed and she didn’t want to get her old behind up.” While Priscilla situates herself as disabled in responding to my question of whether or not she works, in another way she distances herself from her own biomedical definition of the disabled by constructing an image of disabled womanhood

that is linked to laziness, unattractiveness (having an *old behind*), and being dependent on the help of others.

Contrasting herself with her disabled client, Priscilla continued that while she is *on* disability, that she would like to eventually find another job, perhaps in a group home that might not expect so much individual labor extracted from her. As she is classified as disabled by the state, she notes that she has faced difficulties searching for another job—when workplaces find out that she has a bad back they will not hire her. However, careful not to fall into the definition that she has constructed for her client, she constructs herself as a person who is not content to stay with her mother, that she is “moving to her own trailer soon,” and who is in limbo right now, waiting for her disability settlement to come through so she can move out and live on her own again.

Part of distancing herself from her disabled clients involves situating herself as a once independent woman. When asked to describe some of her successes while growing up, Priscilla told me that she was proud of the fact that she began working while in high school: “I was working when I was in high school. I worked at the factory. This was like working, ‘cause I was like, really on my own. I really didn’t have to depend on nobody.” Thus, even at an age when she might be expected to depend on her family for economic support, she constructs herself as a woman who was happiest when she was able to support herself. Success is often equated with being able to support oneself—in this case, Priscilla talks about working and being on her own since she was a teenager. Now that she cannot work, and is dependent on her mother and boyfriend for financial support, she may be characterized as “disabled.”

Luella Mae, a 61-year old woman at the time of our interview, also characterized herself as medically disabled, due to the arthritis she has suffered as a result of working a string of strenuous jobs. Tracing her work history, Luella Mae listed a number of jobs that may have contributed to her early debilitation from arthritis. She worked at a state hospital as a nursing attendant, at the local apparel factory, doing pressing (ironing) for the factory, and as a custodian at the state mental hospital. Working as a nursing attendant at a nearby nursing home, Luella Mae was expected to lift and carry patients and to bend and reach at awkward bodily positions in taking care of patients’ daily ablutions. As a presser at the apparel factory, she was required to stand all day long and to strain her back, knee, and wrist muscles in ironing garments produced at the factory. Finally, as a custodian at a nearby mental hospital, she was also required to stand much of the day, compromising the strength in her wrists, knees, and back to vacuum and clean the rooms of “mentally disabled” individuals. All three jobs are thusly noted for the arduous labor required of them and for the low wage they provide to the worker, while two of them are also directly related to caring or looking after the needs of other individuals constructed as disabled in hegemonic conceptions of mind and body functioning.

Perhaps in connection with the laborious jobs running through Luella Mae’s family history (her daughter, Karen, is 40 years old and works as psychiatric aide at the state mental hospital and her younger daughter, Corentine, who is 38, worked as a nursing manager at an assisted living facility), Luella Mae’s daughter, Karen, points out that arthritis “runs in the family,” claiming that she was beginning to feel the effects of arthritis like her mother and her sister, Corentine, who is also disabled in part due to arthritis. While not situating herself as a biomedically disabled woman, Karen’s comments on her mother’s and sister’s disabilities are noteworthy in the way that she constructs a contrast between biomedical diagnoses of disability—a label she bestows

upon her mother—and laziness, which she ascribes to her sister. Karen begins by describing her sister as a loner, whose problems exist more in her own mind than they do in physical reality: “Uh, my sister...we’re not as close as we could be. She’s somewhat...turned into a loner. I don’t know if she think that we don’t love her...or that she can’t trust us as a family, but...she don’t open up to us any. We’re really not that close.”

When asked why she thought that her sister “kept to herself,” Karen linked her sister’s turn in mood to an injury that she suffered “on the job” while working at an assisted-living facility. Again, a discursive context of work is linked to physical disability. However, from her own social location as both a worker who like her sister, also suffers arthritis, but who continues to look after the well-being of her mother rather than keep to herself, Karen positions her sister’s ailment as more a result of a personality defect than as something from which she continues to suffer:

My sister, like, gained a lot of weight and she’s tryin’ to actually get disability, I think, from that. Cause she doesn’t *wanna* work. I don’t think...she’s actually a sick person. I don’t think she wants to work anymore. Yeah, she got injured [at the assisted living facility]. On her knee. And uh, it’s just hard, they had the cartilage removed from her knee. So she’s facing that, and the fact that she’s overweight, well she more complains that she’s disabled, but...I don’t think she really wants to work. She’s somewhat like grandma, grandma was a lazy lady. And she’s a whole lot like her grandma, which is her father’s mother. So it’s just in her not to want to do anything.

Despite acknowledging that Corentine had all of her cartilage removed from her knee (due to an accident she suffered while assisting a client at work), Karen situates her sister as one who is lazy; in fact, one who is genetically predisposed to laziness, rather than as one who continues to suffer a physical disability. Karen distances herself from this genetic predisposition by linking this “defect” directly to Corentine’s grandmother. As Corentine and Karen had different biological fathers, Karen directs the line of acquired laziness through Corentine’s father’s line. Interestingly, she refers to Corentine’s father as being her own “real dad” in other passages of her interview, even relating how she felt that had her stepfather (whom she called “daddy”) not died while she was still quite young that she would lead a different life than she does now. However, as part of her narrative on disability, Karen constructs an alternative position for her stepfather (and his kin) in her life, separating them from having any influence on her own character.

In speaking of her own disability, Corentine centered her disability as more a mental one than as emanating physiologically. She spoke of suffering from depression when her life “fell apart” after she was involved in an accident working at the assisted-living facility where she worked for nine years:

One of the guys at work...he had an accident on himself. And I had to bring him back home. And he got upset. And...when I told him to take his pants...off...I kneeled down. And that’s when he got upset and pushed me and then my back hit the dresser. It was, his name was Greg. He was a client. Yeah, and um...I hit my back...and...that was it. And then I passed, I had a...spasms in back...and my knee, I hurt my knee during the accident. But it didn’t...that didn’t get checked ‘till after the accident was over. And...it’s been downhill for me ever since. I got that, I lost everything I had. And...lost my job and, I had to um...go on welfare and I do a little childcare, it helps make ends meet. And...I try to socialize more, but...that’s a hard thing to do.

Eventually, Corentine went to court to receive workman's compensation for this accident and received a sum of money, which she admits, has now run out. Corentine situates herself as biomedically disabled with depression in relation to losing everything as a result of the accident: she lost the trailer she was planning on moving into, she lost her job, she lost mobility in her back and knee, and she has now lost self-respect by being on welfare. From a social location of economic disempowerment as a result of being on welfare, Corentine links her own mental disability to the loss of her job. Ironically, and similar to Priscilla, Corentine's own disability may be directly linked to a job in which she cared for others with disabilities. Also like Priscilla, Corentine spoke of herself as a woman with potential as a future worker. In contrast to her sister's depictions of her being a "lazy woman," Corentine wistfully related that she would like to get a job in the future, working as a security guard at the nearby prison.

Biomedically situated disabilities, then, were not just linked to physical inabilities. Participants, like Corentine, also situated themselves with mental disabilities (namely depression) as a result of traumatic events in their lives. Within a biomedical discursive context, participants constructed their depression as somehow being organic, or from within themselves. Participants medicalized their depression, often speaking of the medications they were taking to treat their depression and the resulting "sickness" they acquired in response to suffering abuse while young.

Flossie's disability narrative is exemplary in this regard. A 34-year old woman, she spoke of being depressed and "afraid of life." When asked about her childhood memories, she described the sexual abuse that she had suffered at the hands of her cousins at age two and subsequent sexual abuse by her stepfather. Working within biomedical notions of "normality," Flossie situated herself as an "abnormal" woman, who "just wanted to be seen as normal" while in school:

I was in special ed and...I want to be in um...like in...like regular school, you know, regular class. You know and I always...I told my, my...my teachers that...you know...I want to, you know, do like them other kids do. You know, have big re-, have big books, you know lotta books, you know and, you know, studyin' and all that kinda stuff. One day they did that, I say, I couldn't handle it.

Ever since she was a child, Flossie has been labeled as disabled, or "abnormal" in some way. She speaks of being in special education classes in grade school, but wanting to be seen as "normal," not "slow." She spoke of herself as being treated poorly by other children at school, by her own family while growing up, and by those with whom she became romantically entangled when older. As a result of constant abuse, whether physical, in the case of the molestation she suffered while young, or emotional, Flossie characterized herself as an "unfit mother" who was unable to devote proper attention to her own two children.

Flossie related that several years ago she began to suffer flashbacks of sexual abuse from her childhood, and that this resulted in her becoming depressed. She describes herself as one who is unable to function in life, who "walked the streets aimlessly" (before taking depression medications), which contributed to her inability to focus on her children. Similar to Karen's take on her sister Corentine's disability, Flossie also constructs a genetic predisposition for her depression, describing her mother in much the same way that she describes herself. While growing up, her mother was teased mercilessly by her own sisters for being "slow"; her mother also "walked the streets" aimlessly, and she and her mother take the same medications for depression. Flossie

describes her mother as being “incapable” of raising her or of protecting her from the sexual abuse that she suffered while a child.

Concluding this linkage drawn between her own depression and that of her mother, Flossie stated that she was happiest in life when her mother was “happy,” or not treated poorly, and when she, herself, was treated like a “normal child.” Flossie continued to label herself as abnormal throughout her interview, continually focusing on her inability to “cope” with life. She spoke of others “calling her names” while she was growing up—this was trenchantly visible in the very next interview I conducted with Priscilla. Upon completing my interview with Flossie, I hurried over to Priscilla’s house, explaining that my interview with Flossie had taken longer than expected. In a small town, where “everyone knows everyone,” Priscilla immediately launched into a discussion about Flossie and her family—that “everyone in her family is slow”—also situating Flossie as possessing from within a genetically derived “sickness” of mental disability.

While several of the participants constructed themselves, or others, with disabled identities using a biomedically-derived discourse of bodily malfunction, especially in relation to a social location of trauma (whether suffered at work or while growing up), other participants worked within a framework of disability in terms of an inability to function within their own community. In these cases, the participants were not referring so much to their own physical or mental bodily malfunctioning, as to the wider body, or well being, of their families and communities. Being thought of as disabled within the discursive context of the community, in not being able to fulfill gendered expectations leading to connotations of “good womanhood,” could be equally as oppressive for the participants.

Afrocentric Perspectives on Disability

In addition to biomedical constructions of disability, which center on the individual’s malfunctioning body, participants’ growing-up stories also focused on the ability to fit in, or function, within their community. Especially related to connotations of what it meant to be a “good” woman, participants invoked an Afrocentric discourse to situate themselves and others as able or disabled within the community. Afrocentrism emphasizes a connection with African history or culture (Burgess 1994; Feldman & Tegart 2003). Gendered expectations of African-American women within their own communities derive from this perspective:

Many of the activities and characteristics of Black women in America have their roots in Africa. Leadership in the community and in the home, prominence in the world of work, independence and pride in womanhood are usually pointed to as evidence of the strength of African American women. Individual women [are] expected to 'carry their own burdens,' irrespective of gender...[this] necessitates an understanding for the tradition of female independence and responsibility within the family and wider kin groups in Africa and the tradition of female productivity and leadership in the extradomestic or public domain in African societies (Burgess 1994, p. 397).

Afrocentric discourse asserts that African Americans hold strong self esteem through their group identities—notably through their connections with others in kin-related and religious activities (Daly et al. 1995). From an Afrocentric perspective, women have a dual responsibility of being self-sufficient, strong, and resilient, while also holding responsibilities to care for one's family and surrounding community.

Within one study on African American women and disability, the authors noticed that participants' narratives centered on their ability to fulfill a "family role" in continuing to care for other family members, despite their biomedically diagnosed disabilities (Nabors & Pettee 2003). Thus, a person who might be pigeonholed as dependent and frail through a biomedical diagnosis of disability is transformed within an Afrocentric perspective centering on women's continued perseverance—as being the stalwart "backbone" of her family and community. Like biomedical conceptions of disability, use value also figures into Afrocentric versions. However, it is not conceived of in the same way as it is in a dominant discourse of value based upon one's productive contributions to the national political economy. Rather, a woman's use value from an Afrocentric perspective relies upon her ability to care for others, maintain the household, and build relations within the community. Nabors and Pettee (2003) note that one client in their study said that she only felt useful or valued if she was able to continue performing her caretaking role, thus she felt the need to deny her disability to herself and to others.

A Black Feminist approach to disability, incorporating both an analysis of oppression faced by the disabled at the structural level and a more communal worldview of African American women, might more cogently analyze the way African American women situate themselves and others as disabled than do biomedical models (Feldman & Tegart 2003). A Black Feminist perspective to health and wellbeing considers the importance of the family/community linkage to health for Black women; it also centralizes the definition of health and well-being for the participants in themselves. A Black Feminist perspective also recognizes and critiques aspects of the myth of the "strong Black woman" found in Afrocentric models, in which the sanctity of the Black community rests squarely on the shoulders of its Black women members (Cole & Guy-Sheftall 2003, Wallace 1999). The participants in my larger study on gender socialization often spoke of themselves as being socialized to attend to the needs and demands of others (Feldman & Tegart 2003), rather than encouraged to focus on their own needs. On the other hand, if participants did speak of their dependency on the help of others, or variously, were unable to care for others, then they were situated as disabled women within their community.

Being an "unfit" mother may be related to hegemonic constructions linked to a woman's socio-economic capability to provide all for her children, and to her "worthiness" (in terms of race, class, and citizenship) for the job of motherhood. Other women who fall into the wrong social class, race, or citizenship status are deemed as "less fit" or as "unfit" mothers (Collins 1999). However, within an Afrocentric discourse centering on the caretaking contributions a woman makes to her family and community, structural issues of race, class, and citizenship are not as crucial to establishing oneself as a "fit" mother, so much as are a woman's ability to deny her own self or well-being for the sake of her children. At the root of attaining the status of good woman within an Afrocentric framework, then, is a woman's ability to have a child of her own (Dougherty 1978), and then to sacrifice herself for this child.

Simone's interview illustrates the way a participant might construct herself as disabled due to her inability to attain the status of woman in her community. Simone was 36 years old at the time of our interview and she spent much of her interviewing focusing on the achievement of the birth of her son a year and a half before. She described the difficulties that she faced in trying to conceive a child.

I was used to trying to get pregnant. But I didn't get pregnant, I would never get pregnant. And they say it was, like, a high risk. So I went and got this test thing they do...with the tubes. With the things stuck in you. And that's when I went to the Women's Center in University Town, and they told me, they said I can have it, and that was good, so. They said, you just gotta stop thinking about it and you'll have one, so. Cause I had him when I was thirty-five. Yeah, but I prayed for him. Oh boy! I guess...I ain't want to wait 'till I was too old, but I always used to want to have kids. See, I used to pray all the time. But I...like I say, if it's a time for everything. You know, like...so they may not come when you want 'em, but you always on time. Even like, I used, always want to have kids. Like, I'm always having people's kids, you know what I'm saying. Playing with people's kids. I always...wanted to have kids.

Simone describes herself as a “barren” woman for much of her life, situating herself as reproductively disabled according to a medical diagnosis of “blocked (fallopian) tubes.” She takes up a biomedically-loaded phrase of being “at risk” to situate herself as a woman who was perhaps too old to have a baby; her reproductive organs not functioning the way they should have to give birth to a healthy baby. In a sense, this language figures into biomedical constructions of women's use value, in which once they reach a certain age (nowadays 35 years old) their bodies are constructed as reproductively deteriorated and, therefore no longer of full value as their chances for healthy reproduction are rapidly diminishing (Martin 1987).

In addition to constructing her body as possibly disabled, in a biomedical sense in terms of her physical ability to give birth to a child, Simone also situates herself as an individual disabled in her community because she was unable to give birth to a child. Referencing a human development framework, which holds that Black women in the rural south become women when they become mothers (Dougherty 1978), Simone speaks of her social position within her community as a virtual outcast until she was able to give birth. Within an Afrocentric discursive context, she moves away from an emphasis on the possible deterioration of her reproductive “parts” due to aging; instead, she injects religious overtones to her story of the figurative birth of her womanhood. Her story especially focuses on God's role in her achievement of motherhood. Simone relates that for many years, she selfishly focused on her own needs, using crack and other drugs available in the community. These “street drugs” were literally next door—all she needed to do was knock on a neighbor's door and she could get herself into some “good trouble.” Simone also describes her body as especially appealing to men, and that she relied on her good looks to attract men for relationships. At this time, she notes, she had a lot of enemies in the community, who considered her both aloof and spoiled. Simone constructs these enemies in the community as “demons” who were “fighting against her” in her attempts to get pregnant. She admits that it took a turn in her faith in God, with a renewed devotion to prayer and to communal spirituality, to actually conceive her child. With her turn away from selfish pursuits, such as using drugs and their related encumbrances, and her newfound attachment to God, Simone relates that she was able to reincorporate herself back into the community: “My auntie, she go to, she go to church and she um...she said, you know, God got a shield around me, protecting me, so they couldn't do me no harm. There's like, a lot of 'em, like, maybe think like...lot used to say, ‘Simone can't have no kids,’ you know, and then when I got pregnant...you know, I made it my, God made him out of love.” Through her shift to a more spiritual self, as well as through the prayers sent up by family members such as her aunt, Simone was able to birth a child, gaining full status as a woman in her community, and rid herself of the

derogatory (disabling) label of sterility. Essentially, she was able to “treat” her disability through prayer and communal reparations.

Simone now situates herself as a woman fully conversant in the expectations of womanhood within her community. She described herself as an able woman/mother whose first priority in life is now her son, rather than “running the streets” and being concerned with her own self satisfaction. As a role model to children, Simone mentioned that mothers should stay inside and keep to themselves. As mothers, women are to be models of responsibility and respectability for their children—a woman’s children will only turn out as well as the way that they were raised. Working within an Afrocentric discursive context of women as the moral backbone of their communities, Simone used the biblical metaphor “you reap what you sow” to describe the awesome responsibility that mothers hold in their children’s lives. She traced her daily activities as those devoted purely to maintaining the well being of her son, who was born with asthma and suffers many medical complications as a result. Indeed, Simone is not able to work outside of her home because she must be a full time caretaker for her son, as she lives in a rural community that does not contain adequate daycare facilities to look after a son seen as an “insurance liability.” Thus, while now constructed as an “able” woman and mother within an Afrocentric discursive context, within a hegemonic context of Black women’s use value she may be conceived of as just another “welfare mother” unable (or unwilling) to contribute her labor to the public sector.

An Afrocentric ethos rejects the concept of innate or intrinsic bodily malfunction—the dysfunction asserted in biomedical models. Rather, malfunction arises when individuals focus on themselves at the expense of others—it is borne out of communal disregard. Thus, in Simone’s case, she was unable to conceive a child when she focused on selfish pursuits, such as using drugs and “running the streets.” An African-American ethos is focused on group justice and affirms group connectedness (Leslie 1998). From an Afrocentric perspective, morals reside in principles, not in modes of behavior—morals are never divorced from community-based principles. Participants speaking of their own drug use, particularly their addiction to crack cocaine, emphasized the self-centered nature of this pursuit and the ways that their drug addiction took away from their ability (disabled them) to care for others in their family and community. They emphasized the selfish nature of this activity, rather than emphasizing the physiological destruction that drug use caused on their own bodies.

Drug use may be constructed as a disability, serving to “disable” a person’s functional ability to perform (expected) activities (Beatty 2003, p. 229). The National Institute on Drug Abuse (NIDA) calls for research to explore the relationship between substance abuse and disabilities, as biomedically-diagnosed disability is constructed by NIDA as a possible contributing “risk factor” for drug use among Black women (Beatty 2003). In particular, NIDA is interested in looking at the relationship between drug abuse and disability, particularly at the experience of Black women using drugs as a coping mechanism for disability (Beatty 2003). Within an Afrocentric discursive context, however, I am interested in looking at how drug use, itself, is conceived of as a disability within the Black community, as drug users are said to follow a self-centered path in life, in which the narrow pursuit of drugs is paramount.

Those who depart from dominant norms of the body are constructed as possessing “disabled” bodies (Garland-Thomson 2002). Specifically, the historical figure of the monster is used to invoke disability: “As departures from the normatively human, monsters [are] seen as category violations or grotesque hybrids” (Garland-Thomson

2002, p. 8-9). The identity “crack mother” may be situated as a category violation within an Afrocentric discursive context, as mothers who use crack are depicted as violating the category of motherhood, built upon notions of self-sacrificing communal labor, by taking part in a world of drug use foregrounding the self as central. These two identities, woman who uses crack and mother, are mutually violating of full identification with a particular world (drugging or mothering). Thus, the “crack mother,” herself, is a disabled woman—deemed “helpless, dependent, weak, vulnerable—[an] incapable bod[y]” (Garland-Thomson 2002, p. 8).

Muncell, a 43-year old mother of three children, situated herself as a disabled mother in her story of crack addiction. In closely examining her interview, specifically the way she highlights her story of addiction, we can see how her narrative becomes a way for her to enter an Afrocentric community of good motherhood. During much of her interview, Muncell focused on her “crack days.” She spoke of herself as a “heavy crack user” for 15 years—during those years, she said that crack use affected her ability to take care of her children, to form relationships with other people in her community, and to maintain a close relationship with her family. Also during those years, Muncell gave birth to two of her three children. While her son was born five years prior to her initiation into crack use, her first daughter was born five years after Muncell began to use crack. By the time her second daughter was born and three years subsequent to that, Muncell admits that she was literally “using crack while in labor, on the way to the hospital.”

Muncell situates herself as a formerly disabled mother in that she was unable to focus on her children as her first priority while using drugs, instead falling prey to the “siren call of the crack pipe” (Golden 2000). The vilification of (Black) mothers who use crack is well noted in the research literature (Baker & Carson 1999; Erickson et al. 2000; Flavin 2002; Golden 2000; Kearney, Murphy & Rosenbaum 1994; Litt & McNeil 1994; Logan 1999; Lubiano 1992; Meyers 2004; Roberts 1997; Sterk 1999; Woodward 1997). However, I will argue that the social position of Black mothers has not yet been analyzed with respect to an Afrocentric discursive context that relates to disabled identity construction. As Muncell relates, her son’s labeling of her a “crackhead” was an early sign that she was perceived by her own child as being unable to mother—as possessing a mothering disability. She describes herself as a “mess” while using crack, contrasting herself nowadays as an able mother: “I’m different because I don’t, I don’t smoke crack no more. And it make me, you know, I can do things with my kids. I can hold a job now. I can keep a car. You know, I can pay my bills without messin’ my money up. And I can keep money in my pocketbook. And um...uh, that’s different (laughs). Because when I was smoking crack I couldn’t keep anything.” Muncell thus situates herself as a formerly disabled mother who, much as Simone describes herself, once focused on a set of narrow, self-centered, pursuits at the expense of attaining the status of womanhood within her community.

Muncell notes that she tried, for at least five years, to hide her crack addiction from her family: “I didn’t want nobody to hardly see me do it because I know I ain’t really supposed to be doing that. And I would hide out. I would stay out...a week...without bathing or eating or drinking anything.” When her own son began calling her a “crackhead,” it was seen as a sign by Muncell that her attempts at denying her disability were proving fruitless. In an attempt to save face within her community, then, Muncell speaks of trying to hide her drug use, in fact admitting that even when she had been out on the streets for a number of days, that she was the one to call the emergency rescue, to “pick [her] own self up.” Within an Afrocentric context, women may want to

deny or hide their disability from the community, for fear of being labeled as such (Feldman & Tegart 2003).

Muncell's addiction grew so bad, she notes, that she was eventually reported by her own family to child protection services, whereupon an inspector came to her house to investigate her for possible child negligence.

Cause I was messing up the food stamps, you know, I was selling food stamps and...everything else. So my mom and them really, they didn't want to do it, they really got tired of me and I was driving them crazy! So...I was selling food, my food stamps and...taking food from the kids, you know. That was their food stamps to get food and I was taking them and selling. So um...but the [child support] guy come and he looked in my frigerator. They come and I had nothing in there. And they're like, "where's your food stamps?" And I'm like, "I don't know." And so he was like, he had had it with me.

Muncell refers to herself as a once stereotypical crack addict, concerned more about acquiring crack than she was about the well being of her own children. Reliving a poor Black mother's nightmare of being investigated for her worthiness as a mother by "the Man," she relates that in the end she was given a choice of being treated for her addiction or losing her children. Though she later admits that even after treatment she fell back into addiction, she situates herself as a reformed mother who was finally able to "kick her habit" through her own self resolve and perseverance. Thus, Muncell succeeds as a mother in true Afrocentric fashion, by putting off her own desires (for crack cocaine) and through her own inner strength is able to overcome her addiction and become a better mother to her children.

Nowadays, Muncell situates herself as succeeding the Afrocentric Dream of self-sufficient womanhood and devoted motherhood. She decries the way that she used to be: "You know...and a lot of people didn't wanna see me out there in the world, [you could hear] other people talking about me and it was always sorta bad talk"—resolving this image of "unfit" mother within her community by concluding that "[today] all they can talk about is something good about me now because I'm not...out there doing crazy, wild things that I did do. Me and my kids, we, you know, we always doin' stuff, we go to eat, we go to movies, we go to...Disney World, you know." In reference to her former "otherhood" as a disabled mother within her community, Muncell's story of addiction exemplifies the incongruent categories of "mothering" and "crack addict." Now that she is sober she is able to achieve the status of woman and mother within an Afrocentric discursive context.

Postcolonial Remarks: Disability as Transgressive

One problem with relating to individuals as "disabled" or "able bodied," within biomedical and/or Afrocentric discursive contexts, is that these frameworks construct disability with static representations, as not transgressing a particular social position. Thus, while Muncell may now claim herself as an "able" mother as a result of her sobriety, she is either a fit mother or an unfit mother—an Afrocentric discursive context does not allow her to be either/or. Contradictions arise between the dominant ideology of womanhood, in which women are said to be passive, weak, and relegated to the domestic sphere, and Black women's status within dominant ideology, in which they are "unable" (or disabled) from achieving a dominant status of womanhood. Furthermore, another contradiction arises when Black women are perceived of as passive, weak, or self-centered within their own community, as were Muncell and Simone—in these instances

they are positioned as disabled women in an Afrocentric discursive context. Thus, a Black woman may position herself as strong and self-sufficient in her own community and within the public sector—however, within biomedical/dominant representations of the Black female body as deviating from the norm, she continues to be positioned as a disabled woman, well referenced within Sojourner Truth's 1851 speech, "Ain't I a Woman?" Both discursive contexts, then, produce static identities of womanhood, which force Black women into an outsider/within position—in dominant society and, at times, within their own communities.

The "outsider-within" construct is a useful framework from which to explore the position of Black women within a feminist, postcolonial paradigm. Just as post-colonial studies have paid scant attention to ableism as a form of oppression; disability studies, themselves, are equally as complicit in ignoring the stories of Black women who, by the mere fact of the intersectional oppressions they face in terms of race, class, and gender, may be positioned as disabled in terms of their participation in the dominant political economy (Dossa 2005; Feldman & Tegar 2003; Hayman 2003; Kliwer & Fitzgerald 2001; Nabors & Pettee 2003; Vernon 1999). Black Feminist theorist Patricia Hill Collins (2000) uses the term "outsider-within" to describe the enlightened vision to be gained by Black women, who face structural oppressions and are constructed as subordinate in a dominant framework, but who use an "outsider" status to gain a different perspective on those "inside" or included in the dominant hierarchy. An outsider-within position allows for distinct views on the contradictions between dominant group ideologies and practices concerning womanhood, allowing for a different perspective on oppression.

Looking at disability from a postcolonial lens may allow the subject to transgress the negative connotations of disability (Dossa 2005). While the subject may be constructed as disabled within either a biomedical or Afrocentric discursive framework, as an outsider/within she may also gain new wisdom, or a "third dimension," on the artificial and reductionist construct of the gap between "us" and "them" (Bhabha 1994; Collins 2000). This dimension allows for a transgressive identity, for a "slippage between identity categories" (Lacom 2002, p. 140).

Luella Mae's story is particularly evocative of a transgressive identity achieved through disability. I noted during my interview with Luella Mae that she spent a lot of time focusing on her medical problems—at the expense of describing other parts of her life. As an anthropologist interested in getting at the "whole picture" of Luella Mae's life, I wrote in my field notes from the day of our interview that I was frustrated with my inability to direct the interview toward other significant events in her life, apart from events focusing on her various bodily ailments. However, upon reviewing her interview, and in fact in writing this paper, I realized that the central logic in Luella Mae's interview was in situating herself as a woman who has transgressed a disabled identity. Through the spiritual wisdom gained by Luella Mae in suffering her many bodily ailments, she was able to invoke a caretaking role of sorts within her family, thus transgressing a negative identity of disability.

Jacqueline Mattis (2002) writes of Black women being able to transcend their own desperate life circumstances through their relationship with a higher power—they are able to re-envision and recreate their own destiny, as well as the destiny of their loved ones through a claimed intimate relationship with God (314). And so it goes that Luella Mae situates herself with an identity of enlightened spirituality through a discussion of the health problems that she has suffered for the past twenty years—linking her own (spiritual) mothering capabilities to significant events in her life grounded in either her

own illnesses and related health problems or those of other close relatives. Through these events she is able to claim herself a self-sufficient, strong woman who is capable of directing her own life (and the lives of others).

Luella Mae began her story of transgressive disability, describing a heart attack that she suffered back in 1995. Expressing that this attack was not important enough an event to stop her from performing her ritual obligations of attending church that day or preparing the Sunday dinner, she emphasized her commitment to a cultural world of spirituality. Hers is a role of spiritual leader of her family, and through her denial of the import of this health event, she situates herself as a woman able to sacrifice her own wellbeing for the maintenance of familial obligations. Thus, despite suffering a heart attack, she is able to accomplish gendered expectations in an Afrocentric discursive context.

In 1999, Luella Mae developed a blood clot in her leg. Related to this new health event, she continued to foreground her own spiritual responsibilities, describing how her daughter, Karen, prayed through the night while staying with her in the Intensive Care Unit: “Seem like it was yesterday or this morning. And then [Karen] say, she stayed all night one night. And...read the Bible and prayed and she say, ‘Mom, I don’t have nobody. I don’t have no husband. I don’t have any kids! Please don’t go Momma!’” Not only is prayer central to her own well being—through this example, Luella Mae demonstrates how much her daughter relies on her for the emotional comfort and strength she provides.

Luella Mae continues on with this theme of spiritual strength through another health event story, this time about an asthma attack that her grandson had a couple of years ago while working at a nearby feed mill. Luella Mae sets the scene for a miracle about to happen. According to her story, her grandson was delivered to the very same bed in the hospital that she was in when she suffered a heart attack just a short time before. Luella Mae describes a scene the night of her grandson’s attack, when she and her family gathered in the hospital waiting room and prayed for her grandson’s survival:

We prayed. And so one of the doctors came by as we was prayin’. And [the doctor] said, “I’ve heard lots of prayers.” He said, “but I never heard one like that one before!” He said, “that was an awesome prayer!” And he say, he stood there, you know, for...a few seconds and listened. And say then, when he left there, he went to the patient’s room, to check him. The vital signs had started going. (Knocks the table with her hand a couple of times for good luck). Somebody’s watchin’ out for us!

Luella Mae constructs a story of miracles for her grandson, in which he regained his health due to his position in the “spiritual bed” that she has made—both in leading her family in prayer for his returned health, as well as by literally lying in the same hospital bed as she had during her previous admission to the hospital. Situating herself with an aura of spiritual strength, she notes that even a (busy) doctor was struck by the power of her prayer. She concludes by claiming that God watches out for not only her, but through her spiritual guidance, for the wellbeing of her entire family.

Luella Mae links her family’s ability to “be blessed,” health-wise, with her own spiritual work. After her grandson’s asthma attack, she says that she became aware of the increased importance for her family to go to church. As the spiritual mother of her family, Luella Mae is responsible for maintaining the sanctity of her own soul, as well as the salvation of her entire family:

I tried to explain to my daughter that they go to church and...and serve the Lord. Because the end of time is not far. And I believe if you don't believe, it's time to start thinkin' about believin'! Because it's crucial for everybody, and the Bible says we gonna burn in hell. In the Revelations. And I don't wanna burn in hell! I done caught enough hell right here! (Knocks the table with her hands three times).

Luella Mae constructs her grandson's health crisis as a wake-up call for her; that she must (or should) take up the cloak of spiritual responsibility for the rest of her family. Through her own and her grandson's health problems, she situates herself with an identity as spiritual mother—thus transgressing connotations of bodily helplessness or weakness in herself with an image of spiritual fortitude. With this gained spiritual strength, Luella Mae recalls a sense of urgency that she felt regarding the spiritual lapse of her own two sons, who she notes were both involved in selfish pursuits as crack users and who had let their spirituality and connection with God go by the wayside:

I told my boys, I say, "ya'll need to get ya'll self right." Because I know they not right, they using drugs! I said, because the Lord...(Chuckles) So I just told them, I say, "now see, I almost died. And [my grandson] almost died." "Ya'll need to get yourself together to come to church and serve the Lord." So, my one son says, "oh, that's just a coincidence of some kind!" And I said, "God can do things on, to get your attention!"

Luella Mae uses her experiences of ill health to transform herself from a mother physically unable to take care of her family, into a woman steeped in spirituality, who transgresses biomedical and Afrocentric mothering disabilities through the moral caretaking she performs with regard to her family. Pointing to her responsibility as the spiritual figurehead in her family, Luella Mae linked her own bodily deterioration to her previously ill spiritual health: "I don't ask God to move the mountain, just give me the strength to climb it." With each physical illness, or mountain, that she has faced in life, she has realized a renewed spiritual strength to transgress past disabilities and to provide an alternative kind of caretaking for her family.

Luella Mae's story might be viewed from a biomedical perspective—as she spent some time in her interview tracing a work history filled with manually laborious jobs. As a conclusion to this type of story, she claimed herself as disabled, due to the debilitating arthritis she suffers as a result of a life of hard work, which keeps her in a wheelchair and makes it difficult for her to move around or take care of herself on her own. From this perspective, Luella Mae situates herself as a woman whose body no longer functions properly—she has a body that has "given out" on her and thus no longer allows her individual self-sufficiency. Hers is a physically weakened, docile body, requiring another (her daughter Karen) to look after it, move it around, and survey it for further possible damage.

Alternatively, in an Afrocentric discursive context, Luella Mae would also be situated as a disabled woman—as Karen described how she had to look after and take care of her mother (and their household) from an early age. In tracing her own growing-up story, Karen relates that she did not participate in extracurricular activities, and did not have any romantic relationships until she was nineteen years old. She reasons that this was a result of the burden of responsibility she faced at home, where she felt it her duty to serve as the head of the household because her mother was unable to do so. In this context, then, Luella Mae is constructed as a passive, disabled caretaker who, through a role reversal, must rely on her own daughter to take care of her.

However, Luella Mae subverts both of these disabling discourses by invoking a role as spiritual mother within her family. Flipping discursive contexts of biomedical and Afrocentric disability on their heads, she links her increasing spirituality and concern for the spirituality of those around her with the increased deterioration of her body. As an outsider-within, both in terms of biomedical conceptions of bodily dysfunction, as well as within Afrocentric conceptions of self-sufficient communal mothering, Luella Mae may be viewed as a woman with disabilities on two fronts. However, through the enlightened vision, or wisdom, that she has gained as an outsider-within, Luella Mae transgresses oppressive identities to establish herself as a capable woman in her community.

Conclusion

In terms of the social construction of disability, I have shown how the seven participants of this study take both their social location and a discursive context into account in representing themselves (or others) as disabled. Stories told from a biomedical perspective tend to focus on the (dys)functioning body or mind, as revealed in Priscilla, Luella Mae, and Corentine's stories. Especially noteworthy in these stories is the way that the participants have been exploited as workers in a service-sector economy. They are literally disabled by their past jobs, in which they themselves are expected to take care of other medically disabled individuals. Stories told within an Afrocentric discursive context, on the other hand, stem from an equally as oppressive situation—one in which women are expected to be self-sacrificing caretakers of community members. From this perspective, then, a woman's value stems from her ability to devote herself to others, often resulting in her own compromised wellbeing. Simone and Muncell represent themselves as failed mothers in the past, in which their own selfish attitudes led to their being conceptualized as disabled within their community. They do not attain the status of valued women in their community until they are able to reform their past self-centered selves into new selves devoted to their family members. Both biomedical and Afrocentric discursive contexts are thus equally as complicit in reinscribing hegemonic norms—the first in terms of dominant, medicalized connotations of the body—measured by the amount of labor a body *is able* to contribute to the state political economy; the second in terms of local gendered and racialized (over)expectations—that Black women take on a Christ-like burden, hanging themselves on the cross (sacrificing their own wellbeing) for the salvation (health) of their community.

This research study contributes to a reassessment of both “postcolonial” and “disability” as identity and discursive categories, as well as questions certain assumptions written in these fields of study. In examining Afrocentric discursive contexts of ability within this paper, I aim to take a more localized, anthropological perspective and to, thus, broaden the field of analysis beyond dominant inscriptions of normality. Postcolonial studies of disability reference, and often rely upon, hegemonic norms of the body—even while critiquing these same norms. In other words, while a postcolonial take on disability posits the transgressive potential of those classified as disabled—as outsiders—by arguing and positioning an enlightened vision of reality (as do I in this paper by presenting Luella Mae's narrative)—the disabled body continues to reflect hegemonic norms inscribed upon the body.

Noteworthy in this paper is Luella Mae's narrative on disability. It does *not* work, I feel, to transgress dominant constructions of the able body so much as it rests within a context of local, Afrocentric conceptions of the valued female body. Postcolonial

analyses fail to recognize more local interpretations of ability. This analysis, while equally oppressive, however, recognizes other value systems outside of a dominant (Capitalist) ideology. A similar critique may be launched against disability studies—what does it mean that dominant conceptions of the disabled body respond to hegemonic norms of ableism written upon the white male body—and do not include a diverse array of normative definitions? Thus, both postcolonial and disability contexts fall prey to an ethnocentrism of sorts, once again reflecting or reinscribing the white male body as norm, evading a potential diversity of normative/oppressive definitions.

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