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# When the Road Is Covered in Nails: Making Sense of Madness in an Urban Mosque

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## ABSTRACT

This study returns to the classic interactionist approach of earlier work on mental illness to understand how communities attribute nonconforming behaviors as symptoms of mental illnesses and how their informal labels shape the ways in which they interact with people perceived as ill. It draws on six years of in-depth fieldwork in a low-income urban mosque community, where members frequently interacted with fellow Muslims they labeled “crazy.” Through repeated interaction, members come to understand madness as part of living in a poor neighborhood and then perceive themselves as also at risk of developing mental health problems. Many members avoided getting close to people with mental illnesses, but their shared religious identities meant that at the end of life someone who had previously been excluded from social networks could receive burial care. I discuss the implications of their responses for understanding the role of community care.

**KEYWORDS:** mental illness; urban; community; ethnography; religion.

Since the mid-20<sup>th</sup> century, the locus of mental health care in the United States has resided in community-based approaches that seek to integrate individuals with mental illnesses into the fabric of everyday social life (Mechanic 2014; Schutt 2016). Where they live reflects a larger pattern of durable spatial inequality (Sampson 2012). Of the estimated 10 million American adults diagnosed with a serious mental illness (U.S. Department of Health and Human Services 2014), the majority reside in neighborhoods characterized by high rates of poverty, crime, and segregation (Scull 2011). Mental health resources, while deliberately concentrated in these areas, are woefully lacking. Fewer than half of community mental health care centers (CMHCs) proposed in the Community Mental Health Safety Act of 1963 were built (Dowdall 1999), and chronic shortages of trained mental health care professionals leave existing clinics understaffed (Kakuma et al. 2011). Due to service gaps and being stigmatized, people who experience episodes of behavioral nonconformance often are unable to keep a job or pay rent (Mechanic 2017; Yanos, Barrow, and Tsemberis 2004). Many face chronic homelessness and repeated incarceration (Baillargeon et al. 2009; James and Glaze 2006). They are forced to live out their problems in public view, often on the streets of poor neighborhoods.

An immense thank you to the Masjid al-Quran (MAQ) community for their many years of participation, patience, and support. I also thank Stefan Timmermans, Elaine Howard Ecklund, Jim Elliott, Erin Cech, Marie Berry, the editors of *Social Problems*, and three anonymous reviewers for helpful comments on earlier drafts. Please direct correspondence to the author at the Department of Sociology, University of Amsterdam, 1001 NA Amsterdam; email [prickett@uva.nl](mailto:prickett@uva.nl)

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Community mental health care thus puts the onus for daily care on everyone living nearby, including neighbors, teachers, retail employees, and anyone who participates in the myriad local institutions that frame social life—schools, recreational facilities, and religious organizations. However, what care looks like from the perspective of people in the community remains unclear. Extensive survey research suggests laypeople may be inclined to seek social distance (Link et al. 1999; Martin et al. 2007; Pescosolido 2013; Pescosolido et al. 2007; Siltan et al. 2011), with urban respondents notably intolerant of people who display “disturbing” behaviors (Martin, Pescosolido, and Tuch 2000). If we look at this qualitatively outside a medical setting, we will see how people not privy to patient information or medical expertise attribute mental illness in interactions and what they understand as the impacts of these interactions on community life.

Drawing on the symbolic interactionist approach of earlier ethnographic research on deviance (Emerson and Messinger 1977; Goffman 1961, 1963) as well as recent work by Emerson (2009, 2015) on how people manage everyday interpersonal troubles, this study examines one urban community’s approach to dealing with members they perceive as having a serious mental illness. I focus on face-to-face interactions in which one party’s actions are labeled “crazy,” examining how members attribute nonsensical or bizarre behaviors to a mental illness, how this affects their attempts to include labeled members, and why members situate their experiences in wider structures (e.g., race and place). I do so from the perspective of members of a longstanding African American-led mosque in a high-poverty neighborhood in South Central Los Angeles, where the majority of members also lived.

Religious organizations line America’s city streets (McRoberts 2003) and represent the most common type of institution in the United States (Emerson 2006:156). Black religious organizations, in particular, have a long history of providing health-related social support to members (Drake and Cayton [1945] 1993; Lincoln and Mamiya 1990; Taylor et al. 2013), and clergy are often the first point of contact for people concerned with their mental health (Timmermans, Orrico, and Smith 2014; Wang, Berglund, and Kessler 2003; Young, Griffith, and Williams 2003). This makes the congregation an ideal site from which to explore how people understand behaviors attributed to a mental illness independent of assigned medical labels and what community care among peripheral contacts might look like.

## DEINSTITUTIONALIZATION AND THE SHIFT OF CARE

Reports of people who seem to be possessed, delusional, or mad appear throughout history, but the specific boundaries of normal/abnormal behavior are locally drawn (Parr 2008; Scheper-Hughes [1979] 2001). The contours of these boundaries comprise the bedrock of the sociology of mental health, generating research on non-normative behaviors (e.g., acting bizarre or delusional), the ways people label such behaviors, and the stigma associated with these labels (Link and Phelan 2001; Pescosolido 2013). Both the recognition of behaviors and the way they are labeled matters in how the public responds to mental illness. Survey research finds a persistent preference for social distance of behavior perceived to be non-normative (Link et al. 1999; Martin et al. 2007; Martin, Pescosolido, and Tuch 2000; Pescosolido 2013; Pescosolido et al. 2007; Siltan et al. 2011). This preference remains, despite evidence that Americans have become more accepting of the idea that mental illness is caused by involuntary neurobiological disorders (Pescosolido et al. 2010).

Public desire for social distance from people who exhibit nonconforming behavior contributed to nearly two centuries of “great confinement” of the mad, poor, and deviant (Foucault 1965). Those who could not fit in with the rhythms of 18<sup>th</sup> century industrial life found themselves locked away, often for life (Parr 2008). Facilities became overcrowded, neglectful, and sometimes violent spaces where patients failed to get better, and, in many cases, grew worse (Brodwin 2013). When a confluence of factors in the 1950s and 60s—including an emerging anti-psychiatry movement, rising medical costs, and the reorganization of public health programs—led to a decline in the forced confinement of people deemed deviant, hospitals began releasing patients into local communities as

well as limiting the number of beds available to new patients. Deinstitutionalization shifted the responsibility of care back to local communities, under the medical profession's guidance that community engagement, "along with moderate social pressure to conform to behavioral norms," would facilitate patients' greater rehabilitation and recovery (Dear and Wolch 1987:62). Scull (2011:430), however, argues that policymakers had a "mythical vision of a community anxious to re-embrace the mentally ill."

Experts agree that within a community care policy framework, patients need to be able to draw on supportive relationships with social networks beyond close family and friends (Perry, Pullen, and Pescosolido 2016; Pescosolido 1992, 2006). Evidence suggests the longer the ties and the more frequent the contact, the greater the sense of obligation to help (Perry 2011). However, what support from "peripheral" associates—including neighbors, coworkers, and other acquaintances—looks like, remains fuzzy. It may include providing advice and information that influences whether a person seeks care (Perry, Pullen, and Pescosolido 2016), but this requires that people have the ability to provide such support. This cannot be assumed, as the communities where resources are concentrated tend to be the same neighborhoods where residents themselves experience greater rates of stress, depression, and trauma caused by chronic exposure to violence (Clark et al. 2008; Kim 2010; Ross 2017; Silver, Mulvey, and Swanson 2002).

### PUTTING CARE IN MICRO-POLITICAL CONTEXT

We know that laypeople tend to focus foremost on observable behaviors to assign labels of mental illness (Estroff 1981), just as medical professionals do (Dobransky 2009). These informal labels are the first step towards a person acquiring the role of mental health patient (Goffman 1961). Perceptible symptoms of excess (e.g., delusions, hallucinations, grandiosity) will likely generate labels of mental illness more easily than symptoms of deficit (e.g., acting depressed or having flat affect) (Perry 2011:466). At the same time, the interpretation of these behaviors is context-dependent (Scheper-Hughes [1979] 2001). As Emerson and Messinger (1977) argued in their classic work on the micro-politics of deviance, in any social setting we will find a local system for working out what constitutes trouble that depends on the meanings people attribute to actions. Once a behavior becomes identified as problematic, the actions people take to respond provide insights into how a person deemed mentally ill may (or may not) be granted inclusion into the community (Emerson 2015). As Goffman (1963) argued, stigma becomes "real" in social interaction, where it is experienced as rejection and exclusion.

In the context of a low-income urban neighborhood, where people with serious mental illnesses are most likely to live, existing studies hint at the notion that people who violate expectations of social interaction will be perceived as "crazy" and provoke both suspicion and aggression (e.g., Anderson 1999; Duneier 1999). In these moments, it remains unknown whether residents turn to the police for help, or whether the pervasive cynicism that characterizes residents' attitudes towards law enforcement will come into play (Kirk and Papachristos 2011). Community responses to people perceived as mentally ill have the potential to shape a person's illness career and health outcomes, especially within the first few years following diagnosis (Pescosolido 1991).

Many people diagnosed with a mental illness report relying on religious beliefs and activities to cope with daily struggles (Tepper et al. 2001). Within urban America, there are potentially tens of thousands of religious communities trying to work out how to provide mental health care at the everyday level. In Los Angeles, where this study takes place, the religious landscape includes at least 6,000 congregations (Flory et al. 2011). For congregations in resource-depressed areas of the city, the connection between religious community life and mental health stands as an untapped area of study, especially when we take into consideration the support function of religious institutions (Lim and Putnam 2010). Black religious organizations, in particular, have long been thought to fill holes in a racially unequal social safety net, providing health-related support to members directly through

health promotion initiatives as well as indirectly through forms of spiritual-based healing (e.g., prayer) (Lincoln and Mamiya 1990; Taylor et al. 2013).

At the same time, stigma around mental health issues and lack of access to care leave many in the Black community suffering from untreated health problems (Villatoro et al. 2018). Schnittker, Freese, and Powell (2000) suggest that African Americans are less likely than non-Hispanic Whites to believe that genetics or family of origin play a role in mental illness, which may limit their propensity to seek treatment. This tension puts black religious institutions on the frontlines of community mental health care, working out what care in an extended network might look like amid persistent stigmatization. While we have extensive survey data on public opinions and interview-based research with church leaders, we lack ethnographic research that can show how/if a community tied by faith feels bound to help its members with mental illnesses and what the perceived impact of this care is on a community.

## SETTING AND METHODS

Data for this study come from a larger project on the role of religious-based social support among members of an African American-led mosque in a low-income neighborhood in South Central Los Angeles. “South Central” serves as shorthand for a vast swath of land south and southwest of the downtown business district of Los Angeles. The area spans more than 50 square miles and includes some of the poorest and most segregated and violent neighborhoods in the city (Ong et al. 2008). In the mosque’s neighborhood, more than 40 percent of families live below the federal poverty line and the risk of being the victim of a violent crime, while down from previous decades, remains twice as high as the risk for the county as a whole – 14.7 violent crimes per 1,000 persons compared to 6.3 crimes per 1,000 persons (Ong et al. 2008:26). The vast majority of residents are people of color (99 percent) who face systemic social and economic marginalization (U.S. Census 2010). Unfortunately, for those who wish to find mental health care to deal with the burdens of living in South Central, there is a chronic shortage of adequate medical facilities. South Central has the lowest rate of adults who receive “sufficient” social and emotional support (L.A. County Department of Health 2015).

During 64 months of fieldwork (2008–2013), I observed and participated in prayer services, fundraising events, holiday celebrations, religious classes, and community events at the African American-led “Masjid al-Quran” (MAQ), a mosque rooted in South Central for more than fifty years (Prickett 2014).<sup>1</sup> I also attended community-related events outside the mosque, held at nearby parks, hotels, and community centers. As a result of my closeness with several members, I spent many nights and weekends at the mosque outside normal operating hours, visiting members in their homes, and joining members on “go-alongs” around the neighborhood (Kusenbach 2003). For 13 months of the study I rented a room in a house close to MAQ, and as a resident, I attended neighborhood civic meetings and volunteered at a center for at-risk youth. Living in South Central enabled me to observe how some of the people who came to the mosque and acted nonconforming carried this behavior into public streets and other neighborhood spaces, such as restaurants and stores.<sup>2</sup>

It is important to stress that I did not set out to study mental illness, but that it emerged within the setting in two independent ways. First, while not an everyday occurrence at MAQ, people disrupted services or social activities with bizarre behaviors frequently enough that I needed to understand how members worked through these moments. Consider, for example, that a man bursts into a crowded mosque and shouts that he will harm someone, but members do not call the police and, instead, let him return the next day. It would be easy to imagine this scene leading to a much different outcome in another setting, which prompted me to ask why. Second, mental illness was an important

1 All names have been changed.

2 For an additional 22 months (2013–2015), I made regular visits to MAQ but without the same level of intensity as my first five years. By this time, my relationships with several members involved spending time together outside the mosque more than in it.

topic of everyday conversation among members, but not as something faith could help heal, as previous ethnographic research suggests people diagnosed with mental illnesses want to believe (Estroff 1981). Rather, members saw problems with mental health as part and parcel of life in South Central. Engaged in abductive analysis, which involves an iterative process of moving between data and theory in search of surprising findings, these unexpected observations warranted closer inspection (Timmermans and Tavory 2012).

Not wanting to impose psychiatric labels on the data, I coded for a range of behaviors and responses to determine where the boundaries of normal/abnormal developed.<sup>3</sup> For example, I compared how members dealt with loud verbal outbursts as opposed to signs of intoxication (slurred words, physical impairment, etc.). As I moved into focused coding, I also examined *who* was considered disruptive, comparing how members responded to behaviors by Muslims and non-Muslims. After multiple rounds of coding, during which time I wrote memos that focused on unpacking the details of tense interactions and putting them in conversation with the literature on religion and mental health, I conducted informal interviews with members to make sure I understood their interpretations. My time spent attending community-organized events at other venues and following members around the neighborhood also enabled me to look for intersituational variation (Tavory and Timmermans 2014). This was especially important for drawing out the ways that members linked mental health problems to living in South Central. Above all, the length of my fieldwork provided opportunity to analyze responses in depth over time, comparing members' initial reactions to fellow Muslims who acted "crazy" with their understandings of this "craziness" after months and years of interaction. As Duneier and Molotch (1999) have argued, most studies of troubled interactions tend to rely on post-event interviews. This study focuses on troubled social interactions between mosque members as they occurred and analyzes what these interactions reveal about everyday understandings of mental health.

### *Attributing Mental Illness*

In the course of participating in religious and social activities at the mosque, members regularly observed people display unusual or bizarre behaviors that disrupted the flow of interaction. These behaviors included the use of loud and obscene language, evidence of delusions such as believing one is a religious prophet or famous person, physical harassment, excitability, and, occasionally, public undressing. In these moments of behavioral nonconformity, believers were quick to attribute behaviors to symptoms of mental illnesses. The following excerpts from my field notes demonstrate this well:

After prayer, believers file out the door. Women crowd around the shoe rack, grabbing pairs and leaning against the building to put them on. Suddenly Sister Sherri starts screaming, "Fine, I'll do it!! I'm 62 . . . (inaudible)!!" She doesn't appear to be directing her anger to anyone in particular. Her eyes are wide and darting around the patio wildly. No one approaches her. A few believers roll or widen their eyes at each other. Sister Mira says to another woman, "That's bipolar for you." [July 2009]

I'm sitting across the table from a young man who tells me he is the "leader of the Muslim world." The man says he traced his family back to royalty in Pakistan. Someone else at the table tells him there is no king of Pakistan. The man responds that there is, they just aren't recognized. He said his grandmother "just" died over there and he looked her up online. At first I

3 Like members, I was not privy to individuals' medical records and cannot determine whether certain behaviors were evidence of specific mental disorders. Neither am I discussing how disruptive persons understood their roles in community life. Rather, I have designed the study to assess how community members interpreted certain disturbing behaviors as evidence of mental illness and how this folk psychiatry impacted members' actions, situating their patterns of meaning- and decision-making within a larger context of structural disadvantage.

thought he was joking when he said he's the leader sent by Allah but as we talk I understand he's serious about believing he is a prophet. After a while, Sister Ava comes over and makes a face at me. She ignores the man and says firmly to me, "Let's go." We walk across the lot together as she explains that one of the brothers listening in to the man told her to "rescue" me. We join Sister Aisha, who says there is no way the man could be from Pakistan. "Maybe Blackistan," she jokes. Ava calls the man a "jailhouse Muslim," saying men like him come here straight from prison and implying they aren't right in the head. [September 2008]

In the first excerpt, the sister observing Sherri describes her erratic behavior as a symptom of bipolar disorder. In the case of the young man who believed himself a prophet—a blasphemous act in Islam—Ava discounts the man as dangerous and instead attributes his behavior to the mental health consequences of presumed incarceration. Her "rescuing" me indicated that the best response was to avoid further interaction by seeking physical distance. Rarely did members try to find out what caused outbursts or oddities; instead they seemed annoyed or even amused. These moments of behavioral nonconformity were treated as what Emerson (2009) calls "ordinary troubles"—understood as "fleeting troubles that in many instances are quickly resolved and come to nothing" (p. 537).

However, their ordinariness does not mean these interactions were unimportant. Stories of people who behaved oddly were later retold and reimagined in everyday conversation, informing how believers understood what it means to engage Islam in this setting. Indeed, it became part of the community's folklore (Scheper-Hughes [1979] 2001) about itself to see the mosque as a magnet for people who suffer from mental illnesses, demonstrated in this conversation between two believers, 42-year-old Brother Hasan and 65-year-old Sister Ava:

*Hasan:* You know they call us the graveyard? It's sad.

*Ava:* Fifty-one fifty!

*Hasan:* Right, or Fifty-one fifty. Where the old people and crazies are.

"Fifty-one fifty" was colloquial shorthand for Section 5150 of the *California Welfare and Institutions Code*, which allows agents of the state to place a person under an involuntary psychiatric hold for up to 72 hours when perceived as being a danger.<sup>4</sup> Implicit in calling the mosque "Fifty-one fifty" and "the graveyard" is that members saw the organization as attracting the mentally ill and the old, two vulnerable populations subject to greater rates of social isolation than others (Keller 2015). It also points to the way community members interpreted their faith as one that requires them to accept people they perceive as "crazy." Said another sister: "It's al-Quran! We like them ['the crazies']. It'd be boring without them!"

The handful of members who worked in the field of mental health reinforced the collective sense that the mosque was a magnet for people suffering from mental illnesses. For example, healthcare worker and longtime member, Sister Khadijah, repeatedly said in both public and private conversation, "I should bring my DSM down here," referring to the *Diagnostic and Statistical Manual of Mental Disorders*. Khadijah thought many of the believers, especially the men, needed mental health treatment and called the use of drugs by some "self-medication." Her words reflect an understanding that mental health problems and substance abuse are intimately connected (Drake et al. 2001). At the same time, Sister Khadijah joked that she needed to get her "van" to take away all the believers

4 California Welfare and Institutions Code Section 5150 reads: (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.

who needed professional help, which generated laughs among the sisters. One mocked that she'd "watch [that] with popcorn."

### *How Labels of Mental Illness Unfold*

The language that members used to describe fellow Muslims who displayed symptoms of a serious mental illness was undeniably stigmatizing, and it points to how quickly even an informal label generates social exclusion. At the same time, their use of the word "crazies" and the jokes about people perceived as suffering from mental illnesses also shed light on the need people feel to resolve the confusion caused by situational improprieties, which Goffman (1971:389) argued is a problem as "profound and basic as social existence can get." Disruptions must be managed, because, as a long legacy of sociological research has shown, a central goal—if not *the* central goal—of face-to-face communication is to promote smooth interaction (Goffman 1971).

As the opening excerpts suggest, once a person has been labeled "crazy," members often ignore or avoid them. But how do members determine whether to apply a label of mental illness? This is best analyzed with the community's handling of one particular man, whom I was able to observe over a three-year period. The first time I observed him participate in religious services, I recorded the following:

Believers are waiting for *jumah* (Friday community prayer) to begin. It's very quiet inside the *masjid* (mosque) when suddenly a tall, thin man in white jeans and a white t-shirt bursts inside the front of the men's area screaming, "Where is my ID?!" He paces back and forth in the front screaming, "Where is it?!" A muffled male voice says, "Brother, we're [praying]." The man doesn't acknowledge the brother, instead yelling, "Whoever got my ID is dead!" Bill gets up off the floor and moves towards the man. Another member of the security team, Khalifah, joins Bill and they crowd the man out the door. Before leaving, the man bursts out the name of the late Nation of Islam leader, "Honorable Elijah Muhammad!" Outside, the man continues to scream non-sequiturs as he sits on a chair to put on his shoes. Khalifah charges over, yelling at the man to get off the lot. Bill bites back at Khalifah, telling him not to start a fight. Now Khalifah and Bill are exchanging angry words. The visitor's bald head is wet from perspiration, and the veins on his forward [forehead] are visible from 15 feet away. He looks to be in his forties. Once his shoes are on, the man stands up and quickly walks off towards the street. Bill stays outside, watching the gate. A sister inside the *masjid* stands up and closes the sliding glass door, securing it tightly. She turns to her young daughter and says, "I don't want you to play outside."

Faced with an interactional dilemma, members looked for cues to understand if the man was a fellow Muslim. He knew to take off his shoes inside the prayer hall and to step around the praying men as he charged through the room, following codified dimensions of in-group worship (Tavory 2010). Marked as a Muslim, they first spoke kindly to him, saying "Brother." Only when his behavior turned threatening did they push him off the grounds. The moment clearly created tension, evidenced by the quarrel between Bill and Khalifah, as well as the mother's directive to her daughter to stay inside. However, once the disruptive behavior was out of sight, members quickly returned to normal. Importantly, they did not call the police.

By keeping responses minimally confrontational, members engaged in a form of "moral work" in which the person who causes the disruption remains someone worthy of interacting with (Emerson 2015:250). Leaders reinforced this, maintaining that the mosque should be open to anyone who wished to "make *salat*" (prayer). By contrast, members were less tolerant of the outbursts or strange behaviors of non-Muslims, who sometimes entered from the street looking for food or money. If they caused disruptions, the security team immediately pushed visitors off the lot and discouraged them from returning.



Brother Fareed, who managed the masjid office, told me after the incident in the prayer hall that the man had started to come by every day. When I asked why, Fareed replied, “He got nowhere to go.” Indeed, the man became such a regular presence at the mosque over the next months that believers dubbed him “the Boxer,” both because he professed to be the famous Muslim boxer Muhammad Ali and because he often stood by himself jabbing the air with his fists, as if *in* a boxing match.

As the Boxer increased his participation at the mosque, members began to reframe what constituted normal or expected behavior. When the Boxer performed prayer without disruption or helped set up for an event, he was described by a brother as “not *that* crazy.” On occasions when the Boxer’s behavior became more harassing, though, he was kicked off the property and pushed to the street. This happened twice in the same day:

I’m standing with Sister Aisha, her adult sons, Brothers Hasan and Rahman, and their cousin, Lamar, who is not Muslim but visiting for the afternoon. Out of the corner of my eye I see the Boxer charge across the grass lot, arms stiffly at his sides. Within seconds he is at Ava’s car, leaning into her window. Ava flinches. Watching, I wonder aloud to Aisha if the Boxer may have tried to hit Ava. At that, Hasan and Rahman begin moving towards the parked car. Aisha shouts at her running sons, “Get ‘im!” The men come up on the Boxer and he says he is leaving. “Keep moving faster,” Hasan orders. Rahman then follows the Boxer through the grass lot and out the gate. When the man gets to the street he turns back and starts punching wildly into the air towards the masjid. Back in our circle, Hasan and Lamar start laughing. Hasan tells his cousin the man comes here all the time and knows how to pray and everything. He just gets like that when he doesn’t take his “meds.” Lamar says he could tell the guy was off and was about to stop him because he didn’t look like he belonged here. Lamar adds the Boxer looks like someone he did community service with after prison and claims he saw the man clutching a (crack) pipe. Hasan says the Boxer was “trippin’” and repeats that the man probably was not on his meds.

Like when he disrupted prayer services by making a verbal threat, the Boxer had now violated community gender norms. That he harassed long-time and beloved Sister Ava—whose role was much like that of a “church mother” (Gilkes 2001)—meant that Rahman and Hasan were willing to act on their own without calling for masjid security. However, within seconds of the incident, Hasan laughed and diminished the Boxer’s behavior as “trippin’.” I have no way of knowing if Lamar’s claim about the Boxer smoking crack is true, but I draw it out because Hasan did *not* engage illicit drug use as a possible reason for the Boxer’s behavior. Instead, he attributed the man’s erratic actions as evidence of his not being on the right drugs (i.e., medication), fitting this new interaction with the Boxer into an emerging social diagnosis among believers that the man was ill.

Of course, kicking the Boxer off the street did nothing to solve the underlying problem and he returned hours later:

As a handful of believers perform *asr* (late afternoon) prayer, the Boxer comes back and begins screaming outside. He’s yelling at the driver window of a green SUV parked on the lot, its engine running. The Boxer spots me watching from the door and shouts something before starting towards me. When I quickly return to the women’s area, Ava asks if “he” is back. I nod yes. The Boxer gets to the glass sliding door and at spotting Ava says, “Oh, I’m gettin’ out of here.” Brother Bill appears and shouts, “Yes you are. Hurry up!” The Boxer runs down the steps and out the gate. Bill watches as the man crosses the street. Twenty minutes later Ava tells me we should leave. She adds, “I’ll drive you to your car,” which is only 40 feet away.

After her encounter with the Boxer, Sister Ava showed me the iron pipe she carried under her passenger seat, asking me to pull it out in case the Boxer came back. She said, “You don’t show them no fear.” Drawing on a lesson her mother taught her while growing up in a nearby public housing development, Ava continued, “Even if they be crazy and off their meds, you gotta show no fear.” In this way, Ava’s comments fit in a larger body of scholarship on the ways that residents of neighborhoods with high rates of violence must, as Anderson (1999:77) argued, “campaign for respect” through pre-emptive intimidation. Yet, within minutes, Ava began to reframe the Boxer’s behavior and, like Hasan, minimized the Boxer’s aggression by labeling it the symptom of an underlying medical problem. “[He’s] actually a nice guy when he takes his meds,” she told me. Then she took it further, saying the Boxer had had a difficult childhood. Situating the Boxer’s behaviors in a wider social context allowed Ava see the man’s illness as caused by external forces and thus not individual wrongdoing. This became clearer when she next professed that the Boxer “doesn’t bother [her],” adding that the person who really bothers her is another brother whom Ava suspects of stealing to feed a drug addiction, the implication being that mental illness is involuntary, while drug use is not.

Believers did not escalate their method of social control even as the Boxer became increasingly erratic. Instead, as they interacted with the Boxer and his delusions over time, members began to revisit notions of what was expected of him. Provided he did not disrupt worship services or threaten a sister, he could stay. He crossed a line getting too close to Ava, requiring the brothers to sanction him, but once back in accordance with local gender norms he could return. He did so two weeks later for the annual *Eid al-Adha* celebration during which he stood alone in the middle of the grass yard punching the air. A sister watching said, “That’s not normal,” but then quickly laughed and egged him on, “Hey, I’m Laila Ali!”

While sensitive to the underlying medical causes of mental illnesses, the process of diagnosing someone as “crazy” limited members’ willingness to engage with the person or include them in social activities. The Boxer may have been accepted as Muslim, but he was not a member in the sense of true incorporation into everyday community life. No one incorporated him into their extensive networks of material and social support. I am not sure whether anyone knew his real name or where he lived. So, when security kicked the Boxer off the property, this only shifted the problem to some unknown elsewhere. Left temporarily with one less safe space, the Boxer had to live through his mental health problems in public view. I saw him repeat his signature disruptions day and night in different parts of the neighborhood, including at 11:30 p.m. in front of a nearby fast food restaurant and at 5:30 a.m. outside a popular donut shop. Except for the occasional mention of the “crazy brother,” he was all but forgotten when he stopped attending prayer.

### *Feeling the Community’s Stress*

As members attended to disruptions over time, through repeated interaction and discursive revisiting, they began to situate their experiences in wider systems of meaning. In doing so, it became clear that members framed mental health problems as an expected part of local life and, therefore, a social problem. Sitting in my car with Sister Ava one afternoon outside a mental health clinic where she sometimes sold homemade food, Ava pointed to a man being dragged from the clinic to a waiting police car and said, with noticeable sadness, “I see something like that every day.” Ava thought many of her family members suffered from untreated mental health problems and that she too had a “touch of bipolar,” as if a mental illness were something one could catch, like a cold. I found others expressing the belief that mental illnesses were everywhere around them. Sister Latifah, whose son was diagnosed with schizophrenia and either “in prison or the hospital, prison or hospital,” said that for a long time she did not understand what was wrong. “It’s not like a broken leg. You can’t see it and watch it heal. Mental illness is different.” I suggested she might be more attuned to others who have mental illnesses as a result of her son. Latifah paused, and, after a noticeable silence, said, “It’s so true. Afterwards, I started seeing crazies everywhere.”

The shared sense that people with mental illnesses were “everywhere” and that one could develop a mental illness from living in South Central led members to see themselves at risk of becoming ill, as the following conversation among three longtime members discussing funding cuts for mental health services demonstrates:

*Ajeenah:* It’s the first to get cut.

*Jasmin:* That’s the thing they need to keep most.

*Malikah:* People be losing their minds . . . my daughter went crazy and then her husband.

This conversation may help explain why urban residents appear less willing to interact with people displaying symptoms of untreated mental illnesses (Martin, Pescosolido, and Tuch 2000). By interacting with someone who is ill, people may fear they too will “lose their minds.”

Interpreted through the eyes of believers at MAQ, the structural violence that develops from living in a high-crime, low-income urban area devoid of adequate mental health services produces a particular kind of social madness. This was made clear to me after an incident at a conference for sisters held in a nearby hotel. During the event, one of the women started screaming loudly for no apparent reason. When a sister gently touched the agitated woman’s shoulder and tried to calm her with the endearment “Sister,” the woman screamed, “Don’t fucking touch me!” The entire ballroom turned silent as the woman proceeded to falsely accuse several of us of inappropriate behaviors. After several minutes of this, she was escorted out by hotel security.

The incident became a popular topic of conversation among sisters the next day. Sister Haneesa, a registered nurse and mental health counselor, commented that I looked anxious during the incident. I shared with her that my heart was pounding when the woman screamed at me. In a soft tone, Haneesa said, “Think of her. Poor baby. She’s not well.” Then Haneesa added, “The community *feels* that stress.” She expanded on this point later during a pre-planned workshop on mental health, saying in her presentation that people in black communities suffer from post-traumatic stress disorder (PTSD) as a result of repeated exposure to gangs and violence. Haneesa told the audience, “Maybe it wasn’t your son that was killed, but it was [a] boy next door that you’ve known his whole life.” She wanted believers to understand that mental illness is a disease, like cancer, and not the result of individual choices. She discouraged members from calling someone “crazy,” and she advised them *not* to call the police. “Once you call the police,” she warned, “it can go any number of ways.” She offered the number of a crisis hotline to call instead of 911, which the sisters asked her to repeat several times.

Two points from Haneesa’s presentation warrant further attention as they help to draw out recurrent themes in the ways that members—especially women—linked mental illness to race. First, in referencing PTSD, Haneesa pointed to the social-psychological consequences of systemic and institutionalized spatial violence, supporting established research that growing up in neighborhoods perceived as dangerous contributes to symptoms of depression and anxiety (Aneshensel and Sucoff 1996). She minimized the individuality of the phenomenon and, instead, highlighted how all are affected (“the community feels that stress”), recognizing that social factors can lead to higher levels of stress (Aneshensel 1992). Second, Haneesa uses her professional authority to discourage members from calling the police, reinforcing perceptions that the law is ill equipped to ensure either the safety of the mentally ill or the larger community (Kirk and Papachristos 2011). Many of the women at MAQ had husbands, sons, nephews, or other kin serving time in prison or jail, and many of the men at MAQ suffered the mark of a criminal record. They may have complained about annoyances by “jailhouse Muslims,” but the women also felt an affinity with the struggles of black men and a collective unease with the overall system of formal control in South Central (Rouse 2004).

Importantly, in none of their everyday conversations about mental illnesses did members use religion as a frame to interpret behaviors (i.e., evidence of demons or sins), nor did it serve as a source for healing (e.g., prayer) (Idler and George 1998). Rather, here we find a community bound together

by faith attributing the cause of mental illnesses to structural conditions, including neighborhood violence and the retrenchment of mental health care. This made them willing to accept a certain degree of behavioral nonconformity from fellow Muslims but this acceptance did not extend to the kind of care from social networks that can lead to a better set of health outcomes for people in the beginning stages of an illness career (Perry 2011; Perry, Pullen, and Pescosolido 2016; Pescosolido 1991).

*“Last Resorts” and Community Care of a Religious Kind*

While the immediate support that members offered to fellow Muslims with mental illnesses was limited—providing a safe place to let them act in nonconforming ways but no help seeking treatment—some older members received deeper kinds of care. Sister Sherri, believed to have bipolar disorder, was a long-time MAQ member, having come first through the Nation of Islam and later transitioning to Sunni Islam in the 1970s, along with many of the older members. Sherri had been working towards a doctorate and was poised for a promising career when her health deteriorated. She continued to suffer from various health-related problems decades later when we met. I watched her once get kicked off the lot when she would not stop cursing loudly in front of believers, including young children, and I knew she attended AA meetings held inside the mosque.<sup>5</sup>

Like the Boxer, Sherri did not appear to have regular housing. Unlike the Boxer, however, Sherri successfully garnered limited forms of organizational and community support. She used the mosque as her mailing address and was allowed to use the office computer.<sup>6</sup> On occasion, Sherri tried to stretch the boundaries of this support by sleeping inside the masjid against the explicit instructions of the imam, but she was always allowed to return. After Sherri became sick one year, a couple took her into their small apartment five miles from the mosque, bringing her to *jumah* and buying her food.<sup>7</sup> However, when the husband went to prison for a parole violation and the wife became overburdened by her own mental health concerns, Sherri had to leave the house.

No one seemed to know where she had gone, until a few months later when the imam announced Sherri’s passing. What she died of he chose not to share, focusing instead on the community’s responsibility to ensure Sherri received a Muslim burial. Estranged from her family, including her siblings and grown children, Sherri’s body sat unclaimed at the county morgue. According to the head imam, the organization spent nearly \$5,000 in attorney and court fees to gain control of Sherri’s body and another \$3,000 to bury her. These amounts would be significant for any small organization, but were especially high for a community that collected only \$600–\$1200 per week in contributions. Had they not claimed her, Sherri’s body would have been cremated and her ashes buried in a potter’s field.

The cost of burial plots in Los Angeles meant MAQ had to bury Sherri far out of the city center, nearly 90 miles away.<sup>8</sup> Few members could attend the service, so more contributed towards a dinner in Sherri’s honor during Ramadan the next month. The dinner also stood in as a memorial service for Brother Ali, or “Big Ali” as believers called him, another longtime mosque member with a history of odd and sometimes aggressive behavior whose burial was paid for by the MAQ community.<sup>9</sup> The ways in which these members died alone and unwanted by their next-of-kin underscores their marginalization, but the community’s actions highlight an unexpected way in which caring for people

5 Led by two former addicts, these meetings were the only advertised form of community support for people struggling with drug or alcohol addiction.

6 I saw envelopes addressed to Sherri sitting in the masjid office.

7 Ava was skeptical that it was not Sherri’s own money the couple used, suggesting they probably took Sherri’s government checks in exchange for room and board. Unfortunately, I was never able to get the couple to agree to meet with me to talk about their charitable act.

8 It costs approximately \$3,000 for a Muslim plot and burial in an outlying county and more than twice as much for one closer to the city.

9 From what I saw, Ali never entered the prayer hall, spending most of days and nights alone in the dark shadows of the mosque property with his signature wood cane and wheeled suitcase. I also saw him at bus stops in the neighborhood wheeling the same suitcase. He was one of a handful of men who lived off and on at the mosque or in a vehicle parked nearby.

with mental illnesses can bring people together. Sister Ava said, “We’re like a family down here. . . . We fight like family but [we’re] still family.” The mosque, she added, is “their last resort.”

In the classic sociological sense, a “last resort” is a form of extreme sanction or social control (Emerson 1981). Last resorts come into play out of necessity rather than what should or ought to be done (Emerson 1981:4). In describing the mosque as a last resort—albeit one providing minimal material care and not therapeutic intervention—Ava suggests there is no other course of action possible and the mosque must fill in where other social institutions have failed. This reflects an understanding of the ways in which institutional neglect of people with mental illnesses pushes care onto local communities like MAQ, whether members want to help or not. At the same time, there are limits to members’ willingness to step in and provide support, evidenced in their less intimate and arguably more fleeting relationships with people labeled as mentally ill. They provide care, but in rather limited ways and only to members they have known for decades, suggesting greater support at the end stages of an illness career rather than in the critical first years that can determine whether someone will “drift” downward (Pescosolido 1991).

## DISCUSSION AND CONCLUSION

In his groundbreaking treatise on mental hospitals, Goffman (1961) saw the care of patients as a type of repair service (“tinkering-services model”). To explain how this client-service relationship *should* work, Goffman used a metaphor of a nail on the road that stops a car. The repair worker removes the nail, patches the tire, and the client moves on. In a mental hospital, however, the patient seeking to get “fixed” will not be fixed, because the system is designed to serve the interests of institutions and not the patients. Goffman showed how this organizational structure shaped the lives of patients for the worse.

How might we reimagine the tinkering-services model for contemporary mental health care? We now have a medical model that better empowers patients against demoralizing institutions (Gong 2017; Mechanic 2017), but that simultaneously undermines their health by concentrating them in communities with too few tools to try to help (Schutt 2016). Returning to Goffman’s metaphor, with one nail in the road, the environment is not to blame, because it was just a happenstance occurrence, but for some medical disorders, the environment will exacerbate the patient’s ability to recover. According to Goffman, “instead of there being one nail on the road, the road is covered in them” (1961:343). This is an apt way of capturing how participants in this study understand the community-wide implications of living alongside people who suffer from untreated mental disorders as a result of inadequate resources. They expect to interact with people who cannot conform to social expectations, and in their interpretations of nonconforming behaviors understand them as often involuntary actions caused by both neurobiological disorders and socio-environmental factors. However, this did not stop members from using stigmatizing language or rejecting labeled members (Pescosolido et al. 2010). Meanwhile, references to stressful interactions and the effects of repeated exposure to violence (i.e., PTSD) suggest that people in the larger community understand that stressful life events can contribute to the onset of a mental disorder (Aneshensel 1992). From their perspective, racial- and place-based inequities cause trauma, which can, in turn, lead to the deterioration of a person’s mental health. This perspective allows them to situate mental disorders in structural context, but also leads them to reflect back on their own mental health. Members worry that they too are at risk of “losing their minds,” suggesting acceptance of the social causation thesis, or the idea that social factors, such as low socioeconomic status, may increase risk of mental illness. This study thus finds members of a low-income black community believing they too bear the costs of an incomplete mental health care system, the structure of community mental health care implicating everyone not so much in support provision but in declining mental health. With the road covered in nails, everyone passing through is at risk of being bruised. This suggests that, in order to heal, we have to address the systemic poverty, violence, and racial inequalities that contribute to mental health problems.

The case of MAQ in South Central Los Angeles reveals a partial picture of how communities handle their burden of community care, but also suggests a need for further scholarship on how care works in communities overwhelmed by economic hardship and chronic exposure to violence. With nowhere else to go, Muslims suffering from mental health problems could find a relatively safe place to temporarily “make it as crazy” by acting in nonconforming ways (Estroff 1981). However, the inclusion that people at MAQ experienced was rather limited. Most members were not trained in mental health services and they demonstrated apprehension about interacting with people they saw as “crazies.” A funeral shows the strength of the community’s religious commitment, but it does not serve as a health intervention during times of acute need.

Religion served as a source of identity to determine who had the right to act “crazy” on the mosque property; however, members made little reference to religious-based frames to explain behaviors deemed bizarre or nonsensical. Instead, members situated episodes of behavioral nonconformity to living in a poor urban neighborhood. We see this in members’ everyday conversations, where they express a belief that dealing with “crazy” people is part and parcel of living in South Central and that everyone is at risk of “losing their minds.” The stigmatizing language that members used to label someone in the community as ill and the limited engagement that followed reveal one way in which labels inhibit social inclusion (Link et al. 1989). What was unexpected was the way members also turned these labels around on themselves, believing they and their families were also going “crazy.” We see how mental illness is understood to be a social problem, not limited to individuals, although this does not necessarily lead to greater care.

If a community with longstanding ties such as MAQ does not see itself able or obligated to provide care outside burial assistance, what can we reasonably expect from others? With further scholarship aimed at untangling the complicated role of mental health care in communities like this, we may consider ways to improve the everyday conditions of people with mental health problems and equip the communities they live in with better tools to participate in community mental health care. What is more, as this study clearly demonstrates, we need to address the structural factors that create an unsafe social environment in spaces like South Central, so that the road is clear of nails for all.

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