

MI MAMÁ ME LLAMA GUERRERA:
THE BORDERLANDS AND POLITICS OF INSANITY THROUGH A XICANA
LENS

A Thesis

Presented to the faculty of the Department of Sociology
California State University, Sacramento

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF ARTS

in

Sociology

by

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SPRING
2018

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Abstract
of
MI MAMÁ ME LLAMA GUERRERA:
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This thesis explores, through my auto-ethnography, how low-income womxn of color experience mental illness, which I would rather refer to as mental variances categorized as illnesses by society, and the navigation of the institutions surrounding it. It will also challenge and decolonize current modes of knowledge production, while filling the void of voice and candor that exists in current research regarding mental conditions. I am exposing myself and producing this research to give a perspective from the inside out: a patient's perspective.

_____, Committee Chair
Jacqueline Carrigan, PhD

Date

ACKNOWLEDGEMENTS

Todo lo que soy y seré se lo debo a mi mamá y su mamá: mi Malicha. To my siblings, my big brothers Tony and Santy: thanks for growing up so fast and helping mom out for us. My hermanita Maile, sorry you were born to serve a queen, I love you! Para toda mi familia here at home y en México linda y querida; Papuno, Tia Gaby, Tio Jorge, Kathy, the cousins, Liz, Gigi and Baby Santi... todos, todos, todos. To my theoretical mamá: Gloria Anzaldúa, who awakened the burning desire to speak out, write it down and shine my light in the darkness. Who also struggled with chronic health issues, but never stopped luchando. Lastly, this is for all who have been made subjects by the psychiatric institution, especially the young womxn I encountered in my hospital stays who were afraid just like me.

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“Personal experiences – revised and in other ways redrawn – become a lens with which to reread and rewrite the cultural stories into which we are born.” – Gloria Anzaldúa, *now let us shift...*

“And those who were seen dancing were thought to be insane by those who could not hear the music.” –Friedrich Nietzsche

Un Mundo Nuevo

I was supposed to be at the hospital by now, but I got the ambulance EMTs to let me go. I convinced them by playing the part of a so-called normal person. Sitting in the ambulance, staring them right in the eyes, I tried hard to focus my wayward thoughts as I pleaded my case. “My mom just doesn’t get me, I’m fine. I don’t need to go to the hospital,” I explained, using everything in me to maintain my focus and sound believable. “Look at me. I’m fine,” I said to them with feigned authority. The two EMTs eyed me suspiciously for a moment, then looked at each other trying to decide what to do. “Okay you can go, but you have to sign this release,” the young male EMT told me. “Where do I sign? Let me go!” I was good at acting normal, I’d say whatever it took to get what I wanted in that moment. I couldn’t go to the hospital, I felt they wouldn’t help me, I didn’t need help and I wanted more time to explore. They bought it. I scribbled illegibly on the form and hopped off the back of the ambulance disheveled and disoriented. Cars whirred by on the busy street we had stopped on the side of; I sprinted across not worried that I was not in the crosswalk, not worried that a car could hit me. I was invincible. In this

space there was an overwhelming exuberance to life, everything was alive and calling to me in ways I had never seen or felt before; I was in a world separate from the one I knew to be reality, it was the same physical space I had inhabited before, but all together distinct. Plants visibly breathed, strangers were all so very intriguing; the mundane took on a new face. I was euphoric, elated, grandiose and delusional at the height of it all. I had no idea what was happening or why, but I liked the freedom. I was no longer constrained by the rules or conventions I had learned and adhered to in the past. The limitations that held me down were gone. I was in a new world, un mundo nuevo. I was manic, I was free...

In 2013 I experienced a manic episode for a number of days, this transformative experience was pivotal in my sociological understanding of the world and my place in it. In Anzaldúan terms this was the beginning of my Nepantla state: the state of confusion, the liminal space where transition takes place and rebirth occurs (Anzaldúa 2009). Through reflection of this time and experience, I have realized that even en el otro mundo I was aware of how my particular intersection in society affected my treatment by the police, the level and quality of my psychiatric treatment and the outcome of this experience as a whole. This thesis explores, through my auto-ethnography, how low-income womxn of color experience mental illness, which I would rather refer to as mental variances categorized as illnesses by society, and the navigation of the institutions surrounding it. It will also challenge and attempt to decolonize current modes of knowledge production, while filling the void of voice and candor that exists in current research regarding mental conditions. I am exposing myself and producing this work to

give a perspective from the inside out: a patient's perspective. My experiences are not unique to me; patients face subordination every day, which is what makes the exposure and analysis of my particular experiences relevant, and a useful tool in resistance to subjugation (Szasz 1994).

¿Qué Se Ha Dicho?

The conceptualization of mental conditions as a social problem is hardly new; it has captivated and confounded many great minds. Ancient thinkers from Hippocrates to Aristotle developed definitions of mental illness, and the famous terms mania and melancholia came to be. The livelihoods of the population deemed and labeled mentally ill have always been in the hands of persons or institutions in power, and the same continues today. The history and modern-day manifestations of mental illness are the key elements of the research outlined below.

The first definition of depression was created by Hippocrates in the fifth century B.C., when he wrote that long periods of sadness or fear are called melancholia (Hippocrates 1923-1931 as cited by Horwitz and Wakefield 2007). Foucault (1988) detailed the rich history of "madness" as it pertained to Europe and ultimately Western society as a whole. His analysis begins by delineating a parallel between the end of leprosy in Europe and the need for its social replacement. The hospitals used for leprosy needed new residents, but more importantly, society needed a new scapegoat, a new spectacle to produce fear, the production of said fear being extremely conducive to the adherence to social norms, values and structures that were set in place (Foucault 1988). Likewise, Szasz (1970) compares the concept of mental illness to the inquisition of

witches; he describes a move from the theological to the medical, a switch to the belief that those thought to be witches and heretics were actually just insane. The confinement of the mentally ill was crucial in the production of this fear. These members of society were excluded from it, chained to walls, excluded from living a dignified life, as described by Foucault (1988) the mentally ill were forced to live by subhuman standards with the greater purpose of social control. “Confinement merely manifested what madness, in its essence, was: a manifestation of non-being; and by providing this manifestation, confinement thereby suppressed it, since it restored it to its truth as nothingness” (Foucault 1988). Tracing the historical aspect of this illness, though definitely shock producing, is fundamental in understanding how earlier conceptualizations still resonate in our society today and guide the ideologies behind treatment, hospitalization and stigma. Though these times seem to be long gone, the figurative equivalent still lives on, and mental patients are still reduced to the nothingness Foucault wrote about, we are still nobodies when left in the hands of the medical institution.

It seems there is an issue of problem closure in the research of mental illness. Problem closure happens when a specific definition of a problem is used to frame all other studies of the problem and its manifestations (Hajer 1995 as cited by Guthman 2011). The societal conventions and over-arching narratives, i.e. the medicalization of mental illness, are used as the common foundation and perspective of mental illness research. Rejection of this model is viewed as deviant in scholarship and has caused controversy. American psychiatrist Thomas Szasz has long been scrutinized for claiming

mental illness to be a myth. His first article regarding the issue was published in the 60s. Szasz (1994) gives a different perspective stating that diagnoses are social constructs that vary from time to time and from culture to culture. One look at the history of the ever changing Diagnostic and Statistical Manual of Mental Disorders (DSM) gives life to this point. Szasz further notes the power relations involved in the cementation of these social constructs. “For more than a century, psychiatrists constructed diagnoses, pretended that they are diseases, and no one in authority challenged their deceptions. The result is that few people now realize that diagnoses are not diseases” (Szasz 1994). There is tremendous power and authority in diagnosing and treating diseases, however, this power dynamic is not always at the forefront of research. “The point, is that psychiatrists have the power to accredit their own claims as scientific facts and rational treatments, discredit the claims of mental patients and psychiatric critics as delusions and denials, and enlist the coercive power of the state to impose their views on involuntary ‘patients’” (Szasz 1994). Szasz arduously stresses that behaviors or misbehaviors are not diseases, the term “mental illness” itself is a metaphoric and not literal use of the word illness. Whether mental illness is a myth is still up for debate, but what is clear is that there is a dominant ideology surrounding mental illness and that is its medicalization, which will be further reviewed in the literature.

Deleuze and Guattari (1983) distinguish a link between the schizophrenic process and our social conditioning through capitalism. They maintain that capitalism leads to schizophrenia: capitalism “produces schizos the same way it produces Prell shampoo or Ford cars, but the schizos are not salable” (Deleuze and Guattari 1983). To them, the

reality of the self is the flow of drives; society is a system of coding and inscribing meaning to the flows of desire through codes. Desires, which are coded and organized by society, are by nature revolutionary, they can tear apart social structures. Deleuze and Guattari (1983) expose this revolutionary capability through the schizophrenic in the midst of her delirium; she is desire decoded and wild, a pure process of desire. Therefore, the conclusion is reached that schizophrenia is the exterior limit of capitalism, and the suppression of the tendency of decoded desire is key to capitalism's survival.

Schizophrenia, and the untamed desire exhibited by the schizophrenic, is capitalism's worst adversary and the ultimate weapon for its destruction (Deleuze and Guattari 1983).

As previously discussed, confinement is a running theme throughout the history of insanity. Goffman (1961) provides an in-depth analysis of the mental hospital, which he labels a total institution, and groups into the category of an establishment created to care for persons incapable of caring for themselves, while also thought to be a threat to the community. The central characteristic of a total institution is the breakdown of the barriers that usually separate sleep, play and work. In a total institution, all three activities take place under the same authority, with a large group of people and in adherence to a regimented schedule (Goffman 1961). Not surprisingly, this setup creates social strata where social mobility is restricted and social distance is great. The population divides into two groups: the supervisory staff and the inmates. The patient reaches a key milestone at hospitalization according to Goffman (1961); this event marks the social beginning of a patient's trajectory regardless of the psychological beginning of the variance.

Contemporary research literature on socioeconomic status and mental illness provides necessary insight as to how the two are intertwined. The general consensus regarding socioeconomic status and mental illness is that lower socioeconomic status adversely affects an individual's mental health in a variety of ways. Reiss (2013) reported that household income and low parental education had greater impacts on children's and adolescent's mental health problems and that children receiving welfare were two times more likely to have mental health problems than the rest of the population.

Miech et al. (1999) studied two facets of socioeconomic status and mental illness: the selection and causation hypotheses through a longitudinal study of adolescents transitioning into young adulthood. The selection hypothesis states that mental illness leads to being in the lower socioeconomic strata and the causation hypothesis states the opposite, that being part of the lower strata leads to mental illness. Their findings showed that mental illnesses had to be studied specifically to gather more conclusive evidence of each theory instead of only studying general measures of psychological distress (Miech et al. 1999). Also found was that anxiety is linked to causation, but there was no support for either causation or selection in depression (Miech et al. 1999).

The use of drugs prescribed by medical professionals to treat mental conditions is widely accepted in our society. The questioning of what separates these "good" drugs from illegal "bad" drugs remains pertinent. Co-Occurring Disorders, that is the existence of both a mental condition and drug use is common (Schlosser and Hoffer 2012). People with COD's face distinct challenges from those of either mental condition or drug use alone. These include but are not limited to maintaining stable housing, participating in

and completing treatment programs, navigating institutions that provide services and avoiding victimization (Drake 2002). Khantzian (1977) developed the Self Medication Hypothesis (SMH), which posits that a person's inability to deal with their emotions or lack of coping mechanisms motivates them to turn to drugs. In revisiting his hypothesis, Khantzian (1999) later voiced his concerns about simply using diagnostic categories to measure problems of affect. He later emphasized, "...it is not so much a psychiatric condition that one self-medicates but a wide range of subjective symptoms and states of distress that may or may not be associated with psychiatric disorder" (Khantzian 1999).

Bourdieu's theory of capital was used as the theoretical framework by Pinxten et al. (2014) to illustrate how socioeconomic status affects mental outcomes. Quantitative data from Belgium was used in the study and it was found that each of the forms of capital have an interplay between them that can be important in acquiring and maintaining good health. It is clear how good economic and social capital can positively influence the mental health of an individual. For example, having the economic means necessary for getting through a stressful life event can mean all the difference in the individual's vulnerability to negative effects on the mind. Likewise, having a strong social network is also beneficial. Cultural capital comes into play in the knowledge the individual is exposed to regarding health and living a healthy lifestyle. Without attaining these forms of capital it is easy to slip into a negative state of mind where mental disorders are likely to develop.

Neighborhoods and their social cohesion were the focuses of Fone et al. (2014). They found that having residence in the most deprived neighborhoods of England was

negatively associated with mental health. This negative effect was dramatically lower when high social cohesion neighborhoods were looked at. Using longitudinal analysis of data from the Caerphilly Health and Social Needs Cohort Study, Fone et al. (2014) found that over a seven year period there was a strong connection between neighborhood deprivation and increasingly poor mental health. The data reported that living in a medium or high social cohesion neighborhood was strongly linked to improvement in mental health. Other studies also found that low-income populations do experience more stressful life events and have less resources to cope with them. Maisel and Karney (2012) used data collected from The Florida Family Foundation survey which interviewed 4008 Floridians. What they found was that those who were more affluent were better able to protect their relationships from demands and other external problems such as stressful life events. Additionally, Lorant et al. (2003) reported that lower socioeconomic status groups faced more disabilities and were less likely to use specialized mental care.

Gender, race, and their effect on mental illness and mental health care, is a major component to the experiences given voice to by this research. Existing research shows that womxn have higher incidences of common mental disorders such as depression and generalized anxiety (Patel et al. 1999; Baskin, Bluestone and Nelson 1981). “Gender dynamics and power relations which lead to an unequal status for womxn in a variety of situations are likely to make their lives more stressful” (Patel et al. 1999). In their study of a low income clinic in the Bronx, New York, Baskin et al. (1981) found that Latinxs had the highest levels of receiving the diagnosis of depression, and posit that minority

womxn deal doubly with feelings of helplessness and powerlessness because not only are they womxn, but they hold minority status.

The interplay between race, gender and social class become important in access to mental healthcare and the social stigma surrounding mental illness. The link between homelessness and mental illness has been of great interest to many researchers. In the 50s and 60s, due to growing popular concern regarding mental hospitals and patient treatment; deinstitutionalization, as it has come to be known, released all patients who had been “given adequate preparation for such change” to the community (Torrey 1988, Nelson 2010). Community supports however, were not adequately developed resulting in non-adherence to the original plan put forth by the National Institute of Mental Health; the support received upon discharge usually consisted of medication exclusively (Bachrach 1976, Torrey 1988, Nelson 2010). The relationship between homelessness, institutionalization and discharge is apparently cyclical; risk factors for homelessness after hospitalization such as being homeless before and comorbid substance use were likewise associated with reinstitutionalization (Irmiter et al. 2007, Chen and Ogden 2012). The seriously mentally ill often solely rely on social safety nets for their survival, and for the past 40 years the issue has placed psychiatrists at the center of policy debates where the medical and socioeconomic intersect (Rosenbeck and Scivoletto 2016).

Cabassa et al. (2007) studied Latinx adults’ access to mental health care. Minority groups have unequal access to care when compared to the white population. It was reported that among Mexican Americans who had been diagnosed with a mental health disorder only 9.3% received services from specialty providers (e.g., psychiatrist,

psychologist etc.) while 19.9% received care from general medical providers (family practitioners, internists etc.) (Cabassa et al. 2007). Jurkowski, Westin and Rossy-Millan (2010) studied Latinxs in the New York area and administered a 70 question survey to 286 participants, what was most notably found was that 46 percent of the womxn suffered from depression or anxiety and that 70 percent had delayed getting access to medical care.

These studies point to a gap in access among minority womxn. Alvidrez (1999) researched ethnic variations in mental health attitudes and service use among low-income womxn of color. Her study consisted of interviewing womxn at a large urban clinic and found that attitudes regarding mental health varied ethnically between Latinxs, African-Americans and white womxn. However, when Alvidrez (1999) statistically analyzed the probability of making a mental health visit she found that Latinxs were one-tenth as likely to make a mental health visit compared to their white counterparts. Stigma could be part of the answer. Nadeem et al. (2007) statistically analyzed whether stigma kept poor young womxn from seeking mental health care. She found that immigrant African, immigrant Caribbean, U.S.-born Latinx and U.S.-born black womxn were less likely to want treatment than U.S.-born white womxn (Nadeem et al. 2007). Immigrant groups of womxn were significantly more concerned with the stigma surrounding mental illness and depressed immigrant womxn were least likely to state that they wanted care (Nadeem et al. 2007).

Stigma surrounding mental illness goes back centuries and is still ubiquitous today. Mental illness has been found to be one of the most highly rejected statuses,

comparable to societal attitudes on prostitution, drug addiction and convicted status (Albrecht, Walker and Levy 1982 as cited by Link et al. 1989). Modified labeling theory as conceptualized by Link et al. (1989) states there are five steps to the process. First, societal beliefs about devaluation and discrimination regarding mental patients are internalized. This is learned through socialization. Second, the official labeling occurs through treatment. This official label brings personal relevance to what being mentally ill means in our society. The third step, the patients' responses to their stigmatized status, is further broken down into three more steps. Secrecy, withdrawal and educating others or preventative telling. Secrecy involves hiding the stigmatized status for fear of rejection or discrimination in the many facets of social life. If the stigmatized person is resorting to withdrawal they are creating social distance between themselves and most of society because of the same fear of rejection. When a person educates others they hope to enlighten and gain acceptance by being vocal about their stigmatized status (Link et al. 1989). Step four is the consequences of the stigma process on the lives of those labeled. Negative outcomes from either the direct belief about the community's attitudes internalized or by the withdrawal methods used for protection. Withdrawal from society can be problematic if there is no way to provide for oneself by refraining from engaging with society. The final step, step five, is the vulnerability to future disorder. Stigma has the possibility of creating a vulnerable state that increases the likelihood of experiencing repeated episodes of disorder (Link et al. 1989).

Analysis of the existing research regarding mental illness, and its prolific manifestations in the lower classes and minority populations is vital in understanding

how these vulnerable subsets of society are affected. However, a gaping hole exists in the research and that is the patient's voice. The voices and lived experiences of the mentally variant are muffled by the reduction of human subjects to statistical variables. While statistical analysis of the problem is undoubtedly useful, there is power in the voices and stories of those who are actually dealing with these issues that so greatly affect the poor and underserved populations of our society. This leads to the aim and purpose of my auto-ethnographic study, which is to unveil what has long been silenced in academic research, to give a face and name to the womxn who endure and manage living mentally variant in a system that was not made to serve their needs or foster their advancement.

Why Auto-ethnography?

Though the brutal days of confining the mentally ill as Foucault wrote about have seemingly ended, distorted objectives on assisting this community continue, and a shroud of silence remains, veiling our experiences. The secrecy and hiding stem from the stigma that still plagues our society. Academic scholarship exacerbates the silence, by quieting the voices of "subjects," and reducing their experiences to quantifiable data under the guise of remaining "objective" (Ellis, Adams and Bochner 2011, Spry 2001). This notion is commonplace in Western scholarship where the privileged have long told the stories of and for others. In resistance and defiance, I have chosen to conduct my research using a reflective auto-ethnographic method, what Anzaldúa (2015) called *autohistoria*: *conectando experiencias personales con realidades sociales*. "It's a way of inventing and making knowledge, meaning and identity through self-inscription." Auto-ethnography is a qualitative method of producing research where the researcher is the focal point,

drawing from and analyzing personal lived experiences, then using them to broaden our understanding of society and culture. Postmodernism and the “crisis of confidence” are known as the roots of auto-ethnography; it rejects Grand Theorizing, the myth of objectivity in research and challenges canonical ways of doing research and representing others (Ellis and Bochner 2000, Ellis, Adams and Bochner 2011, Spry 2001). To achieve the aim of this research, I will be reliving my experiences by delving into the memories of not only my manic episode, but of the healing and coping processes that accompanied it as well. Inspired by the work of Anzaldúa and her ever-inspiring messages to womxn writers of color, the process of producing this thesis will become a vehicle of healing and transformation. I will be the observer and the participant, the subject and the object (Anzaldúa 2015). Even though the memories remain seared into my being, I will be cross-referencing personal journal entries to get a clearer insight on my state of mind during all of the stages. Journal entries will be cited as Sandoval Field Notes. However, because of the nature of my scattered processing they will not have exact dates, but the years will be accurate.

My auto-ethnography is broken down into four sections, each beginning with a narrative vignette and ending with sociological analysis. The first two sections expose the *Nepantla* state or the place between worlds, between ordinary and non-ordinary realities (Anzaldúa 2015). The third covers diagnosis, access to care, medication management and my experiences with the psychiatric institution. The final section unravels the healing process and a call to spiritual activism. My process is not within the lines of traditional research, it is often a practice of mental and emotional time travel, going back in time to

re-experience and attempt to re-feel mania, all the while keeping myself grounded in the now for my own well-being. Through this telling, I aim to produce what Dorothy Smith called “a sociology for the people” which veers away from the traditional and begins with the everyday, exploring social phenomenon that are often not readily visible (Smith 2005, as cited by Wehr 2009). Mental variances are definitely not readily visible; they can and do go unnoticed, by society and by the experiencers ourselves every day.

An extremely important part of this project is accessibility; I aspired to make it readable and digestible by my community. I purposely veer away from any academic standard that discards our anecdotal experiences from the realm of research. I tell and show how my personal experiences are just an echo of what I have seen, heard and know happens in the daily lives of the poor and mentally variant.

The process experienced in creating this work is permanently ongoing, as the variances in my mental processing meet me daily, and in doing the work, I have been submitting myself to a constant rehashing of my experiences and troubles. Reflection comes at all times, memories of trauma from mania and hospitalization play back sporadically and I have to process whatever arises. Carolyn Ellis (2007) writes that doing auto-ethnography requires the researcher to bounce back and forth between experiencing and analyzing the vulnerable self to reveal the broader context of that experience. To produce, I do just that, I write narrative vignettes of relevant experiences, and take socio-analytic notes when insights are meaningful; this method encapsulates my internal processes and my walking in a reality forever altered by these experiences.

In the analyses of the institutions involved I use academic and non-academic sociological knowledge created by others to reinforce my analysis and expose the cracks in a system that so many feel targeted by. In exposing my inner-workings and myself, I will humanize and illuminate the understanding of what it means to be mentally variant/deviant, and how gender, race and class affect that experience. By writing ourselves, we share the realities we live, and as researchers, we abstract and expand on these experiences to draw conclusions about social phenomenon. The storytelling compulsion has existed in me before any knowledge of what Agger (2000) calls “secret writing:” science oriented writing that removes the author as much as possible and separates sociology from the literary. The erasure of voice and authorial fingertips in search of validity produces boring, often inaccessible work, and embracing polyvocality will only enrich our understanding of social realities and issues (Agger 2000). By telling stories, analyzing them and situating them socially, the narrations take on new life; they become research and a different lens through which to view society.

Challenging hegemonic ways of producing academic knowledge is political. This method allows me to reclaim power and tell my story because it matters, because through it we view society from a new lens, my internal lens of a patient. Mary Louise Pratt (1992) emphasizes the political nature of auto-ethnography:

A third and final unconventional term I use is “autoethnography” or “autoethnographic expression.” This term in either form refers to instances in which colonized subjects undertake to represent themselves in ways that *engage with* the colonizer’s own terms. If ethnographic texts are a means

by which Europeans represent to themselves their (usually subjugated) others, autoethnographic texts are the others' construct in response to or in dialogue with those metropolitan representations (Pratt, 1992, p. 7).

By stepping out of the shadows, I will shine a light on some of the experiences of not only the mental patient, but of the poor womxn of color who has not had the ability to speak for herself, who has always had her stories told for her from the position of privilege.

My method then becomes spiritual activism as Anzaldúa (2015) described it: a process of inner work to produce and participate in public acts of resistance and reimagining. This work is ultimately an act of resistance, resistance to the current imagining of what it means to be mentally variant, as well as the medical and personal treatment that imagining entails. There have been times where I have been afraid to expose my variance and myself through this project, but resistance is far more important than my fear. This work is a small piece of the tapestry created by those who engage in creativity and vulnerability to envision better psychiatric treatment, a better life and more understanding for the mentally variant. The unified voices of resistance that permeate my world through art, music and activism, inspire and embolden me; they create a yearning, a need to produce and participate in shifting human consciousness toward justice and peace. With hopes that my fearless telling and exposure will help someone in some way, I push forward. Moved daily in varying ways, the process is ongoing and writing blocks get smashed through; la sombra never stays long. And when I do waver I remember: "Our task is to write against the edict that womxn should fear their own darkness, that we

not broach it in our writings. Nuestra tarea is to envision Coyolxauhqui, not dead and decapitated, but with eyes wide open. Our task is to light up the darkness” (Anzaldúa 2015). Here we are invited to re-member our multi-colonized and dismembered mestiza bodies. We carry our ancestral mothers within us at every moment. By comparing the disjuncting struggles of the self-reflecting creative process to Aztec moon goddess Coyolxauhqui, decapitated and mutilated by her brother Huitzilopochtli; a vivid imagining of our task is born. When we write our stories, we find new ways to put ourselves back together. Just as Coyolxauhqui was thrown to the sky to bring light in the darkness, so too must our stories be sent up as offerings to illumine the unseen and unspoken.

Se La Llevó La Policia

Riding the wave of other worldly inspiration, fearlessness and euphoria, I arrived on the other side of the street unscathed. Feeling guarded and protected by some unseen force, something told me it was okay to explore this mental state and everything that came with it, algo me estaba cuidando. Euphoria and a certainty of the unity of all things overcame me in alarming amounts, almost too much to handle and process. Adrenaline coursed through me and I needed to expend it. A strip of trail was on the side of the hospital where I was supposed to be and I went for it, running the strip until I ran out of breath. Cheeks burning bright red from the run, I threw my sweater on the dirt covered trail and took off to my next adventure.

All the while, my family had no idea where I was. I was supposed to be at the hospital right now, but I convinced the paramedics to let me go, and they thought I was

lost for good. The old structures of time and “normalcy” were so far removed from the space I was now in, all that mattered was being, and following any whim that naturally arose. Plants and the natural grasped and held my attention unlike ever before. I stopped to touch some plants on the trail, their presence and life were mesmerizing. They were alive like I’d never seen before.

Mind still racing, I sat down at a bus stop, where an older womxn and child waited for the next bus, the child was gorgeous; his dark skin and big eyes melted my being. I could see unifying light and life in all. It was like a deeper sight I had not had access to before, and it was brightest in him so far; his innocence permeated the space, beautiful and illuminating. His light yet to be completely muddled by society and other structures, he emanated a purity so raw. His caretaker was on the phone, so I started chatting with him and she was okay with it. I wanted to make him aware of his beauty. He laughed with me while sitting on my lap, and his eyes pierced into me almost in recognition, as if we weren’t strangers. Soon after, something else caught my eye and I was off. A dog bark in the distance made me suddenly think my dog had been stolen. Wandering through the parking lots of a medical complex, I came across a police car parked in front of a 7-11, as I got closer I saw a policeman in the driver seat watching the area. Frantically I approached for help: “Can you help me please! Someone stole my dog...” I didn’t even finish my sentence before he reacted violently: “Back the fuck up!” he yelled. I exploded in anger and realization of why he screamed at me the way he did. Moving quickly he overpowered me, cuffed me and threw me in the back of his squad car.

Livid, and at a new height of my elevated state, I knew I did not deserve this treatment. Ah of course, we were in a “ghetto” part of Antioch. “What do you think I am? I just asked you for help! DIDN’T YOU BECOME A POLICE OFFICER TO PROTECT PEOPLE? You are a piece of shit!” I screamed as I rotated my body and kicked hard at the door repeatedly with both legs. The cuffs were so tight, my wrists were cut and bleeding. I kicked and screamed to no avail. Paramedics arrived, examined me from the squad car and carried me onto a stretcher. Chain straps holding me down, the thoughts were racing faster than ever, harder and harder to control... (Sandoval Field Notes, 2013)

Antioch California, a predominantly working class suburb of the Bay Area, was once a white town. Understanding the racial and socioeconomic makeup of the location where I experienced my manic episode is fundamental in the analysis of my experience. According to census data, in 1960 the population in Antioch was 99.6 percent white, and while there may be room for error in the reporting of this data, it is nonetheless a testament of the lack of racial diversity in the city. The most recently updated 2010 figures show a drastic change with 48.9 percent white, 31.7 percent Latinx and 17.3 percent black (Anon 2018). In just 50 years, the demographics of Antioch changed drastically, most of the increase in minority population caused by exceedingly high rent prices in Bay Area cities closer to San Francisco, and the availability of larger homes accepting Section 8 housing vouchers, in suburban Antioch. Census data corresponds with the notion that as more people of color made their way to the suburbs, whites moved away. Antioch is a clear example of white flight: the systematic migration of white

residents, away from neighborhoods recently populated by significantly large minority groups. When whites leave a neighborhood, they take their social and economic capital with them. Antioch deteriorated in the eyes of mainstream white society, and is now perceptually aligned with violence and crime. A place where only certain enclave neighborhoods are considered safe and all the others crime ridden. This label is still a wound for Antioch, the societal perception of the community was marred and its value reduced.

Many residents of the city knowingly or unknowingly align themselves with the racism and classism embedded in our society by displaying animosity toward the perceived purveyors of violence and “destroyers” of their city without taking into consideration the macro-structural factors and historic systemic oppressions critical to the dynamic and culture of violence and crime. This figurative demarcation commonly attributed as tension between the “haves” and the “have-nots,” produces a non-cohesive environment where discrimination, classism and racism can blossom unperturbed. The demarcation becomes physical when white avoidance incites the beginnings of residential segregation, and communities with high concentrations of poverty are socially isolated, left to their own devices (Massey and Denton 1993). Theories regarding the class-consciousness of the “middle-class” have been in production for over a century, and the characteristics outlined in many, are readily visible today in working communities like Antioch. The same systemic forces or economic interests of the proletarian working-class do not drive those who consider themselves “middle-class”; even when their material economic reality is becoming more like the lower classes, they continually align

themselves with the upper class and thus better than their proletarian neighbors (Burriss 1986, Kautsky 1971). The hierarchal separation created by perceptions of success and membership to the dominant in-group is illusive, a byproduct of the false consciousness of those supposedly enjoying the comforts and status of capitalism, the notion of the “middle-class” and mainstream white society (Burriss 1986, Guerin 1973, as cited by Burriss 1986). Because these societal perceptions and tensions occupy the consciousness of many communities, they have very real effects on the policing that occurs.

Antioch made national headlines when The New York Times wrote a story in 2008 detailing the migration of Bay Area Section 8 recipients (largely Black families) to the suburbs and the tensions that followed. A collective named Antioch Section 8 Families for Fair Housing put a class-action lawsuit forth against the city and its police department. This case details the discriminatory tactics of the Antioch Police Department against more than one Black family. The Antioch Police department was accused of targeting Section 8 families with a policy of threats, coercion and intimidation against both renters and property owners in an effort to drive these families out of the city (Burgarino 2011, Advocates 2018). Accusations stated that the special unit created in 2006 called Community Action Team (CAT), was set-up to target voucher-receiving renters. Forty percent of CAT cases involved non-criminal activity and Black families were approximately four times more likely to be subjected to the special team’s investigations, making up two-thirds of their total cases while constituting only 14 percent of Antioch households (Advocates 2018, ACLU 2011). This case provides legal documentation of the discriminatory practices and perceptions of the Antioch Police

Department against the poor and racially marginalized. However, it is also representative of the social function of crime and in turn its policing. Said function is to provide a sense of solidarity among members of an in-group, in this case “good” citizens (i.e. white law-abiding people), by shunning the out-group, “bad outsiders” (i.e. Black urbanites) (Wehr and Aseltine 2013). Among in-group members, this activity is not viewed as problematic; on the contrary, it is praised and viewed as necessary.

It is no secret that police personnel in communities like mine are not the friendly guardians and heroes of the films and TV shows churned out by the white corporate mainstream media. Police officers frequently develop a perception of the neighborhood they patrol based on race, previous experiences with citizens, and neighborhood distress (Novak and Chamlin 2012). The hostile police officer I encountered had parked across the street of a government-housing complex, and was waiting vigilantly for something to occur in the impoverished neighborhood. Not surprisingly, the majority of people who live in the public housing complex are not only poor, but people of color and in this particular complex, mostly Black. The Prison Industrial Complex sustains the notion that the hypervigilance of one group of people will produce criminals of the same kind. It is not uncommon for cities to use their police force and other institutional resources to hyper-monitor poor communities of color, falsely assuming these practices will reduce crime as a whole (Wehr and Aseltine 2013). These approaches become embedded into the everyday policing and treatment of the citizens living within the jurisdiction of said activity (Blumer 1958). Aggressions span from discriminatory practices and racial profiling while making routine traffic stops to the over incarceration poor citizens of

color by hand of nationwide publicized efforts like the “war on drugs” (Mahmood 2004, Smith and Hattery 2006, Wehr and Aseltine 2009). A traffic stop for a person of color could not only be inconvenient, but dangerous and frightening as well (Sklansky 1997). Meanwhile, dominant racial groups see the police as allies, and for many whites the targeting of minorities or minority neighborhoods is a sensible tactic (Blumer 1958). Because most whites enjoy the protection of the police and think of them as allies and heroes, people of the profession are generally held in high regard within the white community, and any criticisms are treated with skepticism taken as an affront to their group interests (Weitzer and Tuch 2004). Given the racial and socioeconomic makeup of Antioch and the struggles between its police force and the community of color, it is fair to assume that had I been a white womxn in a well-to-do neighborhood displaying the symptoms of mania, my treatment could have been categorically different.

In her memoir detailing her experiences with mania, Terri Cheney (2008) writes of two separate instances in which she had encounters with the police. Cheney is a white womxn, and at the time of her encounters a successful entertainment lawyer in Los Angeles. Both of her run-ins happened while physically and mentally impaired, due to constant changes of her psychiatric medications. The first took place in front of a Saks Fifth Avenue in a wealthy neighborhood, she was wobbling around disoriented when an officer graciously assisted her to her car and let her drive away. The second mention was completely different. Driving medically impaired in a minority populated, impoverished community, she was pulled over for running a red light and was thought to be drunk. The officer arrested her and took her in for processing, where the police force treated her

without respect and subjected her an anal cavity search, an experience she recalls as extremely traumatic (Cheney 2008). These instances demonstrate the differences in treatment a white womxn received in two economically and racially distinct neighborhoods, corroborating the notion of differences in police perception throughout socioeconomic lines.

My run-in with the APD occurred when I was in a state where I recognized a unitary divinity to life in a deeply profound way without being able to separate that others were not where I was mentally, spiritually or emotionally. This is why I did not fear the police, and thought I would get help. The hostility I was met with is one experience of a multitude that are testament to a flawed police system that does not properly educate or train officers to be conscious of, nor compassionate toward the social realities of others. Officer training on mental health is dismal; officers attending the police academy in California receive 664 hours of training on use of force, but only a 6-hour class or 10 percent of their total training on sensitivity toward people with all disabilities including mental illness (Lew, Pham and Morrison 2014). The homogenization of disabilities and minimal training, though testament to the lack of knowledge, is not the only problem. The public and the police, garner their understanding of the mentally ill from an ideology that dehumanizes the mentally variant and seeks nothing more but to control and restrain us for our “safety” and the “safety” of others, even when no imminent danger is present. Governing institutions draw from this ideology in the creation of policies and practices, thus oppressing the mentally variant at extremely vulnerable times where we are completely subject to these institutions (Arrigo 2002). The criminalization of mental

variances has put police at the frontline of a reality they simply are not prepared to take on. Due to their lack of understanding and because they are trained to be aggressive warriors who see threats in every corner, police kill hundreds of mentally variant people each year (Vitale 2017). So much power lies in the hands of undertrained officers, they wield the power to discern from their level of perception whether a person is in need psychiatric detainment or typical detainment and in other cases whether to use deadly force; but even when the officer chooses psychiatric treatment, as in my case; there is still ample space for mistreatment. Chesney-Lind and Jones (2010) argue distorted perceptions and narratives of young womxn being more violent, sexually irresponsible, sad and overall “out-of-control,” have run rampant for decades; with non-white womxn being targeted even more so. Preconceived notions won the day of my detainment. I did not get the Cheney (2008) Saks Fifth Avenue police escort treatment. Even though I am of lighter complexion, and definitely afforded privilege for it, my dark long hair and “ethnic” features coupled with my manic wandering in jeans, old flats and an old tank top through the “ghetto,” no doubt influenced the treatment I received. I was asking for help, I was not a threat, there was no place for me to conceal a weapon, and he could discern I was not in an “equilibrated” mental state, and even so, he acted with the utmost ignorance and disrespect for the human condition. After he cursed at me and cuffed me so tight, my wrists bled; he “did the right thing” and called in for an involuntary psychiatric hold.

El Otro Mundo y Las Pastillas

*My nails dug into the arm of the paramedic at my side. I gripped, dug and dug deeper into her skin as my inner experience accelerated beyond control. The panic of hurting her delicate arm flashed for a moment within the racing thoughts bombarding my whole being, but I couldn't stop, I was peaking! The highest of high points, my thoughts spiraled faster, I couldn't keep track anymore, everything blurred and then went black. I completely left my body. There was darkness all around, but I was conscious, the spiral of uncontrollable thoughts was behind me and I felt something new in the void: peace, comfort, and joy unparalleled. It felt like I was free falling outside myself and somewhere else, but I didn't know where, and a magnificent force caught and embraced me. Held and supported I floated, finally allowed to rest in the most comfortable formless hug. This wasn't a dream, I wasn't asleep. A loving, soothing energy enveloped me assuring me it would be okay, it cradled me and I felt flashes of understanding: *todo va estar bien*. My cousin Mark who had passed away four years before was there, not visibly or in body form, but his presence and essence made itself known. Stoic and comforting, his being was there to help, like a big brother aiding me on a journey he had already taken. Feeling his being brought me an added layer of peace and reassurance. A formless yet all-encompassing love engulfed me, supported and sustained me. Allowed me to rest. I had never felt this back in my body. Somehow transported yet still within, I rested in this niche of existence, a place I had never been to and felt as if I would never get the directions on how to get back. I was in boundless love; reveling in a level of emotion that is truly indescribable, it has to be experienced. I wanted to stay forever, but it was*

lovingly communicated that I had to go back. Suddenly, the deepest most terrifying pain came over me, a vision of a vast open desert with a blazing sunset blinded my sight for a second as if I were traversing above it, but the pain wasn't mine. It felt foreign yet I was feeling it, holding it, experiencing it. My unattached form was writhing in emotional pain. It was the pain of a mother who had lost her child; flashes of mothers in my family who had lost their sons came over me. The extreme despair and pain kept its hold on me, but it wasn't over. Soon after the first wave passed, I felt the pain of a mother who passed before her son. This was worse only by a little, I felt consumed by this pain; it was unlike anything I had ever experienced. I heard the wailing of what sounded and felt like a thousand mothers but in one solitary voice far off in a distance; the pain so extreme it was as if to come from the very source of all pain. I held it a little longer; and it was time to go back. When I came back to my body, I was in the stretcher at the door of the county hospital and back in the reality where I was prisoner, the reality of involuntary mental patient. Screaming, punching and fighting was of no use, my kind of patients do not have freedom or choice. A slew of hospital workers lined the stretcher to hold me down, I punched someone in the face and a doctor forcefully injected me with a sedative. A completely different type of darkness came over me; an empty numbing darkness took control. Hours later, I came to in a dark room, restrained at both wrists to a vinyl-covered bed and a matching pillow. I had no concept of time. There was nothing in the room but the plastic bed and a door with a glass square for monitoring. Fear and panic immediately brewed within me, but there was nobody to turn to. I tried moving to find comfort, but my body felt foreign and stiff. My muscles ached; inexplicable pain ran

throughout my entire body, and the handcuff cuts on my wrists stung against the new restraints. Frightening screams from other patients erupted outside the room and I was terrified. I had to adjust to the fact that I was back in this body and the consciousness I consciously and unconsciously had not been in for more than two days. Any morsel of comfort escaped me, I tried to sleep on my side with my hands up near my face the way I always do, but the restraints forced me to stay on my back. I recoiled in desperation, side to side with my wrists pinned to either side of the bed. The sterile harshness of the room threw me further into a panic. Staying was not an option; I needed to get out (Sandoval Field Notes, 2013).

Involuntary hospitalization into a psychiatric facility can and frequently is a traumatic event in the life of the involuntary patient. One study in England found that 80 percent of participants reported trauma from the experience, while 66 percent reported severe trauma, including instances of physical or sexual assault while hospitalized (Tarrier et al. 2007). In addition to the psychological effects of stripping patients of their freedom, standard psychiatric practices such as the use of restraints, forced injections and seclusion worsen the already traumatic experience of being forcibly taken while in the midst of life altering mental events (Frueh et al. 2005, Cusack et al. 2007). Questioning whether the perceived benefits of involuntary hospitalization outweigh the trauma is vital to any discussion regarding the effectiveness and purpose of psychiatry. Mainstream media portray psychiatric hospitalization in a stereotypical manner that does not accurately depict reality. The lack of realistic psychiatric patient representation in

society's collective mind makes it so that when a patient faces a "real-life" psychiatric hospital, the chances of shock and fear resulting from it being out of our even fictional conceptualization, are inordinately high. The secrecy, confinement and security surrounding psychiatric treatment centers cause the initial exposure to be extremely rattling, increasing mental distress instead of having any type of soothing effect.

For womxn, the trauma exists with additional layers; psychiatry reinforces the longstanding societal belief that we need domination and control over our lives at the hands of men and male institutions. Patients overwhelmingly report the requirement to take on the gender specified role of submission and "do what they say to get out" of the institutions confining them. We are infantilized and manhandled to submission; male power dominates these male establishments (Creswell 2014, Potier 1993). The DSM has authoritatively materialized societal perceptions of "female madness" since its inception, "advancing" from initial diagnoses of "hysteria" to modern day "borderline personality disorder (BPD)." The overarching "regimes of truth" dictate how womxn's madness is defined and regulated through texts like the DSM; "hysterical" states have always been linked to the essence of femininity, thus symptoms such as; depression, impulsive sex, binge eating, aggressiveness and uncertainty of long term goals or career choice have been perpetually feminized (Ussher 2013). In addition, otherwise mundane aspects of our nature, add to the anguish of confinement. An aspect of patient trauma not discussed by any of the authors cited above is menstruating while sustaining the events of mental episodes and while held in a foreign, controlled setting. Menstruation is typically a private event and may even take on ritualistic forms for some. However, in the instance

of involuntary hospitalization, that level of privacy does not exist. The subjection to menstruation under confinement is an additional layer of humiliation and discomfort that men simply do not encounter. The stripping of a woman's personal articles of clothing, as well as the confiscation of bras that have wiring, is not only traumatizing, but also exemplary of a fundamentally patriarchal institution. The hospital gown given in replacement symbolically cements our surrender, becoming a visual representation of the demoralization many patients withstand.

The routine practice of involuntary hospitalization bears witness to the argument that the psychiatric institution, while no longer employing some of its more heinous traditions such as; beating, chaining, lobotomies, psychosurgery and aggressive shock treatments, is still a strong-armed mechanism of control. Conrad (1979) defined medical social control as the way medicine wittingly or unwittingly tries to secure adherence to social norms. The medicalization and policing of mental variances along with their subsequent treatment provides reassurance for those frightened or hassled by the variant, as well as a means by which to label, monitor and control the differences (Arrigo 2002, Foucault 1988, Scull 1979). Whether it be by involuntary hospitalization or by means of social pressure, the "mentally ill" person must first be subject to coercive social control, especially when we reject the patient role (Szasz 1994). My experiences, along with those of countless others illustrate this need to control. Law enforcement plays its role, along with frightened loved ones who call the authorities, knowingly or unknowingly adhering to the superseding ideals of mental normativity and control in the process.

The social power held by psychiatry today is born of the foundational factors and ideals of medicine and psychiatry, as well as modern-day manifestations of not only medical social control ideals, but also capitalistic stakes in the medication of the mentally variant. Scull (1979) and Foucault (1988) analyzed the early days of European psychiatry, and the formation of a moral machinery, which would take the place of corporal punishment, but continue to force conformity. “To see in all of this only the benevolent face of moral treatment – its break with the crude coercion of the past – is to ignore the latent power of these techniques” (Scull 1979). Underlying power runs throughout the entire process of either discovering a need for external psychiatric help or the coercion into said help by law enforcement, family members or society. Foucault (1988) described this suggestively subtle exchange as more pervasive than the brute ways of the past. There is inherent power in the authority to label a person ill, the acceptance of a definition of illness, the agreement that illness is an undesirable state, and once accepted as an issue or deficiency, its inevitable treatment (Zola 1972). The power dynamics in psychiatry are clear, the patient is other, subject to the institutions created to enforce social normativity and the restraint of the mentally deviant, by historically and presently employing trauma-inducing, freedom-depriving methods of “treatment.” Psychiatry is responsible for the medicalization of many normal human emotions and functions (Arrigo 2002, Foucault 1988, Scull 1979, Szasz 1994). The governing norms and institutions of our society impose monolithic “truths” about our consciousness and the mental corrals we are to stay within. Deviation is then “treated” or better yet, dealt with, according to the direction appointed by the corresponding force.

Though its goals and achievements are highly debatable, institutional psychiatry continues to be the established method of diagnosis and treatment of mental variances. Therefore, whether we think of psychiatry as an enforcer of social control that doles out sub-par, often inhumane treatment, or not, the question of access to elective care is still relevant. It is a logical assumption, and glaringly obvious that those without financial means have a harder time accessing psychological services within this country's capitalistic medical institutions. Investigations and studies have found what people in my class have lived: poor people of color have higher chances of requiring psychological attention and less chances of receiving adequate care (Alvidrez 1999, Alegria et al. 2002, Surgeon General 2001, Chow, Jaffee, and Snowden 2003). DeGruy's (2005) concept of Post Traumatic Slave Syndrome (PTSS) further embodies this assertion. The theory of PTSS argues a legacy of never-addressed trauma passed down generationally, produced by over 200 years of slavery and the continual oppression that ensued long after. This is especially problematic for our low-income communities given that research links low socioeconomic status to adverse mental health outcomes repeatedly; further proving this vulnerable population is experiencing disproportionate psychosocial distress (Alvidrez 1999, DeGruy 2005, U.S. Department of Mental and Human Services 2001).

My personal experience as well as the experiences I have witnessed in my low-income migrant community, attest to this. People with mental illnesses are overrepresented in high poverty neighborhoods (Anakwenze and Zuberi 2013). We live extremely strenuous existences in our society, where our perceived value is measured in terms of our labor and the adherence to, or assimilation into dominant social norms. It

feels like we are in an eternal state of vigilance and survival mode. We feel financial pressures immediately at birth, culturally we are othered for being different, we are othered for our poverty, and our caretakers live in a constant duress that seeps deeply into our mental and emotional environments. There is mental and emotional strain in multiculturalism, a “strain of borders” and tearing of the soul at being mix breed (Anzaldúa 1987). The inner struggle and straddling of worlds, ideas and cultures, produces a double and often multiple consciousness of our inferior societal positioning (Du Bois 1994). All this without taking into account the traumas we face non-exclusive to poverty or race. It is not a shocking revelation or an assumptive leap to state that these factors affect our psychological outcomes in varying, often hindering ways. If, and when we do feel a need for external assistance, it is not easy to admit, accept or access. Poor people of color disproportionately lack the knowledge, resources and accessibility to mental healthcare when compared to our white counterparts, and we often endure symptoms without treatment (Alvidrez 1999, Alegria et al. 2002). To give a glimpse, Latinx in the US without health insurance range between 32-37 percent, compared to 16 percent for US Americans (Berdahl and Torres Stone 2009). Without health coverage, the poorest of the poor must seek the few options that are free of cost. Safety-net providers such as public hospitals and free community centers are sources of care for low-income and migrant patients; but these providers struggle to provide adequate levels of care (Anakwenze and Zuberi 2013). Wait-times at free clinics are incredibly long and appointment lengths just as short. At a free community clinic in Sacramento, the wait time for a routine psychiatric medication management appointment, was six months. Care

in county-run facilities for the poor, is sub-par at best and traumatizing at worst. This is one of the greatest barriers holding those in need from finding any semblance of care available in the mainstream today.

Likewise, working under the assumption that ethnic groups disproportionately make up the lower classes; cross-cultural factors must then inform analysis of access as well. Communal cultural distrust of the medical profession, as well as the stigma that saturates our communities, additionally impede access. The Black community has long harbored legitimate distrust in the medical system. Historical trauma is at the forefront of distrust with events such as; the long-held phrenological belief of Black subhumanity, and atrocious “medical” experiments practiced on slaves and later freed Black persons in the name of “science” (DeGruy 2005). The medical trauma endured by the Black community continued well into the modern era. Established in 1911, Crownsville Mental Hospital for Black patients, exploited inmate labor, trialed deadly vaccines on them and was in a constant state of infectious disease and overcrowding (Stuckey 2017). In Xicanx culture, distrust is often a product of placing trust in something else. Whether it be god, a curanderx, La Virgen De Guadalupe, the saints, a shaman and so on, spirituality and faith are cornerstones of trust. Some migrant families also hold healing practices from their motherland tight, creating a questioning or aversion of anything alien (Anderson, Toledo and Hazam 1982, Bach-y-Rita 1982, Stenger-Castro 1978). We also place our trust in the family unit; tribalism or hierarchal collectivism is common in families even when we may not be as connected to our indigenous roots due to colonization, generations of migration, acculturation and assimilation (Padilla 1984, Smith-Morris et al. 2012, Strunin

et al. 2013). Migration can reinforce tribalism, family members often cling to each other for refuge and assistance in a new country. When something is amiss, we go to our families for help. Because our culture also relies heavily on ideas of strength, there is an unmistakable level of shame in asking for outside help, and the perception of weakness weighs heavily (Kouyoumdjian, Zamboanga and Hansen 2003). It seems that over time this distrust has dissipated. The Latinx of my generation are more open to receiving mental aid, I see this amongst my peers and in online trends via international social media communities. The surge of mental health awareness is hope producing, but at the same time, there needs to be a critical spotlight on the massive issues and flaws surrounding psychiatry and its affiliates. What good is access and our recognition of need, if the institution would rather stay beneath the coercive umbrella of contemporary psychiatric ideals instead of implementing radical change that would fulfill our psychosocial needs in a deeper holistic way?

Psychiatry did not always bask in the authority and credibility it revels in today. At their inception in England, asylums were more like boarding houses for mentally disturbed members of rich families (Scull 1979). They were a place where families could dispose of their troubles. Practitioners of the past were not medically trained physicians, and the field was not associated with the “hard” physical sciences (Angell 2011). The prestige we now associate with psychiatry was born of the field’s move from psychoanalysis to a biologically based, disease-centered model, effectively cementing its place as a physical science (Szasz 1994, Breggin 2008, Moncrieff 2008, Carlat 2010, Angell 2011). The widespread adoption of the belief that adverse mental occurrences

were inherently physiological in nature and due mainly to chemical imbalances in the brain required that psychiatrists become fully trained medical physicians (Breggin 2008, Moncrieff 2008). Western psychiatry today uses this model as its template, but it is highly problematic. Psychiatrists (Breggin 1999, 2008, Moncrieff 2008, Carlat 2010) argue that the human brain is incredibly complex: There are billions of neurons, trillions of interconnections between those neurons mediated by neurotransmitters, and no way of locating the source of any “mental illness” issue in the brain, but psychiatry claims to know enough to deem physical disease as the cause of distress. Scientific trials for psychiatric medications often study placebos vs. psychiatric drugs finding weak, questionable results only to endorse psychiatric medications anyway (Moncrieff 2008). Other studies rely on mammalian animal brain tests since testing extensively on a living human brain is not possible (Carlat 2010). Lastly, the very disease-centered model that assumes drug treatment is best because they correct an underlying disease gives birth to the trials, and the interpretations are highly contestable, yet have been widely accepted as fact (Moncrieff 2008). Operating under the flawed guise of scientific authority is deceitful and makes subjects of uninformed patients in distress.

A critique of psychiatry would not be complete without analyzing the psychopharmaceutical complex and its hold over psychiatry as an academic discipline and medical practice. Although there is enough material to write books on the subject, only a birds-eye view is presented below. The disease-centered model and adoption of biological psychiatry, gave way to a bevy of practices that are questionable to most, and repugnant to a growing faction, especially those directly affected by them. The

psychopharmaceutical complex, or the gathered forces of the medical institution, drug companies, the Food and Drug Administration (FDA), and other federal agencies; promote the idea that psychiatric medications are not only viable, but superior forms of treatment by creating a narrative and corresponding propaganda to rid people of their natural skepticism toward consuming psychotropic medications (Breggin 2008). Heavy influence is observable through FDA approval activity, financial support to various mental health associations, direct-to-consumer advertising, and its influence on academic and practiced psychiatry.

As previously mentioned, knowledge of the human brain is immensely incomplete and psychiatric drug trials are contestable from their inception, yet results are accepted as fact. The FDA is an authority that has much to do with this phenomenon. Created in the 60s as an agency whose purpose was to ensure consumer protection by the regulation of food and drugs, the FDA has been in decline and without permanent leadership since George W. Bush's administration (Barber 2008). It was originally tasked with ensuring ads were not false or misleading, that they presented a fair balance of risks and benefits, and included facts pertinent to a drug's usage, as well as a brief summary noting every risk on the drug's labeling. In the 90s, after a boom in business due to prescription drug marketing campaigns, the FDA eased up on advertising restrictions, after which, ads were required to include only major risks and direction to resources for further, fuller information (Parekh and Shrank 2018). Drug companies have infiltrated and arguably taken control of the approval process for psychiatric drugs. The Prescription Drug User Fee Act (PDUFA), its first version passed in 1992, effectively

sped up the approval process by stipulating that drug companies pay the FDA millions in fees to review their drugs on an expedited basis. Fees facilitate the hiring of additional FDA personnel required to achieve the expedited 6-month process as opposed to the standard 10-12 month process (Berndt et al. 2005). As a result, the funds collected in fees make up almost 20 percent of the FDA's entire budget and about half of their drug-reviewing budget (Barber 2008). Drug companies have essentially bought the FDA's sociopolitical authority by filling the agency's coffers. An inevitable outcome is the emergence of bias caused by the conflict of interest. Drug companies try to make products seem safer and more effective than they actually are; the FDA repeatedly drops critical scientific concerns and has instructed agency employees to find "creative" ways to approve problematic drugs (Barber 2008, Breggin 2008). Business has effectively taken over the evaluation and regulation of prescription drugs, lessening the quality and standards of their studies. Many drug trials are shaky in foundation. For years, "samples of convenience" were permissible; allowing the usage of test subject individuals who were not diagnosed with the illness the drug in question treated. In addition, trials only need to last six to eight weeks, even when the initial effects of the drug take around a month to fully develop (Barber 2008). With prescription drug consumption being so high, and Medicare/Medicaid being the largest payers, the regulatory climate has a long reach, influencing federal and state budgets as well as insurance premiums and patient out-of-pocket costs (Parekh and Shrank 2018). The intricate connections, dependencies and conflicts analyzed at the surface level here, ultimately extend to the health and livelihoods of the patients of our society at very intimate levels. The dependency created

between governmental bodies and industry is dangerous. PDUFA and the fees it generates has become integral to the existence of the FDA, if its latest (sixth) version were not approved critical FDA salaries could not be paid and forced layoffs would ensue (Barlas 2017). The FDA is literally in the grips of the very entities it was created to monitor and regulate. Keeping the people's eye on governmental "watchdog" agencies is crucial to our efforts toward liberation and collective well-being.

Globally, and across medical and nonmedical settings alike, professionals use the aforementioned DSM, to diagnose, learn about and treat mental issues. The DSM, often dubbed "the bible of psychiatry," now in its fifth edition, is a household name in Western psychiatric and psychological institutions. It is an essential component in bolstering the multibillion-dollar psychopharmacology industry, as well as responsible for 46 percent of the American Psychological Association's 2011 revenue (Cosgrove and Wheeler 2013). Governmental agencies and insurance companies alike use it to determine a number of things including eligibility for coverage and aid. The issue-riddled authoritative text is a compilation of completely subjective guidelines for diagnosis and treatment, which as of its third edition, builds on the notion that psychological disorders are biological "diseases" (Breggin 2008, Moncrieff 2008, Carlat 2010). The DSM is merely the opinions of the task force gathered for any given revision, built upon the opinion of those who came before them; this approach is controversial and filled with holes, as alliances and financial conflicts can and do easily pervade the revision decision-making process (Angell 2011). The drug industry has been more than influential in said revisions since the third edition. In 2006, the entirety of two DSM panels: Schizophrenia Disorders and

Mood Disorders had financial ties with industry, and 68 percent of the 2010 taskforce as a whole had financial ties. Which is to say, taskforce members either served on speaker bureaus, corporate boards, or received honoraria from the pharmaceutical industry. This is worth noting given that the DSM has historically omitted or underrepresented the important issue of diagnosing negative effects associated with psychotropic medications, even when such effects are life-threatening diseases such as diabetes and other metabolic conditions. (Cosgrove et al., 2006, Cosgrove and Bursztajn 2010). The shifts in diagnostic categorization are dependent on the ruling medical ideologies of the times and the institutional powers-that-be. A clear example is the changes in the psychiatric diagnoses of womxn, whose everyday emotions are medicalized far more than men's are. Homosexuality was once listed as a mental disorder in the DSM, and the inclusion of premenstrual discomfort as a diagnosable disorder is another case in which femininity is medicalized and potentially dangerously treated. Again, there is significant reason to question the drug industry's dealings in these decisions. Major pharma player Eli Lilly happened to rebrand Prozac into the drug Sarafem, marketed to treat Premenstrual Dysphoric Disorder (PMDD), right around the time their patent on the active ingredient was set to expire. A roundtable gathering of psychopharmacological influencers including doctors, FDA reps and Eli Lilly employees produced an academic article that not only concluded that PMDD was an actual diagnosable disorder, but that antidepressants were effective as treatment. To no surprise, the PMDD panel for the fourth edition of the DSM was financially involved with Eli Lilly (Cosgrove and Wheeler 2013).

Financial conflicts of interest involving psychiatry and pharmaceutical companies plague our society in a slew of ways from various levels of impact, making it fair to question if the two are dyadic and thus regarded as a pair (Anand 2012). Medicating the masses has quickly become a mainstay of the global economic landscape. U.S. drug company revenues for 2006 made it the second most profitable industry in the country, but what is not commonly known is that the majority of that revenue came from psychiatric and cardiovascular medications (Barber 2008). The subjective diagnosing of mental disorders as either chronic or lifelong diseases thus requiring medication for extended periods, if not lifetimes, certainly makes the prescription of psychiatric drugs incredibly lucrative. Direct to Consumer (DTC) advertising is vital to the pharmaceutical economy. The U.S. and New Zealand are the only countries in the world to allow DTC advertising of pharmaceutical drugs. These ads flood broadcast television with over-emphasized depictions of the benefits surrounding prescription drug use. The FDA eased advertising regulations in the late 1990s stating that ads need only provide consumers with the major risks. However, studies have found that DTC ads misinform patients by promoting drugs over healthy lifestyles and over-emphasizing benefits while under-emphasizing risks (Parekh and Shrank 2018). Because psychiatric diagnoses are subjective in nature, prescribers, prominent psychiatric scholars and countless others in the field become highly susceptible to financial conflicts in comparison to general medicine practitioners (Breggin 1991, Barber 2008, Moncrieff 2008). The conflict of interest does not go unnoticed by members of the psychiatric community; doctors and other influential leaders are treated to financial perks ranging from lavish travel and

lodging for speaking engagements to funding for scientific research and academic publication. Drug companies regularly sponsor American Psychological Association (APA) conferences and seminars likened to a circus where marketing techniques are outlandish (Breggin 1991). The compilation of these cemented practices are not one-off nor the case of a few “bad apples;” the core is the dangerous dependence of psychiatry on industry formed by policies, incentives and behavioral norms, as well as the economies of influence and the alliances formed because of it (Cosgrove and Wheeler 2013). The practices and issues outlined in this chapter intellectually, factually and statistically evidence what we patients regularly endure, but do not always put forth in these formats and often do not even put into words. The psychiatric industry is just a subset manifestation of the problematic systems and governing societal ideals that emphasize profit and individuality over the livelihoods and well-being of our people. Much like those amassing capital from the Prison Industrial Complex, psychiatry and its financial benefactors thrive through our societal policy of control, incarceration and the widespread acceptance of profiting from criminality (Breggin 2008, Mahmood 2004, Smith and Hattery 2006). Fortune 500 companies commonly move parts of their operations to prisons, exploiting the labor of inmates (mostly people of color), while other Fortune 500 companies endlessly produce “new” drugs for psychiatric consumption; both sets take from the vulnerable to maximize their profits (Barber 2008, Smith and Hattery 2006). Involuntary committal, like prisons, can easily be seen as a method of removing unwanted, un-useful or unnecessary members of a capitalist society (Foucault 1980, Wright 1997). The overlap in interest between these enormous pillars of

industry is always capitalistic gain, at any expense. It makes sense then; if schizophrenia really is the philosophical destructive weapon of capitalism, then its restrictive containment must be of principal interest to capitalist institutions (Deleuze and Guattari 1983). Trauma, whether endured first-hand or passed down generationally, is often at the center of both the criminal and the mentally variant (De Gruy 2005). As referenced throughout, marginalized communities and identities are at higher propensity to psychosocial distress, distress that manifests in many ways. Possibilities for managing it to the best of our abilities and minimizing our profitability is the topic of the final chapter.

Sánate y Sana La Tierra

“Close your eyes, and focus on your breath... in, out, breathe deep, in....and out. Don’t let your mind wander,” soothingly whispered the white womxn with a turban on her head teaching the yoga class.

I couldn’t focus.

The space was tranquil to say the least, lit by candles and the bodies clad in white clothing that lined the room.

My mind’s chatter was relentless...

Wait; there was chatter in my mind? Why had I never noticed that?

I looked around at everyone sitting comfortably and peacefully in their silence.

I tried again, but I couldn’t stop thinking. I wasn’t used to this kind of stuff, everything is loud where I come from, there is always something going on.

“Ya cállate!” I scolded myself.

I cheated and opened my eyes one more time.

I looked around at all the white faces in white clothes one more time, and slammed them shut again.

Ok, now I was serious about receiving healing from this class.

Surrender

Surrender

Surrender

y me rendí.

I left class feeling great, told myself I would go back and never did. A couple years later and now a grad student, something called me back to the mat. Sitting in my sanctuary introspecting, and reminded of that first experience, I pulled my laptop out and did a search for some videos. One video led to another, which led to one from Kundalini Live based out of Monterey, CA and nothing was the same.

“Keep your arms up, keep your arms straight, don’t let them come down. Breathe through the pain,” Sukhmandir instructed.

My arms felt like they were going to fall off, I wanted to bring them down so bad, but I also wanted to push through.

“Keep up and you will be kept up,” Sukhmandir reminded. “You will reach a point where your arms just float.”

“Yeah right,” I thought to myself as my arms burned in the 60-degree angle I had them in for over two minutes now.

“A minute can seem like an eternity sometimes can’t it?” Sukhmandir laughed knowingly.

Then one day it happened. I had been devoted to my practice for some time and out of nowhere, I felt something rise from the base of my spine, just how he said it eventually would. The unseen force travels up like a serpent and the spine automatically aligns in response. One day my arms stopped hurting and they were floating, sustained by the energy!

“Your life will change doing this yoga, what you want to see in your life will change, what you put in this body will change, you will change,” Sukhmandir’s words still inspire and motivate me (Sandoval Field Notes, 2013).

“If I told you that a flower bloomed in a dark room, would you trust it?”

– Kendrick Lamar

I want to start this meaningful discussion by stating how frustrating it has been to have to cite and support the experiential knowledge gleaned throughout my life and trauma in the margins. The knowledge learned in the streets of my “ghetto” neighborhood, holding my undocumented brown mother’s hand as a child - a literal extension of her, and as an involuntary mental patient. It was hard to read the academic jargon of prestigious journals repeatedly, only to find the conclusions I already knew because I *lived* it, but the nature of academia and science especially, makes it so our anecdotal evidence does not weigh as heavily. I conceded, to strengthen my propositions and get this degree, but this final space is mine and I will cite as I see fit.

Healing from the traumas of marginalized life is a privilege, and those who need it most have a harder time getting to it. Increasingly popular modes of healing and awareness such as yoga classes, holistic healers, alternative psychiatric care, retreats in spectacular nature sites, private rehab centers and organic whole foods, just to name a few, are expensive and generally thought of as “white people things” in our communities. Capitalism is central in any discussion of healing; we have seen that healing under capitalism is business before anything else, a way to profit from and control those who need it due to the very nature of life it has created. Healing requires tremendous amounts of time and energy that the working class already eliminates from their being through work. The focus on preservation prevents the healing process and perpetuates trauma by forcing the poor into the mind and spirit-numbing task of survival before anything else. We live in the root chakra of survival, and the exploitation of our labor seems to be the only way to get by. Paying the bills and keeping food on the table are the focus and priorities of a working-class home, we learn this at a young age, and all too soon, these become our priorities as well. Living in a survival mindset does not leave room for the inner exploration and dedication that healing demands. Our lives are threatened daily, keeping us on high alert. Whether the threat be from food insecurity, eviction, deportation, violence or death at the hands of law enforcement, staying alive and afloat takes top priority. Even so, poor people of color lead resistance movements all over the world, standing up to the powers-that-be to demand justice, because the alternative is to lay back and get trampled. We want freedom and we demand it, but that puts us in political danger as well. Angela Davis (2016) reminds us that Assata Shakur is on the Ten

Most Wanted Terrorist list for her involvement with the Black Panther Party, and that it isn't about the individual, but about sending a message to large numbers of people to systematically discourage involvement in anti-capitalist freedom struggles. Still, we persist, even when it feels our efforts are scattered and not really making a difference. Even when we are tired from work and the psychological toll of day-to-day life. We are so caught up in our survival and quest for freedom, it feels as if there is no time to focus on ourselves, but healing is so important. Healing is crucial to the resistance. Because, "How you gon' win if you ain't right within?" (Miseducation of Lauryn Hill 1998).

Coatlícuē:
 "She
 Was ever moving
 Growing
 Changing
 Like a snake
 Shedding her skin
 Reinventing herself
 Always striving for something
 Better
 And new"
 (Juarez 2017)

Mania shoved me into the awareness of my inner turmoil, but not before the awareness of my outer turmoil and social position shoved me into mania. The experience was a shocking realization of all the wounds this body and psyche had endured, and the scars, at varying stages of healing, they left behind. It was a realization of my minuteness, my grandiosity and my connection to the source of all, the energy and light that animates our cells. The process of sorting out, integrating and aligning these realizations

and experiences is a continual healing process that I know will not end. Mania, and the euphoria I felt naturally, the oneness and interconnectedness of all things hurtled me into my healing process. It took such a grand display for me to actually wake up and see what I had been surviving my whole life. Anzaldúa (2015) defines healing as taking back our energy scattered by the wounds we've endured and using the life-force to act on our own behalf and on others' in positivity. Others find healing in like-minded souls or in communion with divine spirit (hooks 2000). How do we do it? What does the process look like?

When I got home from my involuntary hold, my physical and psychic body was still experiencing the ripple effects of trauma and mania. The stressful events locked my jaw so I couldn't eat, my wrists scabbed, my body bruised from the fighting, but my mind was what needed to heal the most. I couldn't focus, I was still feeling lingering effects of mania and couldn't stand watching TV or doing other things I used to do to relax. I knew I needed psychological help and I had health insurance through my job so I started there. All of the service providers I reached out to were booked a month out, and I realized then this system would be full of hurdles and struggles. Because I was an undergraduate, I qualified for services through the university. I called and relayed my story. Soon after, a psychologist called me to follow up. She was a womxn, and she was brown. I don't know how I got so lucky, because I now know how hard it is to find such a beautiful unicorn psychologist. She is the only healer I have found in this psychiatric system, and though she is no longer my doctor, her level of compassion, understanding and care remains unmatched.

Throughout this thesis, I have reviewed and criticized the psychiatric institution, but what is the alternative? I looked to my roots. My Malicha (abuelita) has hated pastillas since I could remember; she grew up en el rancho; around el río, all the plants y los animales. Her abuelo, as well as her tias and the elders of el rancho, taught her about nature and life. She believes in hierba buena, manzanilla, romero, savila and the healing properties of ciertas comidas. Once, as a little girl, I had what felt like the worst stomachache ever, I stayed home from school, and though I did that a lot because I hated school, this time I was actually very sick. Malicha got aceite and started giving me a massage; she pushed hard on me, praying over me, trying to get rid of the empacho. Of course, there was hierba buena tea after and a lot of rest. She has healed me with her conocimiento time and time again throughout my life. Malicha's knowledge is indigenous, a part of la tierra del rancho and even though she is a die-hard católica y muy blanca, that indigenous knowledge runs deep in her being. She knows her great grandparents were indios on one side and güeros on the other. She is mestiza, my original healer and where my quest to know more of her healing ways began.

The advanced technologies of the Aztec empire in architecture, farming and medicine extended into the field of mental health. They split mental issues into two categories: passive insanity and active insanity (Padilla 1984). Healers recognized a full range of variances that resembled what we now call serious mental illnesses. The tonalpouhqui (healers) formed concepts well ahead of their time such as ego formation and catharsis, and they used dream interpretation and psychotherapy (Belsasso 1969, as cited by Padilla 1984). The healers were believed to possess the traits and moral authority

to cure patients with lengthy conversations that were said to free them of evil spirits. A major difference between Aztec psychiatry and that of today, is that the Aztecs believed the heart was the origin of feelings, passions and emotions thus linking the heart to the issues they were resolving (Padilla 1984). When the Spanish arrived to conquer they burned fields of medicinal plants and books filled with healing knowledge. Very few codices with the beautiful illustrations of plants and descriptions of their healing properties remain. Through the mestizaje between the indigenous and the Spanish, healing practices evolved as well (Chávez 2005 as cited by Chávez 2016). Curanderismo comes from the word cura, which means to cure. A curandera is a person who possesses special knowledge of curing and healing people received from an apprenticeship or due to an innate gift. Specializations range from bone setting and massage, to herbalism and spiritualism (Chávez 2016). As far as mental health, curanderas provide patients with pláticas or “unstructured counseling” (Mohr-Almeida 2011, as cited by Chávez 2016). In Curanderismo the patient is not separate from her surroundings or the cosmic world. According to Chávez (2016), the practice of plática as a therapeutic method has not been investigated enough, but undoubtedly shares elements with humanistic-existential counseling. My visions for the improvement of mental health systems blossom from the beliefs of my ancestors, both living and beyond, as well as the healing practices of other ancient cultures.

Ayurveda, the natural medicine system of India, is over 5000 years old and based on the Vedic tradition. Transcendental meditation is part of mental health regimens informed by Ayurveda and Vata, Pitta and Kapha: the three metabolic principles that

govern human physiology (Brooks 2002). This is what Sukhmandir and other Kundalini Yoga teachers have taught me to practice in my life. The ancient breathing technique called “breath of fire” is a rapid diaphragmatic breathing through the nose only, and it possesses the power to change lives. I have experienced the transcendental effects of this practice. As Brooks (2002) describes, transcendental meditation enables practitioners to experience their innermost Selves – pure consciousness. Kundalini yoga has changed my life and brought me the most change. From it, I have received the most healing. I adopted a vegetarian, and now vegan lifestyle, which I could have never imagined before the Kundalini experience. The dietary changes I made in reaction to my practice have only enhanced its healing effects on my being. Throughout my years of practice, I have felt moments of pure bliss along with others of deeply cleansing catharsis and sometimes-painful growth. It has been five years since my psychologist introduced me to Kundalini Yoga and three since I committed to making it an integral part of my life, vowing never to look back.

In my analysis of the psychiatric institution, I outlined its social complexities and interconnectedness to other governing systems. Our thought paradigms need to shift drastically in order for the change I envision, to become reality. We need to remove capitalistic and individualistic ideals from the realm of healing and learn to understand the realities of those who are mentally variant by listening to us. As of right now, from a patient perspective, it feels like the governing idea and motive behind treatment is getting us back to work and being productive instead of actually taking the time to dive into the

issues. My psychiatric appointments are always medication-centric and not about much else. Treatments need to be less about restraint and more humanistic. In the futuristic novel *Woman on the Edge of Time*, Piercy (1976) describes a feminist communal utopia where ideas regarding mental variances were severely different. Notions of going “mad” and the “madhouses” of this impossibly possible utopia are so incredibly separate from what we know. “And Diana goes mad every couple years. Has visions. Per earth quakes. Goes down. Emerges and sets to work again with harnessed passion...” (Piercy 1976).

The treatment imagined brings me hope and yearning:

Our madhouses are places where people retreat when they want to go down into themselves – to collapse, carry on, see visions, hear voices of prophecy, bang on the walls, relive infancy – getting in touch with the buried self and the inner mind. We all lose parts of ourselves. We all make choices that go bad... How can another person decide that it is time for me to disintegrate, to reintegrate myself? (Piercy 1976)

Mania takes on a spiritual form for me, and others who experience it. Hospitals want to control it and they do so by sedating and medicating us out of these experiences. I maintain that under gentle care and a deep understanding of mania, some of us could ride it out naturally and come out of it with less trauma. One of the closest things to the madhouses described above is a temple in India. The temple of Muthusamy was built over 60 years ago, it is a place where the mentally variant can stay without charge and without fear of being restrained. The internees take part in the daily upkeep of the temple and receive alternative healing (Raguram et al. 2002). The study conducted at the temple

found a 20 percent decrease in psychiatric risk factors, and family members reported positive outcomes (Raguram et al. 2002).

My episodes have many similarities to the psychedelic experience, which has created an interest in the healing compounds of certain plants. Tourism to the Amazon in search of the healing properties of hallucinogens Ayahuasca and Huachuma are growing in popularity. To some, myself included, tourism and the uninformed partaking, takes away from the authenticity of the indigenous ceremony and is disrespectful as well as exploitative. These ceremonies are for healing, not an excuse to trip off psychedelic plants just because. Krebs and Johansen (2013) found that the long-term use of psychedelic drugs did not correlate with decreased mental health; on the contrary, in several cases psychedelic use was related to lower instances of mental health issues. This study confirms what the Instagram page @psychedelicschangelives regularly reports. The owner of said account encourages followers to share their experiences through direct messages. A selection of those entries are then shared on the public page. There is an exceedingly high number of testimonials reporting the cure of depression and anxiety, and the embarking of spiritual journeys resulting in tremendous personal growth. There is still so much to be explored and studied when it comes to healing in general, and psychedelic healing specifically, but thinking outside of current paradigms and working toward changing them is key. My vision for the future of the mentally variant may sound utopian to many, but change always seems impossible at some point. In the meantime, therapy practitioners should focus on multicultural theories of counseling and therapy, as mental-health professionals are poorly prepared to serve their diverse populations by

providing culturally appropriate care (Sue, Ivey and Pedersen 1996). I encourage my fellow mentally variant persons to conduct their own research when it comes to the healing and management of their variance. To find which avenue works best for them under the current system, outside or along it.

The last time I went to el otro mundo was when I first started writing this thesis in 2016. I was in the hospital by force for 72 hours and am still recovering from the imprisonment. The wound is still open and painful; I can't sit in those memories too long. My whole life was derailed, and I had to put the completion of this work on hold para sanar again. I had to work for my subsistence at low paying jobs throughout healing, which was incredibly hard and infuriating because I wasn't ready to work but nobody cared. My travels through consciousness and trauma have inspired and urged me to hold on tight to spiritual activism. I subscribe to the idea that we have the collective power to heal our planet and ourselves. "Individually and collectively we can begin to share strategies on peaceful co-existence y despararmar (spread) conocimientos" (Keating 2009). I subscribe to the belief that if it isn't us, it will be our children or our children's children who will see the fruits of the shift we have been working toward. The Ten-Point Program of the Black Panther Party: freedom, full employment, the end of capitalist robbery, housing, education, healthcare for the poor, the end of police brutality etc., is always included in the aim of my spiritual activism (Davis 2016). "We must use our skills, knowledge and magic to come up with creative ways to collaboratively work together to protect our planet and the lives of environmental defenders...no matter how hopeless taking on capitalism can feel, we must never give up" (Salinas 2018). My work

here is incomplete; conducting an exhaustive analysis of the landscape of mental variance I began to paint in this thesis will take years, and like my healing, my work is continuous. I haven't even touched on the next episode... "Carry it on. / Pass it down to the children. / Pass it down. Carry it on ... / To Freedom!" (Shakur 1987, as cited by Davis 2016).

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