Dancing with Madness

Rewriting Identity Through Disruption

by

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ABSTRACT

Madness is disruptive. It doesn't play by the rules. Madness is influenced, created, and caused by many different factors; it can be at different times disorienting, debilitating, or a space of radical potential. In this thesis, I argue for the empowering potential of narrative and rewriting identity in the face of painful disruptions. I argue that the way that we conceptualize madness and how we internalize trauma affects how we reconfigure identity as an ongoing process and therefore whether and how we are able to embrace creative, diverse, and dynamically empowered futures. I argue against positivist traditions of categorization and concept formation when it comes to madness – whether medical or historic//cultural/social. I use similar tools to first "categorize the categorizers" and later break away from positivist tradition through feminist inquiry: pushing against static, linear, and inactive kind and family conceptual hierarchies with my own experience. I use active feminist frameworks and phenomenological ontologies to argue for a corrective epistemic justice. I expose reductive gaps in the literature and highlight the links between violence/oppression/trauma/agency and mental illness that positivist models minimalize. I employ personal experiences of gender-based violence and my own changing and intersectional understanding and experience of manic depression as a lens through which different pathways can emerge. I use memoir as method to disturb the binary limitations of madness models, instead offering a conceptualization of madness as fluid, intersectional, changing, and deeply personal: an experience that cannot be reduced and compartmentalized. I explore the pain of trauma and madness as well as the possibility therein towards action as a way of reclaiming self-agency that is overlooked in most political discussions of trauma and mental illness.

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Thank you, I love you all, and 'DON'T PANIC!'

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CHAPTER 1

MADNESS AS CONCEPT

"My aspirations toward wholeness maintain my sanity, a matter of life and death."
Gloria Anzaldúa

The inspiration for and purpose of this thesis is rooted in the liberating potential of writing identity: of accepting and releasing the past and reclaiming a hope for the future. It is rooted in a desire to think about difference, specifically illness and madness, "as a cultural and social phenomenon rather than a medical disease" (Cvetkovich 2012, 1; see also Frank 1995). This project is based in an understanding of narrative and writing – memoir, autoethnography, poetry – as a meaning making process, both personal and social, that allows one to define the story of self and connect it to a larger understanding of the world. Narrative is how humans ascribe meaning to circumstance; it is a powerful way to communicate experiences of struggle and suffering – a way to order and construct reality (Frank 1995; Hyden 1997; Yanos et al 2010). Writing narrative as knowledge is a phenomenological process of identity formation that has the power to re-connect and fuse a fractured, disrupted experience of reality. It is both liberating and empowering and yet also painfully revelatory, often forcing us to face our own perceptions of self (Cvetkovich 2012; Frank 1995; Voranka 2016). As an artist, an activist, and a scholar, this experimental project is my attempt "to develop a transformational ontology, epistemology, and aesthetics … [my way to] not simply write about suppressed knowledges and marginalized subjectivities … [but to write] from within them" (Anzaldúa 2015, xxix).

Medical and social models of illness and madness, disability, and disruption create binary understandings of marginalized peoples' experiences of 'being-in-world' (Farley 2017) that often ignore factors of gender and trauma and either re-victimize or oversimplify. This is especially true of mental health issues; the suppression of mad voice and a psychiatric control over 'truth' creates both occlusions in knowledge and oppressive hierarchies that disrupt and diminish identity and self-autonomy. Social models that focus on madness as a political resistance, social affect, or romantic touch of genius and creativity conversely ignore the individual pain of an 'othered' experience (Chesler 2005; Cvetkovich 2012; Simplican 2017). Epistemological control over madness, illness, and trauma (and the relationship between them) on the part of doctors, psychiatrists, and society ignores the 'hidden transcript' (Schatz 2009; Scott 1990) of lived experience and tries to generalize the personal into the public by treating the mad, the traumatized, and the ill as either subject, patient, or victim – but never autonomous agent.

Rigid binary frameworks for understanding illness are diminishing and reductive and ignore complicated interlocking factors of oppression, trauma, and the historic unsafety of help for stigmatized or marginalized populations (Chesler 2005; Cvetkovich 2012; Gilman 2014; Hill & Needham2013; WHO 2002). "In the past two decades, feminists and other science critics have challenged the basic premises of [these types of] positivist [medical and] social sciences. These critiques and the alternative epistemologies they underwrite have not been fully addressed, no less integrated" (Erwick 1994, 92). Feminist scholarship has sought to not only challenge the underpinnings of traditionally accredited knowledges but has also sought to expand and

transform normative understandings by discovering and incorporating those that have been excluded (Ewick 1994; Harding 1986; Hawkesworth, 2005). Even seeking to create new frameworks for conducting research, it is therefore surprising that "In traditional research as well as in participatory research, women [and marginalized voices] have been largely excluded from producing dominant forms of knowledge" (Reid 2004, 5). Mary Hawkesworth (2005) discusses this problem in her work, examining the many accomplishments of feminist scholarship and the advances, corrections, and explanations it has brought to the sciences. Hawkesworth points out, however, that "Despite such impressive accomplishments, feminist … [research] has not become a dominant paradigm within the discipline" (Hawkesworth 2005, 141) and for that matter, within academia itself. This fact is incredibly troubling; feminist theory, research, and scholarship has been explicating the inaccuracies of the 'androcentric filter' – and the dangers of the autocracy that inevitably arises – for several decades now (Reid 2004; Maguire 1987). "Feminist action researchers expose the inadequacy of androcentric research and its partial, inaccurate, and incomplete representation of human experience" (Reid 2004, 5) Current academic foundations in most disciplines, established through this 'androcentric filter,' limit the pursuit of what Sandra Harding refers to as "truly emancipatory knowledge seeking" (Harding 1986) which is arguably one of the goals of higher education (Erwick 1994; Hawkesworth 2005).

Unfortunately, "Anyone interested in social change, action research, [resistance] or emancipation [of knowledge], regardless of theoretical frame is marginalized to some degree within the academy" (Reid 2004, 9). Power and privilege in psychiatry, in politics, in knowledge producing institutions, in the government, and in the academy limits the

exchange and proliferation of feminist scholarship as well as creating obstacles to feminist discourse and knowledge production (Behl 2017; Hawkesworth 2005; Reid 2004). It is important to note the existence of the hierarchies in the knowledge order (Behl 2017; Foucault 1965; Weiler 2009, 2). The hard sciences, and therefore positivist and post positivist foundations, are placed at the top of the knowledge hierarchy. The very institutions and leaders in accredited knowledge production are themselves often structures of patriarchal power (Hawkesworth 2005; Weiler 2009). This is especially true with the rise of modern psychiatry and rigid medical models of human 'dysfunction' such as the Diagnostic and Statistical Manual of Mental Disorders: both of which ignore mad voice, are inherently gendered, and are oppressive in their deterministic power over the future and treatment of vulnerable, subordinate populations. Feminist scholarship, psychoanalysis, and personal narrative threatens this dispersion of power by turning "patients" into "people" with the power to reclaim identity. It exposes the misrepresentation of reality that the dominant transcript advances. However, this power to produce self-knowledge is often denied and repressed, both in the medical and psychiatric field and within academic institutions where inclusive knowledges could have powerful liberating potential (Cvetkovich 2012).

Hierarchical structures within academia itself play a role in controlling knowledge production and deciding "whose knowledge [and what knowledge] matters" (Weiler 2009, 2; see also Ackerly & True 2010; Behl 2017; Doty 2004; Ewick 1994; Hawkesworth 2005; Reid 2004). Academics often find themselves facing pressures to produce knowledge in only "scientifically" approved ways, being forced to comply for reasons of tenure, publication, and advancement in their field. As a result, "the dominant

methodology of an academic discipline usually supports the existing power structure" (Reid 2004, 9). Through these hierarchies "gender power and disadvantage are created and maintained" and a paradigmatic hegemony is legitimized, creating a control over knowledge production that "sustains prohibitions, exclusions, denigrations, and obstructions" (Hawkesworth 2005, 146) and limits/destroys the opportunities for marginalized knowledge to 'gain voice'. Knowledge production is in itself a political process; its relationship to power must be acknowledged and examined in order to better understand the "domination and subordination structures" involved (Weiler 2009). In the current system, androcentric dominance is legitimized, reality is misrepresented, and true democracy in knowledge production is impossible (Hawkesworth 2005). Political psychologist and social theorist Ashis Nandy warns that institutions "must begin to act as sources of skepticism toward the victorious systems of knowledge, and, as a means of recovering and transmitting knowledge that has been cornered, marginalized, or even defeated" (Nandy 2000, 118; see also Harding 1986; Voranka 2016).

For this reason, I choose to employ an "ethnographic sensibility" that is "attuned to hidden transcripts" (Schatz 2009; Scott 1990) and utilizes the private knowledge of my own experience to push against the traditional positivist models – both medical and social – of madness, illness, and knowledge production itself. In an effort to explore different ways of producing scholarship, I engage experimental feminist/queer methods that embrace affect theory and utilize memoir, poetry, and narrative as a knowledge producing act through which one creates herself and therefore constructs her world. Gloria Anzaldúa refers to this meaning making impulse as the desire to "reconstruct oneself" and heal. In this way, the reintroduction of the self into research becomes an "act

of calling back those pieces of the self/soul that have been dispersed or lost" (Anzaldúa 2015, 1; see also Doty 2004; Frank 1995; Yanos et al 2010). In speaking experientially – vulnerably – I begin to "read and speak myself into being … [I create a] site where I critique reality, identity, language, and dominant culture's representation and ideological control" (Anzaldúa 2015, 3; Cvetkovich 2012). Much like Ann Cvetkovich's (2012) work[1] to "depathologize" negative understandings of depression as *only* debilitating, disabling, and destructive, I explore mood, disorder, mania, and madness – and trauma healing – as possible sites for radical possibility and "as a possible resource for political action rather than as its antithesis" (Cvetkovich 2012, 2).

I explore madness because of and through my own familiarity with it. I have a mood disorder, sometimes called manic depression or bipolarity. I am a part of the community of those deemed mad or mentally ill because my neurological processing differs from that which is standard and accepted. I remain physically here, and tread boundaries by being 'high functioning,' yet I am often rendered invisible or forced to disappear this part of myself because of the epistemic injustice of the sanist knowledge funnel. I suffered through one semi-psychotic break after being sexually assaulted and have experienced occasional euphoric/semi-psychotic mania, off and on depression, and the sporadic rapid cycling mood swing since. And yet I have chosen to refuse medication, academic umbrellas, psychiatric treatment, and diminished agency in an effort towards self-help, empowerment, and a resistance towards hierarchal typologies. I have stayed silent about my "mad" status for many years. I work diligently to assure that bipolarity

[1] In so doing, I do not erase the often painful, reductive, and enervating consequences of mental illness. Rather, I seek to find a "light at the end of the tunnel" – a way in which understanding, embracing, and overcoming madness can serve as a way to become, in Anzaldúa's words, "the healing of the wound" (9).

does not affect my professional and public life. Instead, I have banished my struggle to the domain of the familial, the relational, and the private – as many women and marginalized communities are forced to do with many of life ‘s challenging contingencies. I am considered extremely high functioning, a description that is tempered both by my silence and my refusal to accept that I should or must be restricted in the world (although I may be) because of my difference or because of the trauma that I’ve suffered. As a result, I straddle a line between two worlds, and belong fully to neither of them (neither a mental health consumer, a psychiatric survivor, nor a mentally ‘sane’ individual), much as many groups marginalized by oppressive epistemic categorization are excluded, banished, or forced to exist in multi-bordered and restricted spaces.

Throughout this thesis, I reclaim and use the term mad to encompass the many differing definitions that neurological difference and affect – subjectively experienced emotions – encompass. People in the mad community have different perceptions on such labels and on the validity of diagnoses themselves. Some resist them and others embrace them. It is an individual experience that affects people’s lives in different ways. Words such as ‘crazy,’ ‘insane,’ ‘disturbed,’ ‘mentally ill,’ are therefore pejorative, reductive, and diminishing much as diagnoses and social misconceptions of madness are pejorative, reductive, and diminishing. As a self-identifying mad person who experiences manic depression, I employ these terms at different times to both communicate and push against their stigmatizing nature. I use the term mad to encompass diagnosed, perceived, or self-determined affective syndromes and neurological differences. Herein I risk the very generalization I push against in an effort to not make diagnoses but allow a fluidity of identification. This is a risk I take willingly while acknowledging my own limitations and

the limitations of language and definition itself. I use ‘manic depression’, ‘bipolar syndrome,’ ‘mental disorder,’ ‘neurodivergence,’ ‘mental health,’ and ‘mental illness’ at different times and in different places for different reasons, often interchangeably. I do this because, despite how I identify, these words are used about me, against me, or for me. Rather than ignore them, I lean into them, try to find myself there, discover that they cannot hold me. In any attempt to break categorization hierarchies, one must roll against the categories themselves, tumble into them, break them down from within, use the very tools of construction to demolish their foundations, or at least expose their flaws.

For this reason, I also use painful terminology that I disagree with because of its negative gender bias and commentary on female sexuality in order to communicate social and self stigmas that can become internalized, especially when dealing with the aftermath of sexual assault. These include words like ‘whore,’ ‘slut,’ ‘trash,’ ‘bitch,’ ‘dramatic,’ ‘histrionic,’ ‘hysterical,’ as well as a few negative terms used for female body parts. These words are destructive and uncomfortable and are used in order to communicate the internalized damage they do to one’s sense of self. They are words that denigrate and reduce, much as trauma denigrates and reduces, and as we as women and people who suffer oppression or marginalization (especially for LGBTQ, women of color, and the mad within these communities) are conditioned to denigrate and reduce ourselves and each other.

I use the lens of trauma to highlight the limitations of positivist models and traditions of binary typologies. This is not to say that all those who experience mental disruption, disturbance, or difference have been traumatized, or that all those who suffer trauma become inevitably mad. Instead, I use the gendered experience of social and

psychiatric trauma along with my own personal connection to both of these to upset positivist rigidity, statistical reduction, and the psychiatric panopticon; I tear it apart with the afterpain of rape, with screams of mad fear, and also with the elation and empowerment I've discovered in mad moments, and other women have found through 'hysteria,' and 'madness,' as a resistance. Additionally, I have chosen to refrain from including statistical data regarding mental health, disability, and sexual assault. I choose to do this in order to write differently and experientially about these topics (Behl 2017) and showcase the ways in which storied voices have powerful potential to upend social and personal stigmas and expose epistemic injustices (Simplican 2017; Frank 1995). Facts, myths, and statistics regarding sexual trauma and violence against women, trauma and mental health, and mental illness as disability are important and have been included in appendices as this data gives important global scope to the project.

Madness as a concept is modeled in various ways: historical, medical, social – all of which fail to convey the knowledge of the madness experience itself or the experience of being adjudicated "mentally ill". By embarking on this project, by addressing the different models of madness and offering up not only my autoethnographic voice, but also displays and reactionary writings regarding sexual assault and manic depression as an experience, I represent myself and break my own silence, confront and reject self-stigma and shame about what happened to me and who and what I am and empower myself as a voice for justice and social change. I rewrite my identity as one intrinsically linked to and yet liberated from both trauma and madness as I push against the labels that society has given me *as a woman* (emotional, dramatic, illogical, less than), *as a sexual assault victim* (weak, object, target, whore), *as a mad person* (hysterical, crazy, insane,

other), and especially *as a mad female sexual assault victim* (dysfunctional, broken, invalid, unhinged). I find the power of labels and hierarchal categories particularly relevant to discussions of interlocking oppressions, action, and social change because many of the social labels attached to mad people and trauma victims are also often indiscriminately ascribed to women – and I happen to be both. More importantly, the labels we ascribe to ourselves, especially in regards to psychopathy, gender, and trauma, have more than mere descriptive power; they can affect symptoms, recovery, and self-identification; they can influence us towards avoidance or action; they can diminish and limit us or invite resistance and empowerment.

This project has been 10 years in the writing, in the meaning-making experience. I was first 'diagnosed' with manic depression when I was 21, shortly after being raped for the second time. Throughout this thesis, I document a decade of reforming identity through autoethnographic reflection and the inclusion of writings – poetry, memoir, and narratives – that were written and rewritten as I processed through trauma and vacillated through occasional epochs of mania and depression. Even when euthymic, my writings have been characterized by the struggle to piece together a fractured reality, to understand sex as weapon, to embrace or resist my own mind, to explore the instability of doubting your own sanity and having to carve out a space for yourself in a world that does not look kindly on difference and personal struggle – one that chooses to see dysfunction rather than possibility.

My writing toggles back and forth between a presentation of traditional models and a resistance vis-a-vis my own thoughts or writings, providing an experiential voice to the academic debate. I do this because *my experience* toggles back and forth between my

academic pursuits and the resistance, inspirations, creative notions, and debilitations of my neurodivergence. Furthermore, my experience of reality is similarly fluid, unbound, and yet limited by social dictations of what is and what is not, whose knowledge matters and does not, and what is 'real' and 'unreal,' reasoned and unreasoned. Manic depression is, for me, both liberating and limiting, the experience resists categorization and neat compartmentalization. It is my hope that this will be both uncomfortable and revealing: that it will be both nonsensical at times and at others provide clarity or insight. I wish to break down the compartmentalization that would relegate illness to a "tale of two cities, one naked one dead," (Townsley 2016) one social one medical, an either/or binary, a generalized and removed description of what is in fact a deeply personal, individual, and intersectional experience.

Throughout the project, I weave in discussions of gender and violence. Social stigmas of mental illness are inherently gendered, as is the psychiatric field, and, I would argue, diagnostic medicine itself. Psychiatry as a hegemonic controller of knowledge and 'truth' when it comes to mental 'illness' (Chesler 2005; Cvetkovich 2012; Foucault 1965; Procknow 2017) has been historically unsafe for women and marginalized groups (especially women of color and members of LGBTQ communities) at the very least and more often violently oppressive. The craze of the witch hunt (a search to destroy that which threatens, or is misunderstood: the inquisition, the leper colony, the resettling of the homeless) has also transformed itself into a search for the mad, hysterical woman who represents a threat to male dominance and gender role norms (Chesler 2005; Cvetkovich 2012; Foucault 1965; Healy 2008) and must be medicated, made dependent, or locked away.

My personal experience of madness was originally triggered through sexual assault and has since been treated and reacted to through a gendered lens. Sexual assault, sexual control, sexuality, and sexual empowerment are recurring themes that show up in my poetry and memoir clips because they have been reoccurring themes of my life. Sex (rape), control, and oppression were the catalysts through which my sanity and a version of my future was taken from me. Through this violence, my identity was dismantled and my sense of self significantly reduced and fractured. The experience of manic depression further deconstructed my identity and forced me into a place of perpetual and life-long re-grafting that is neither linear nor binary and easily categorized. I write about these themes in 'unacademic,' experience near, and unsafe ways that may be uncomfortable. Too often discussions of sexual assault, trauma, and gender violence are spoken of or about, not from within. They are aggregated and presented from removed, statistical, or psych perspectives. I intend to threaten this removed safety by narratively demonstrating the untethered danger, confusion, and pain of "losing your mind" in the aftermath of rape. I talk honestly of the kind of experiences women – as well as children and many members of the LGBTQ community – have of being forced to choke on dicks or wake to the invasion of unwanted touching, being masturbated on top of, drugged, raped, and treated in daily life as powerless objects under constant threat of sexual violence. Narrative allows me to explore the power struggles and psychic pain of my existence. My defiance against imposed definitions of my "insanity" is intricately caught up in my struggle against patriarchal declamations of woman as both a normative and empirical category of submission and diminishment. For me, the two cannot be separated because they have not been experienced separately. The expression of my depression is linked to sexual

violence, gender oppression, dominating hierarchal possession, and the imposition of slave psychology on the less powerful. I first had a psychotic break because I was forced into a subservient and powerless sexual role as a woman [by society and] by a man. Perhaps my expressions of mania are an oppositional political resistance of sorts.

Yet in "going insane" I somehow exemplify the inevitable end to which female resistance is supposed to lead – the mad house, where the hysteric witch or the deranged woman is locked away within her prison/parlor wall/paper, banished from society. You are to be silent and acquiescent, one who "takes it lying down" (as I was forced to do), or you cross into the other scathingly rejected category: crazy, invalid, in-valid, off-her-rocker, unhinged. I am not attempting to claim that all mental illness is caused by sexual assault[2], or that mental illness does not exist and is merely a categorical assignment that society gives to difficult women and othered peoples. Mental health concerns are real, often genetic, chemical, neurological, psychological, socio-political and are not gender specific (DSM-5 2013; Goodwin & Jamison 2007; WHO 2018). However, oppression and social constructions of gendered norms and gender roles play a significant part in the way mental illness is conceptualized, constructed, and treated. As a woman, the stigma, both self and public, of 'being mad' is complex and fraught with various interacting oppressions (Ahmedani 2011; Chesler 2005; WHO 2018). As a person from a double or triple marginalized group, these interacting oppressions become even more complex[3] (Houston et al 2011; Young 1990). With this project, I hope to not only disturb and upset

[2] There is a large body of research that investigates the relationship between sexual assault/gender-based violence and mental illness/psychosis, see appendix (Cheng et al 2018, Hill & Needham 2013, WHO 2018)

[3] Iris Marion Young discusses intersecting forms of oppression that interact across race, class, gender, and areas of social and political oppression in chapter two of *Justice and the Politics of Difference* (1990).

the traditional models and objective discussions of madness, but also to disrupt the very way we choose to conceptualize and know our own identities and place in the world – our own relationship to sanity or madness or typology. I intend to "write against the edict that women should fear their own darkness, that we not broach it in our writings" because "my job as an artist is to bear witness to what haunts us" (Anzaldúa 2015, 8). In so doing, I admit the limitations of my positionality and the biases of my experiences. I write as a Caucasian woman with privilege, despite my stigmatized condition and traumatic experiences of violence. I write as a repeat rape victim. My mental health challenges are deeply connected to my experiences of violation and to the larger experiences of violation that women suffer and have been suffering every day. This is not a claim that all mental illness is connected to trauma but that the two are often linked and madness is a deeply individualized experience (Beresford 2005; Cheng et al 2018; Hill & Needham 2013; Rees et al 2011; WHO 2002; Yanos et al. 2010). I also write as a mad voice existing in both words – both functioning successfully in dominant society yet resisting sanist frameworks and dictations of knowledge. This is an additional tension and dichotomy I must both acknowledge and explore in choosing to write this way.

The literature and prominent scholarship of mad histories are Western histories, and they are male histories. As a result, I admit to both my own limitations and that of the predominant scholarship, and hope that continued feminist/queer exposures of knowledge occlusions will eventually result in creating a space for diverse and alternative histories of madness – ones that are not purely reliant on the Greek to UK to US template – in the academic field. I encourage the reader to see this as a flaw in the dominant literature and a further example of the hierarchal nature of knowledge production (Mohanty 2003;

Ewick 1994; Maguire 1987; Weiler 2009). I also encourage the reader to acknowledge the influence of Western privilege in my own experiences, studies, and understandings of madness and recognize this as a constraint. The conceptualizations of the sane and insane are vastly different across cultures, places, and time and are, in large part, determined by those who control the knowledge of their assignment. I encourage the reader to take madness seriously, but also be willing to shatter pre-fabricated lenses and ways of constructing mental health, mental illness, and behavior as concepts so that they can begin to be understood instead as lived experiences that vary across time, space, and culture and yet are often in forced commune with oppression, violence, and trauma.

I hope not only to face myself and my darkness and glory but to demonstrate through my own narrative identity reconstruction how our conceptualization of self can create or destroy possibility. I explore the ways in which, even in destruction, we can recreate and redefine new spaces for self-actualization. From a standpoint of my own madness, I question the "illness" of mental illness and argue that the way we internalize and externalize illness and trauma marks our identity and sense of self and therefore our capacity to function and create a new and empowered future. I argue for a conception of madness as diversity rather than a medical problem, historic archetype, or social result (in which person is first subject then patient and then victim); I believe that changing perceptions of self and rewriting identity can empower individuals who experience madness towards possibility rather than hopelessness. In the words of Gloria Anzaldúa, "this text is about acts of imaginative flight in reality … [about] identity construction and reconstruction" (Anzaldúa 2015, 7). Narrative works like these are not merely representations or commentary, they are in and of themselves a creation and expression

of the self. Going beyond the claims that are made, the models that are rebelled against, or the experiences that are given, "the form of the narrative, its presentation and organisation, also conveys something of the self-image that the narrator hopes to convey to others" (Hyden 1987, 50).

The progression of this thesis mimics the progression of my identity passage as I myself transitioned through different identities of victim, ill person, disabled, and finally into an acceptance of my divergence from the norm as someone who celebrates differences and the radical possibility within struggle. I did not do this intentionally. My subconscious is attracted to the existential, circular, and alchemic and this is often reflected in my writing construction before I become aware of it. In chapters 3 and 4, I include excerpts from journals and personal writings that were over the span of a decade, in different times and places, and under different circumstances. The writing is an embodied ordering of my personal ontological spirituality and epistemological philosophy, a way to "thrash about in … inner and external struggling grounds" while finding and losing and re-finding my bearings (Anzaldúa 2015, 19). It is not linear; it cannot be easily categorized, and it does not follow an 'upwards' trajectory, although the temptation to read this project as such certainly exists because *that is more comfortable*. It is a human desire to move from past to present to future, from disorder into order, from illness into full recovery. However, this is not my experience, nor is it the case for many people suffering from or experiencing oppression, trauma, marginalization, and, especially, madness. I urge the reader to resist a linear ingestion and recognize that this project, much as my manic depression itself, is a fluid continuum of making and

unmaking, feeling in and out of being, destruction and reconstruction … and all the liminal, indefinite spaces in between.

In order to push against linearity, I have chosen to write in first person, second person, third person, and in both past and present tense and to write differently and personally, because my thesis, a testament to my own 'mad' knowledge and truth, continues to evolve. This is a risk I take because the voice expected, demanded of me is not my voice, and because this writing, this project, is not at an end but *continues* and will keep continuing. In order for it to do so,

> I must figure out which person (I, she, you, we, them, they), which tense (present, past, future), which language and register, and which voice or style to speak from. Identity formation (which involves "reading and "writing" oneself and the world) is an alchemical process that synthesizes the dualities, contradictions, and perspectives from these different selves [different places and identities] and [different] worlds (Anzaldúa 2015, 3).

I argue for the empowering potential of narrative and rewriting identity - I argue that the way that we conceptualize madness and how we internalize trauma affects how we reconfigure identity after diagnosis or disruption and therefore how we cope, process, and are able to create newly empowered futures. In the first section, I present my methodology and then introduce the traditional "conceptualizations" of madness – medical, historic/social – with the intention of showing the way in which each is reductive by pushing against them with my own experience. I expose the gaps in the literature and introduce the link between violence and oppression and mental illness that the medical model misses. I also push against the social model as one that is either overly romanticized or overly debilitating – relegating madness to a Foucauldian conception of artistic difference and political control or as a symptom of social sickness and rebellion

that while much more empowering, is still positivist and reductive in nature and therefore influences autonomy and help seeking behavior. In chapter three, I use narrative to display my history of sexual assault and connect it to self-hatred, pain, and breakdown. The included clips from journals and writings show my familiarity with social oppression and trauma as an influence on and trigger for manic depression.

My writing is not always about madness, but also about violence, self-stigma, depression, confusion, brokenness, and transformation. I do not necessarily put these in order nor do I always explain them. Identity exploration and reconstruction is not an ordered practice. If at times these presentations seem disjointed it is because rape, sexual assault, manic depression, and even healing (from trauma, wounding, and stigma) are often disjointed experiences. These writings reveal the ways in which a violently fractured identity is disabling, painful, and chaotic; in which you lose your footing, your bearings, your control over your own reality and struggle to re-anchor and reclaim yourself and your hope for the future. Within this project I discuss illness as identity, the power of illness identity, and narrative and identity reconstruction as forces for change in order to push against categories created for me and others like me that are positivist and binding, strip me of power and voice as they seek to control my narrative and diagnose my future. This I resist, even in moments of recognizing the (subjective) contribution and necessity of medicine, therapy, and aspects of the social disability models.

I present my own insurrection against models in which the mad are either subject, patient, or symptom of society as a personal transition to a self-constructed model in which madness is re-conceived as a form of diversity and where the experience of madness (and the understanding of that experience) can be harnessed as a resistance to

create possibility out of pain. Through self-exploration and self-expansion, I myself have gone through many different “rewritings” of identity; over the past five years I have begun to "break" the externally imposed models of who and what I am, including those that violation forcibly imposes, and begun to see the potential of conceptualizing "madness as resistance." As I review this process of self-re-identification through memoir and re-evaluation, I notice through recent writings that my conceptualizations of self, and even my expressions of mania and depression, have changed drastically from ten years ago and have begun to reflect a creative outlook of empowered vision and self-grace in recent years - which is exciting.

Methodology

During that last semester of my undergraduate degree, as I struggled through a “lack of cohesiveness and stability in the life, [through] the increasing tension and conflicts … [through] the sheer mental, emotional, and spiritual anguish” (Anzaldúa 2015, 2) of the trauma I had suffered and my resulting diagnosis of bipolar disorder, I began to question my own academic arrogance and the subsequent type of research I involved myself in. I wrote what, without realizing it at the time, was a reflexive, autoethnographic, critical theory paper deconstructing my own writing and the academic voice I had adopted. I was beginning to acknowledge the presence of androcentricism in writing, in theory, and in research and academia itself. These realizations emerged through immense struggle after a semester studying diachronic linguistics, critical theory, and – that which I found most liberating – feminist writing. During this time, I was also trying to make sense of that first experience of breakdown and depression and what it meant about who I was. The combination of these studies and the ‘crawling-back-from’

the very personal disruption I had suffered, led to, what for me can only be described as a skylight opening as

> the sun broke through the oppressive haze in my head, taking the form of an angry Gloria Anzaldúa, who curses the phallic clouds in six dialects of Spanish, terrifying the patriarchal dark and blessing feministic revelation. (Townsley 2009)

What I was recognizing, but not fully understanding at the time, was the police action of privileged platform – the "libidinal and cultural – hence political, typically masculine – economy … of which it is at once the effect, [and] the support, and one of privileged alibis … one of phallocentric tradition" (Cixous 1976). I wrote of my experience:

> I feel wholly disconnected from the majority of papers I write and subjects I study. The academic voice and research frameworks I have developed over the years is detached, observatory from on high, and removed. The theories are not interactive and are supported and defended by learned rhetorical strategies. The tone is often aloof, matter-of-fact, deductive, and superior. *This voice is not my voice* … it is what is expected … It is what I have been trained to do. … Under the tutelage of academic expectation, I have learned to pander to the god of form and theory, while remaining apathetic to my subject … [p]laying reverse Jenga with language and syntax, [observation and research], until I have constructed the illusion of comprehensive content … [that I might accomplish] that phantom intellectual quality that will relegate me as knowledgeable. I have become the oppressor and oppressed. (Townsley 2009)

On that day, in that feminist driven class, I recognized my failure, and began to acknowledge a larger problem in the academic voice and positivist underpinnings in research - that false worship of an objectivist ideal. This is a violence inherent in both the academic voice and in theory itself when it is relegated and corralled within phallocentric and objective arenas - when the self of the researcher and the self of the researched is strangled and silenced, done away with. How has this continued? Why does "the academic voice [seek to] silences itself" and "master what it encounters" (Dauphinee 2010, 799/806; see also Doty 2004; Ewick 1994; Harding 1986). Why have we "in our

sanitized, self-evacuated, academic landscape … become the 'hideous beings swallowed up by our scholarly clothes … drain[ing] our voices of any traces of humanity'" (Dauphinee 2010, 808) More importantly, what steps can be taken to rectify and attenuate this violence, to reify the humanity, the self, within research and protect both the scholar and the studied from writing and research that is "its own sort of destruction" (Dauphinee 2010, 801)? In re-entering academia, changed and still wounded, what could I learn, study, and do that would lend itself to my experience? More importantly, how could my own research contribute to making sense of a world that had so recently violently betrayed me? How could I continue to discuss social justice issues, debate theory, talk politics, analyze literature while denying the influence of experiences that had permeated every aspect of my identity?

This is what autoethnograpy – which is still treated with skepticism as valid scientific method of knowledge production (Shehata 2006) – and other feminist methods seek to accomplish (Dauphinee 2010). I would argue that such methods are imperative to the study of political science and to any academic research involving the human sciences. They are necessary because the political is, after all, personal. And knowledge production in itself is a political, and therefore personal process. Theory and research cannot be relegated to a parallel universe devoid of interactive, interpretive, personal processes because our world is one structured and created by human actors (Lowenheim 2010) and academia loses when it dehumanizes and separates itself from the self and the world it seeks to study (Pachirat 2008; Schatz 2008). "Autoethnography allows one to consider how … her/his actions in the world reproduce or change this world" (Lowenheim 2010, 1023) and thereby allows us to understand the ways in which "the academic voice

[inevitably] perpetrates a considered violence against those whose realities it claims to write" (Dauphinee 2010, 806). Understanding this, exploring this, asking ourselves these questions is the only way we can begin to "implement meaningful change in the ways that knowledge is generated" (Dauphinee 2010, 806) and thereby reduce the violence within scholarship.

The integration of the self into academic research positions the researcher not only as an "interpreter of social reality, but as someone who can understand her/himself through thinking about social institutions, practices, and phenomena" (Lowenheim 2010, 1025). It is necessary to understand the story of the researcher and for her to understand herself in relation to the community, the subject she studies, and as a positioned subject herself (Doty 2004; Reid 2006). "Self-understanding carries a great weight of political meaning" (Lowenheim 2010, 1026). Methodologically, enacted autoethnography and reflexivity fosters empathy and compassion – both on the part of the researcher and as a preventative force against oppressive subject/object relationships between the researcher and researched (Lowenheim 2010; Mohanty 2003; Nagar & Geiger 2007). It is important to recognize that the individual, including ourselves, is/are the one/s "upon whom political, economic, and social power structures operate" (Lowenheim 2010, 1027). Autoethnography prevents "theory and research [from being] relegated to a parallel universe devoid of interactive, personal, [meaning driven] processes" (Lowenheim 2010, 1023) and ensures that we do not dehumanize and separate ourselves from the world we seek to study (Nagar and Geiger 2007; Hawkesworth 2005; Erwick 1994; Doty 2004; Pachirat 2008). It provides consideration as to how our actions influence the world and how the world influences us and our actions.

Academia both encourages "radical" writing and also discourages it. Academia's knowledge production control can be stifling, the politics of knowledge production oppressive. Feminist and queer inquiry seeks to upend these oppressions. I employed an interpretivist research design throughout this project (Scwartz-Shea & Yanow 2012) through a feminist methodological lens. My thesis is 'experience near'(Shatz 2009; Pachirat 2009) and expands on the feminist academic notion that the personal is political (Behl 2017; Nagar & Geiger 2007; Reid 2004) to show how the personal, and thereby the political, is also unpredictable. This project is iterative in nature and concerns itself with social justice, social critique, and transformation. It involves research and produces scholarship that evaluates and studies power dynamics and aims to reveal and correct androcentric notions of human experience – especially those of sexual assault and mental illness/wellness (Dahmoon 2013; Hawkesworth 2005; Nagar and Geiger 2007; Reid 2004). Feminist inquiry exposes – inevitably invalidating – ideas that "remain oblivious to the social conventions that structure human relationships and the relations among states" (Hawkesworth 2005, 148), such as those promoted by the medical and even, with the exception of Phyllis Chesler and Ann Cvetkovich, those of the Anglophone, androcentric social model.

A feminist, activist, and autoethnographic exploration poses questions regarding the possession of power, the operationalization of power, and processes of social change; asking not only how agents of power operate in the world, but also why they are able to do so, why violence and the unsafety of help for women has continued – why mental illness is still stigmatized and what relationship gender-based violence maintains with issues of mental illness. Feminist methodologies, interpretive research design, and

methods such as autoethnography encourage this hermeneutic approach within my research, expanding understandings of power dynamics, positionality, social relationships, and knowledge production as a political process (Ackerly and True 2010; Behl 2017; Dahmoon 2013; Hawkesworth 2005; Nagar and Geiger 2007; Schwartz-Shea and Yanow 2012). Furthermore, feminist inquiry and scholarship "focuses on specific, situated meanings and meaning making practices of actors in a given context (Schwartz-Shea and Yanow 2012, 1). After all, "the research role is a human role" and is important because "researchers offer 'situated knowledge' and must consider the complexity of lived experience [for] … all human conduct is understood in terms of the … power relations that are part of all social settings" (Scwartz-Shea and Yanow 2012, 117;111). A researcher's identity, positionality, and experiential framework deserves "attention and analysis[;] … whether it poses a problem or presents an opportunity should be assessed according to situational, contextual, and theoretical factors" (Schwartz-Shea and Yanow 2012, 111). As a researcher in a predominantly positivist field, memoir, poetry, and self-analysis as method is a risk. I use these methods along with archival analysis and positivist presentations to explore that which is missing within the madness models and integrate an experiential, gendered and trauma-based theory of intersectionality, fluidity, and typological and categorizational limitations. I provide a review of positivism's classificatory foundations in relation to mental illness and provide an analytical critique of positivism through its own tools in concept formation. I expose pathways, both of pain and deconstitution and of possibility and empowerment, both avoidant and active in waves, that positivist tools are blind to. I use interpretive, feminist action frameworks and tools to expose positivist obfuscations and occlusions and provide alternative identity

‘maps’ to those that positivist binaries inflict. I do not impose my own personal ‘map’ onto others but begin to do/continue a work of resistance that creates spaces both for pain and for liberation – which I have found, often work in tandem.

CHAPTER 2

MADNESS AS MODEL

> "Manic-depressive illness magnifies common human experiences to larger than life proportions. Among its symptoms are exaggerations of normal sadness and joy … altered thinking … and deeply disrupted patterns of energy and sleep" (Goodwin & Jamison 2007, xix)

In the following chapter, I review positivism's classificatory foundations in relation to mental illness and analytically critique the relevant historical/medical/social models as hegemonic, reductive, and fundamentally limited, arguing that current and future proliferation of new subtypes both medical and social are still incapable of escaping the problematics of binary epistemic injustice. Positivist traditions in classification and typological studies are static, time bound, exclusionary, and reductive. They ignore voice, experience, and the deeply intersectional and dynamic nature of psychic pain, psychic oppression, psychic trauma, psychic difference, and mad empowerment. In the first section of this chapter, I categorize the categorizers and use their own tools against them to reveal the problematic inherent within rigid positivist traditions. I review different "model" literatures: from Foucault's enigmatic *Madness and Civilization* (along with Andrew Scull's more modern *Madness in Civilization* and Michael Staub's *Madness is Civilization*) to the *Diagnostic and Statistical Manual of Mental Disorders* 5 (DSM 5) and Goodwin& Jamison's edition of *Manic Depressive* Illness and David Healy's intense critique of the pharmaceutical industry in *Mania: A Brief History of Bipolar Disorder*. I present a brief history of mania and melancholia, explain the general symptoms of manic depressive illnesses, introduce the social model and discuss the possibility of social and cultural factors as triggers or causal mechanisms

of the disease, highlighting relationships to trauma. I then disrupt the models by putting them in conversation with Phyllis Chesler's gender-aware, deeply corrective expose of psychiatric treatment in *Women and Madness*. I offer an intersectional critique of the models as overly simplified, either oppressive or romanticized, and gender and race biased. While the social model admits mental illness as an aspect of social sickness that may be influenced by external factors, oppressions, or family dysfunctions, it ignores racism, sexism, the prevalence of sexual assault histories, and the historic violence of the psychiatric community against marginalized groups that homogenizes mad experience (Chesler 2005; Cvetkovich 2012).

A Brief History of Categorizing Madness

Manic depressive illnesses have historically been documented for centuries, usually under the umbrella of mania and melancholia, common diagnostic labels that ancients used to describe a variety of mental disorders with affective symptoms (Goodwin & Jamison 2007).

> The terms used for the bipolar extremes, 'melancholy' (depression) and 'mania' both have their origins in Ancient Greek. 'Melancholy' derives from melas 'black' and chole 'bile', because Hippocrates thought that depression resulted from an excess of black bile. 'Mania' is related to menos 'spirit, force, passion'; mainesthai 'to rage, go mad'; and mantis 'seer', and ultimately derives from the Indo-European root men- 'mind' to which, interestingly, 'man' is also sometimes connected (Burton 2012).

According to Goodwin and Jamison, "Medical conceptions of mania and depression are as old as medicine itself[4] … Few maladies have been represented with such unvarying language" (2007, 3). Greek medical writers and those of the Hippocratic tradition

[4] David Healy critiques this claim, believing that ancient histories of mania and melancholy are references to delirious fever and biological somatic infections/diseases.

believed that "melancholia was a psychological manifestation of an underlying biological disturbance, specifically, a perturbation in brain function" (Goodwin & Jamison 2007, 3). Previous to medical documentation in ancient Greek and Roman times, affective symptoms were culturally considered spiritual phenomena – mad persons were either cursed by the gods or touched by and in communication with the spirit world, depending on the cultural and religious context. Once the western medical notion of the four humors spread, affective disorder began to be understood as humoural disturbance, albeit with possible spiritual and creative ties. Aristotle noted the link between creativity and melancholic temperament in his writings and during the first Century B.C.

By the second century A.D., the relationship between mania and melancholy was being investigated. Aretaeus of Cappadocia, known as "the clinician of mania" (Goodwin & Jamison 2007, 4; see also Burton 2010; Scull 2015) had begun to typologize different categorizations of manic melancholia after observing patients who would "laugh, play, dance night and day, and sometimes go openly to the market crowned, as if victors in some contest of skill' only to be 'torpid, dull, and sorrowful' at other times" (Burton 2012). Aretaeus was convinced that both states of frenzy and stupor were the result of the same illness – that mania was, in fact, an extreme form of or defensive reaction to severe depression – however it took several centuries for the idea to solidly take hold in the medical community. Eventually, nineteenth century French alienists, documenting a "circular insanity," began to hypothesize about the cyclicity and potential genetic origin of manic disorders and their resulting melancholic episodes; the modern concept of manic depressive illness evolved.

> The subsequent literature of the seventeenth and eighteenth centuries is replete with clinical observations of manic and depressive symptomatology … [that] paved the way for recognition of the mental disease that ultimately came to be known as manic-depressive insanity (Goodwin & Jamison 2007, 5).

The term manic-depressive psychosis was first coined by German psychiatrist Emil Kraepelin in the early 1900's as a way to separate schizophrenia from circular psychosis and recurrent depression. Manic depressive psychosis was believed to have a more positive prognosis than schizophrenia and was an episodic illness, illustrated by long periods of euthymic, stable mood. Additionally, manic episodes were not necessarily psychotic, and often more easily managed that schizophrenic psychosis. Kraepelin did not, however, recognize a difference between manic episodes and psychotic depression (Goodwin & Jamison 2007; Evans et al 2006).

Understandings of manic depressive illness have radically evolved since the early 1900's, as have the fields that are relevant to "understanding manic-depressive illness – genetics, neurobiology, psychology and neuropsychology, neuroanatomy, diagnosis, and treatment" (Goodwin & Jamison 2007, xix; see also Healy 2008; Scull 2015). During the twentieth century, the development of psychoanalysis in the U.S., and the anti-psychiatry movement of the 60's and 70's, marked a deviation from the purely biological model of psychiatric illness developing in Europe during the same time period (Staub 2011). The term 'bipolar' was used by Karl Leonhard in 1957 to differentiate depression with a manic component, on one end of the scale, and less externally aggressive forms of depression. Some medical professionals of the European tradition posit that both unipolarity (recurrent depression without manic symptoms) and bipolarity (alternating phases of depression and mania) fall within the spectrum of manic depressive illness. The

condition is often genetic, and both schizoaffective disorders and manic-depressive illnesses likely have a similar genetic origin.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (2013), bipolar disorder as a family subtype is organized as a 'bridge' between and in the middle of schizophrenic/psychotic disorders and depressive ones. Anxiety disorders also lie between the two and are often suffered comorbidly with other conditions, especially depression. However, "for a diagnosis of bipolar I disorder it is necessary to meet the … criteria for a [at least one] manic episode. The [categorical threshold] manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes" (DSM-5 2013, 123; see also Evans et al 2006). Other subtypes such as bipolar II and cyclothymia may present with less severe, hypomanic states and only require one major depressive episode for diagnosis.

Personality type and affective temperament may play a strong role in determining a person's experience of bipolar disorder and their functionality or ability to cope (Beresford 2005; Youngstrom and Van Meter 2014). There is some speculation within the medical and psychiatric community as to the relationship between unipolar depression and bipolar depression. Some clinicians speculate that unipolar depression is actually a form of bipolar II disorder, with hypomanic states that, because they do not negatively impact the person's life, go undiagnosed or unnoticed. Because personality and temperament also play a role, it is possible that mania and hypomania are more obvious in people with more extroverted, social, aggressive, excitable, hypothymic or cyclothymic temperaments (Jamison & Goodwin 2007; Evans et al 2006). It is not a curable illness but may go into long stretches of remissive states. Manic depressive

illnesses can sometimes be difficult to treat because of the vacillations in mood. Drug therapies often include cocktails of anti-psychotics, anti-depressants, and mood stabilizers that must be constantly regulated and redistributed (DSM 5 2013; Goodwin & Jamison 2007; Evans et al 2006). Despite a long standing medical history of mania and melancholy, there are a lot of problems with the diagnostic process of determining manic depressive subtypes – symptoms of mood disorders can be similar to reactions to trauma or side effects of certain medications, drugs, or alcohol abuse (DSM-5 2013).

Post WWII, and especially during the 60's and 70's, insanity – as defined by the medical community – experienced push back; madness began to be seen as a sane reaction to the social and political oppression of previous decades: an oppression that included considerations of western colonization, slavery, sexism, war, and a collective human history of violence, suppression, conquering, and power, power, everywhere (Chesler 2005; Cvetkovich 2012; Szasz 1960; Scull 2015; Staub 2011). This new antipsychiatry movement posited that mental illness had no foundation in biological, diagnostic medicine. Instead, psychiatrists were the key players on a witch hunt like stage of asylum oppression and overeager half-doctors. The movement was enraged by the vast abuses that those deemed mentally ill had suffered at the hands of doctors and psychologists for decades … but also because "psychiatrists [and psychoanalysts] are not [were not] physicians in the way that neurologists and cardiologists are" (Chesler 2005, 27; see also Staub 2011). The antipsychiatry movement followed and resulted in a marked trend in deinstitutionalization after WWII. Deeply influenced by the work of

psychiatrist and academic Thomas Szasz[5] and his writings on the myth of mental illness and the metaphorical nature of psychiatric disorders, the movement held that psychiatry, with its violent past, had motivations of social control and medicated brainwashing, that it was often practiced on non-consenting persons, and that madness was a subconscious act of resistance against social oppression (Szasz 1960; Staub 2011). Antipsychiatry began the work of splintering the medical epistemological power hegemony and deinstitutionalizing madness. The keyword here is *began*. The movement was relatively short lived, quickly devalued and discriminated against, and essentially assimilated into the social model, one that recognizes oppression and the flaws of medical models and social constructions, yet still relies on positivist categorization. With the rise of big pharma, medical technologization and advances, and an increasing trend of medicalization, the powerful moment of the antipsychiatry movement quickly lost sustainable potential as its salience diminished.

The history of psychiatric disorder – the history of madness – is controversial to say the least. At stake is – or should be – the very nature of disease, disorder, and illness itself. From philosophical debates about altered states of being and function, to the technological medical advances of the 21st century and resulting social movements such as those of the 60's and 70's, the subject of treating, diagnosing, and medicating that which is deemed illness is charged and far ranging in its camps of thought.

[5] Szasz sought to expose abuses in the history of psychiatric study, specifically in regards to the involuntary confinement and control of people deemed "disturbed" because their behavior was socially unacceptable. Szasz pointed out that the majority of mentally different patients were nonviolent and their behavior was only really a problem to other people – parents, teachers, employers, doctors, authority figures. He believed that madness as a label was more of a moral and economic judgement made by others, rather than a clinical one.

> Studying psychiatric disorders in this way has been rather more difficult, given that we still live in an era of syndromes rather than well-defined nosology, and there remains a strong tradition (Thomas Szasz and friends, and social constructionists in general) of not considering such confections to be illnesses at all. Whether considered to be intrinsic 'unreason' or artificially created out of the natural warp and woof of men's souls and feelings [and their oppression of women], can 'mental illness' be deemed a … [purely medical], scientific enterprise?" (Turner 2008, 106).

David Healy (2008), a respected scientist, psychiatrist, and psychopharmacologist, further explores the very nature of illness and our transmutable definitions of what illness, especially psychological disorder, is, is not, and by whom it is determined (generally those in power, in today's society the pharmaceutical industry) in *Mania: a Brief History of Bipolar Disorder*. Healy critiques the medical model of the DSM and modern pharmacology as short sighted and one track, focused predominantly on marketing disease in a "constant pressure towards illness" (2008, 220) that manufactures increasing categories of mental disorder without taking cultural, social, and personal context to account. It seems that in modern psychiatry, every disturbance of mood, every outburst, stress, distraction, phobia, discomfort, or trauma disorder is to be named, diagnosed, and medicated without individual consideration of what is at the root of the problem and how best healing can be enacted. Manic depression is like candy to the pharmaceutical industry. With the emergence of subtypes and increasingly lax diagnostic stipulations, the percentage of the population suffering from bipolar disorder and recurrent depression has skyrocketed over the past 20 years (Healy 2008; Turner 2008). Healy, in some ways, is skeptical of the categorization of bipolar disorder, especially as more and more children are diagnosed and medicated for 'aberrant' or 'affective' behavior, because of its direct exploitation by corporate pharmaceutical greed

and psychiatric epistemic tyranny. Although medication, subtypes, and diagnoses help *some people*, the damage these positivist typological traditions inflict impose a hierarchical and hegemonic order that is reductive, oppressive, and often violent in nature.

The psychiatric profession is deeply embedded in the psychic, mental, and somatic life of patients. Psychiatry – when floundering – has the possibility to violently and ruinously shatter one's entire conceptualization of oneself as well as make people physically sick and medication dependent. In a role of power over what is not only related to the body, but also to the mind – an interaction that involves an often-vulnerable community – it is naïve to believe that vicious abuse has not occurred (Chesler 2005; Scull 2015; Staub 2011). In fact, it was historically predetermined – the mad 'offer nothing' to society if their madness cannot be exploited somehow, whether by the medical market (drugs, pop psyche advertising, repeat appointments and dependence) or by the "therapeutic" one (talk therapy, sexual release therapy, psychoanalysis, regression therapy, hypnotism) (Foucault 1965; Healy 2008). The very foundation of the medical model is built on a positivist, rigid, diagnostic/prescription tradition; therefore, any expansion or diversity in subtypes that have historically developed are built on the same problematic foundations that are exclusionary in nature. Homosexuality and gender variance are examples of horrible medical model failure and violence when it comes to understanding of mental health, illness, and divergence; up until very recently (1973 officially and 1987 entirely), LGBTQ people were pathologized and diagnosed as disordered within the DSM itself. Homosexuality as a mental disorder was not fully removed from the DSM until 1987, and LGBTQ people, especially women and gender

variant folks, have continued to experience horrific violence and discrimination as psychiatry – through patriarchal hegemonic practice and 'family' hierarchal therapies – continues to attempt to treat and cure that which does not fit the androcentric positivist tradition.

The Social Model and Medical Critique

The 1960's saw a sharp shift away from medical understandings of illness as a socially embedded model emerged through the writings of Foucault, feminist psychiatrists, and the philosophy of Thomas Szasz. Foucault documents a different history of madness; one in which forces of political power use madness as an exclusionary and regulatory tactic. The resulting social model posits that madness is a social construct and that the medical history is not the only version of human history. According to Foucault (1965) both before and since Hippocrates, and often in contradiction to medical science, mania and melancholia have made central appearances in art and literature, been at one time culturally praised and another socially feared and belonged to both the baroque elite and the wandering peasant (Foucault 1965; Healy 2008 Scull 2015).

The (Western) social model claims that madness, illness, and disability are socially and culturally constructed categories that shift and change over time (Foucault 1965; Procknow 2017). Therefore, madness has been constructed and reconstructed as a category of ostracization and confinement, religious devotion, illness, prophetic vision, and divine punishment, among others (Gilman 2015). The social model asks and answers the question: is madness disease or socially constructed difference in which the mad are a victim of social circumstance? Unlike the medical model, the subtypes of the social

model (social circumstance, oppression, impairment, disability) are part of a social/community oriented conceptual framework. They are more flexible and allow for social critique and provide minimal spaces for pushback – especially against medicine. However, this conceptual framework is still positive in nature and dependent on the medical model as antithesis. It is the opposing side of the same coin, and therefore problematic for the fluid, continually reconstituting experience and disruption that madness and trauma both create and require.

Foucault documents the more cultural, literary, and social history of madness in *Madness and Civilization*, beginning with a look at the leprosy epidemic and the quarantine houses to confine the ill that would later transform into mad houses. Foucault constructs madness as a replacement for diseases of the poor; a way of confining and controlling that which was causing social or political dis-ease for those in power – errant behavior, tax resistance, stirring up crowds, raging against sovereignty, promiscuity, aggression, and breaking the rules.

> Foucault makes it quite clear that the invention of madness as a disease is in fact nothing less than a peculiar disease of our civilization. We choose to conjure up this disease in order to evade a certain moment of our own existence – the moment of disturbance, of penetrating vision into the depths of ourselves, that we prefer to externalize into others. Others are elected to live out the chaos that we refuse to confront ourselves. By this means we escape a certain anxiety, but only at a price that is as immense as it is unrecognized (Foucault 1965, viii).

Foucault, and certain social impairment/oppression/disability models locate madness typologies on notions in relation to the nation-state: on issues of capacity, access, and citizenship inclusion/exclusion. In cultural history, madness, especially the conflicting expressions of frenzy and despair, were both a source of fear and of dark fascination (Burton 2012; Gilman 2014). Foucault references the Ship of Fools and the Falstaffian

figure featured often in literature, poetry, and art, to exemplify the exposed freedom madness tropes enjoyed prior to the turn of the 17th century (1965). In literature[6] specifically, the mad figure was a messenger of the divine, touched by the devil, or a fool who spouted political wisdom and social critique – a figure of resistance against the status quo. This, however, wasn't to last (Foucault 1965; Scull 2015).

As labor and work became central to the success of the city (a growing power) and the notion of the nation-state, the confinement of "social and political deviants" became more and more imperative to the exercising of power. It is within this landscape that confinement of the poor and deviant as a strategy experienced a schism. The imprisoned poor had labor potential and could be exploited, however, the less pliable, more aggressive, "mad" among them tended to stir up trouble and resist authority. They were less *controllable*, less *productive*, and therefore more *expendable*. Separate confinement as "protection from self," as a means of social banishment, was born: a familial model that took root through the practice of asylum in which the keeper/psychologist/doctor/father confines, treats, disciplines, and molds the deviant "child" mad person for his/her own good (Foucault 1965; Gilman 2014).

As psychology developed and became increasingly medicalized throughout the early 1900's, the voice of 'unreason,' or "reason dazzled by the light of experience", lost its place and power as a force of social and political resistance in the developing West.

[6] Foucault points to Shakespeare and Cervantes, among others, to draw attention to the literary figure of the mad King (the madness of sovereign power), the hero-in-quest (the madness of forced 'civilization,' conquest, religious war, and imperialistic mission), and poor fool (the madness of unreason: a set apart, politically critical figure).

Foucault claims that modern psychiatry does not listen to the voice of the mad, even with the emergence of talk therapy (1965; Chesler 2005; Procknow 2017).

> The prevalent tradition of clinical psychiatry today as a convenient but ultimately misguided way of evaluating the social meaning of madness … [it is] nothing less than the quasi-academic compartmentalization of certain states of experience into formally reduced of 'illness' that are then logically disposable in the field of curing (Foucault 1965, ix).

Freudian psychiatry and psychoanalysis, with all of its self-purported claim of introspection (an introspection that is still externally imposed by a psychiatric model onto a patient), establishes a power hierarchy that oppresses the voice of the "disordered" by relegating it to the safe space of the therapist's couch or the share-time circle of the institution – controlled and ordered moments of voice that only reach the public through the interpretation of the god figure of the white-washed attendant and psychoanalyst. In a way, psychiatry is the bridge between the social and medical models, marrying the two and reifying power, positivist hierarchal tradition, and patriarchal tyranny, creating binding categories and dismissing deviation, and suppressing and oppressing the voices of trauma and madness.

Sociologist and psychiatric historian Andrew Scull takes Foucault's cultural history of mental dis-order further in *Madness in Civilization*, tracing the different constructions of madness from antiquity to Freud to modern pharmacology with special attention paid to the expression of madness through literature, drama, and the arts. Scull's history of madness exposes the danger of uniform, sterilized, and context-abstracted (medical) definitions of human behavior. He pushes against other historical models and biological/genetic understandings while exploring the vastly different categorizations of madness in civilization over time, documenting how it has inevitably ended in the lap of

the pharmaceutical industry. This eye-opening history exposes limitations of both models, as well as highlighting the dangers, discomfort, joys, expressions and pains not only of madness itself but also of positivist traditions of family and hierarchical categorizations and typologies when it comes to something as dynamic, complex, and fluid as 'madness.' Whatever the 'truth,' if there is such a thing, of *what madness and mental health/illness* are, it is clear that the Western social/cultural model has been yet unable to sever itself from the medical and is still exclusionary of experience, relying on cultural and literary interpretations *by society* of madness over time. Ascribing to a positivist traditional model of mental illness ignores alternative answers to the question of what it means to be human in favor of an 'enlightened,' 'industrialized,' western Descartian answer of being-as-reason; unreason as biological or dysfunction or social oppression. Both fall into the trap of diminutive speaking of and producing knowledge about, rather than from within or from within and without.

According to Scull, the megalomania of the medical model ignores the cultural and spiritual, relational interactions between mad persons and society, and relegates psychological illness to a biological and genetic prison by "thrust[ing] into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence" (Foucault 1965, xii). The primacy of market and industry in civilization illicit an interested desire to order society into productive and classified elements, leading to a trade in for-profit lunacy (2015; Healy 2008). If the mad cannot be forced to produce, if they cannot be made into lucrative citizens, then the treatment of the mad shall become its own industry,

and the mad a tradeable, testable, vendible commodity in the medical marketplace (Healy 2008; Staub 2011). Scull demarcates how this trade in lunacy reached horroristic[7] culmination during WWII, in Hitler's Germany, where approximately 200,000 mentally and physically handicapped persons were brutally sterilized and later involuntarily euthanized through a program called T4 (Scull 2015; USHMM 2018). Ironically, doctors and psychiatrists helped oversee the program and used patient records from institutions and hospitals to aid in the selection of victims.

The Social/Disability Problem

The social model "draws [distinction] between individual impairment and disability and its identification of disabling barriers in society which exclude and discriminate against people with impairments. It is concerned with social causes, social function, and the ability or disability of mad folks to interact successfully with society (Beresford, Nettle, & Perring 2010). The social model blames social constructions and exclusions from the social or 'capacity contract' (Simplican 2017) for mental health issues and considers mental illness to be a social disability. This model acknowledges the political and social influences of oppression, dispossession, and stigma and gained strength through the antipsychiatry movement of the 60's and seventies. However, it too can be productive and tends to overlook and exclude mad voice and brush past more severe forms of trauma and mental illness, especially when it comes to psychosis. "Although it is generally accepted that social risk factors are important in the genesis and

[7] Andriana Caverero discusses a category of human brutality that she terms 'horrorism' in her book *Horrorism, Naming Contemporary Violence.*

maintenance of common mental disorders and affective states, there has been less acknowledgement of their role in the aetiology of psychotic states" (Shah et al 2011).

In Michael Staub's antipsychiatry expose, *Madness is Civilization,* it is noted that despite some of the more extreme factions of the antipsychiatry movement, the notion that society, culture, politics, and foreign affairs play a role in or affect individual's mental health cannot be ignored (Shah et al 2011). To act as though humans are not mentally, developmentally, emotionally, and/or physically influenced by their environment and world is absurd (Cvetkovich 2012). Staub, supported by the more modern critique of Ann Cvetkovich in *Depression: A Public Feeling*, cites issues of oppression, racism, and sexism along with political concerns of war, terror, corporate crime, and extreme poverty as detrimental influences on public and personal health that can be held responsible for the sharp increase in mental health issues over the past half century.

Cvetkovich presents a very personal look at depression (melancholia) specifically as a form of public affect in a world of institutionalization, globalization, and incorporation. She views depression and acedia (spiritual ennui/blockage) as a collective response to violent histories (2012); this form of shared social illness is heightened when societies are transitioning, as new cultural realities are created (current example: globalization, social media world, facing climate change, etc.). Cvetkovich suggests that depression, including manic depression, may be a reaction to histories of political dispossession. "What if depression, in the Americas at least, could be traced to histories of colonialism, genocide, slavery, legal exclusion, [sexism] and everyday segregation and isolation that haunt all of our lives, rather than biochemical imbalances?" (Cvetkovich,

2012, 115). Cvetkovich invokes racism as a strong force for mental illness in the world and delineates the differences between black sadness and white sadness, as well as gendered sadness, pointing out the problem with the westernized, racialized documentation of mental health lineage (Cvetkovich 2012; Chesler 2005; Shah et al 2011; Staub 2011).

Understanding madness, mental diversity, and insanity from a purely medical, biological standpoint means a loss of diversity in the meaning-making of madness, a loss of ability to look past mere diagnoses and symptoms into alternative interpretations of what affect *means*: where it comes from, what influences create, warp, or destroy the mind (not merely the brain), and how the role of self-in-society is generated and determined (Beresford 2005; Scull 2015). After all,

> Disease has always been a social and linguistic as well as biological entity … The conceptual entity – and thus lived reality – we call bipolar disease today is peculiarly a product of our world. It is a world in which reductionist notions of disease have come to dominate our way of thinking about sickness. It is a world of bureaucratic categories and psychopharmaceutical practice (Healy 2008, xii).

A singular definition of madness that ignores medical advances, social influences, and excludes mad experience is limiting. Although social models acknowledge social factors, they focus more on the anti-medical dynamic and seek social solutions without actually including the mad themselves. While medicine and social critique is certainly important, both encourage the development of mental illness into an industry and ignore the seriousness of trauma linked madness and the historic unsafety of help for those who experience mad marginalization and exclusion. Madness need not be an inherent

disability, but it can be disabling in ways that are more than *just a social problem or genetic problem to be medicated.*

Madness can lead to disability. Although they are distinctive entities, "the border between disability and illness is not always clear – and what counts as either one is not clear, either" (Couser 2015, 106). Legally, bipolar disorder is considered a disability, but much as the fluid nature of the term madness, "the meanings we attribute to disability are shifting, elusive, and sometimes contradictory" (Adams et al 2015, 5). Disability is not "a coherent condition or category of identity… [it] is produced as much by environmental and social factors as it is by bodily [and neurological] conditions. Disability goes beyond the limitations of both the medical and the social models because it does involve a form of struggle that "entails limitations that are *not* social or cultural in their basis and which social reform *cannot* ameliorate" (Couser 2015, 107). Disabilities may be both medical and socially constructed but they are subject to and determined by the environment in which they function. Likewise, madness and mental 'illness' have to be seen in light of many different, intersecting factors (Gilman 2014).

Manic depression may be generated by a confluence of genetics, trauma, and social and political circumstances but it generally is, at some point, disabling because it is different (Beresford 2005; Shah et al 2011). This form of neurological difference is still misunderstood; although insightful and necessary, both the medical and social models fail to fully explain, understand, or treat manic depression, operating always within the spectrum of the normative mind and manic depression's deviation from this standard. Although I push against the sanist normative framework that "infects its victims with the belief of their own inferiority" (Chamberlin 1988, 198), it currently constructs the world

we live in. Its dominance is particularly obvious in fields of labor and production, where processing differences may but up against institutional demands. As a result, madness as disablement has to be accommodated for because it exists outside the socially accepted standard of behavior and production. Until social changes are made, mental difference is destigmatized, and more neurological advances take place, manic depression will continue to be a sometimes disabling and alienating experience in which support networks are needed. Mental health issues are increasing, especially on University campuses where support services are often insufficient. Specifically, services that recognize the link between sexual trauma and mental illness are often lacking, and expressions of mental illness that are trauma induced often go unrecognized (Beresford 2005; Castillo & Schwartz 2013; Conus et al 2010; Kelleher 2017; Shah et al 2011).

I experienced both madness as illness and as disability in 2007-2008, when my presentation of semi-psychotic mania and crippling depression was trauma induced. I was in shock, and comorbidly suffering from post-traumatic stress and a bipolar expression of manic depressive illness. I was completely debilitated but did not seek disability services for several (common) reasons: double social and self-stigma, lack of mental health literacy, and a shattered conceptualization of self. Madness can present as disability not only because of issues of functionality but also because of the effect that negative stigmas have on help-seeking behaviors (Ahmedani 2011; Cheng et al 2018; Relyea & Ullman 2013). Mental health education, increased sensitivity to the potential of trauma as cause of mental illness, and de-stigmatization are all areas for activist focus, especially in the university. However, they are not enough. Much like medication, disability supports for mental illnesses treat symptoms without doing anything to combat the privileging of

sanist stereotypes (Cvetkovich 2012; Simplican 2017; Procknow 2017; Staub 2011). While they may alleviate pain and help those suffering to 'manage' their illness and disabled status, they do nothing to empower personal transformation and encourage identity reconfiguration.

Psychiatric Androtyranny

If psychological health has a relationship to political dispossession, violence and trauma, and diminishment, then it is certainly gendered. All of these accounts - from the DSM and medical model to Foucault and disability models to modern day psychiatry and pharmacology – are androcentric in their assumptions. Modern day medicine is still based on inherently *male* understandings of the *male* body, the *male* hormones, and the *male* brain. In fact, until the 1990's, women were banned from clinical trials for new drugs, despite being prescribed them equally. Women and men respond differently to medications – specifically those of a psychotropic nature – and women are much more likely to be diagnosed with mental health conditions, especially forms of depression and anxiety, meaning they are more likely to be prescribed psychotropic drugs (Hill & Needham 2013; Lancet Psychiatry 2016; WHO 2018). This is related to gender bias within psychiatry as well as social constructions of help-seeking behavior (Ahmedani 2011; Cheng et al 2018; Beresford 2005). Although the FDA has taken steps to try and correct some of the gender disparities regarding medical understandings of drug interactions across gender, there is still a strong testing bias when it comes to pharmaceuticals (Jacobson 2014; Lancet Psychiatry 2016). Even more frightening is the gendered history of psychiatric malpractice and violation – a "psychiatric imperialism" that has specifically targeted women (Chesler 2005).

Phyllis Chesler does an excellent job of reintegrating the female psychiatric experience in her book *Women and Madness.* Chesler, one of the first prominent feminist psychiatrists[8], scathingly reviews her own medical training and the gender bias inherent within medical studies, especially in psychological medicine and treatment: "our so-called professional training merely repeated and falsely professionalized our previous cultural education" (Chesler 2005, 2). In the 1970's, Chesler began an extensive project "to document how patriarchal culture and consciousness had shaped human psychology for thousands of years," (2005, 8) investigating the ways in which women had been colonized by the aggressively patriarchal psychiatric community. She was interested in exposing how misogynistic oppression had created a double blind in which women were socially trained and conditioned towards self-destruction; how subjugation, political dispossession, and gender violence naturally lead to a number of mental disorders, and how early 'treatments' were based in a 'curing' psychology that was foundationally mired in social gender expectations. What Chesler discovered was a volley of women's voices who had been and still were psychiatrically imprisoned: lifelong consumers of hospitalization, medication, and a non-liberating psychoanalytical codependency. She found that asylums, institutions, and even psychiatric offices are often nexes of patriarchal power, places where "patients [especially women] are wrongfully medicated, utterly neglected, and psychologically and sexually abused" (26).

[8] In 1970, Chesler bravely addressed the APA and demanded reparations be paid on behalf of every woman who had previously been harmed rather than helped by the psychiatric community and "punitively labeled, overly tranquilized, sexually seduced while in treatment, hospitalized against their wills, given shock therapy, lobotomized, and above all, unnecessarily described as too aggressive, promiscuous, depressed, ugly, old, angry, fat, or incurable" (3). As is to be expected, she was laughed off the stage, called neurotic, and told that she suffered from penis envy. However, this bold move was, at the least, a start towards exposing the existence of a rampant abuse of women within patriarchal psychiatry.

"Women are seen as 'sick' [both] when they act out the [created] female role (are depressed, incompetent, frigid, and anxious) and when they reject the female role (are hostile, successful, and sexually active – especially with other women)" (Chesler 2005, 192). Women are culturally educated to be passive, quiet supplicants who internalize self-hatred (and inevitably end up depressed and self-abusive – and considered mad) or they rebel, display aggression and anger at their involuntarily imposed role and are consequently locked up, medicated – and considered mad. "Madness and asylums [or psychotherapy] generally function as mirror images of the female experience, and as penalties for *being* female as well as desiring *not* to be" (Chesler 2005, 76). It is also important to point out that, even though mad women and mad people of color and of the LGBTQ community have experienced excessive violence from the "sane" community, it is the mad who are feared and stigmatized as violent, not the society that acted violently towards them.

This is also true in treatment and diagnosis. Women, and especially women of color, are "over diagnosed" because the range of behaviors socially deemed appropriate for women is much narrower than that for men. A crying woman, bitter woman, angry woman, violent woman, promiscuous woman, or rebellious woman (also a frigid woman, sad woman, too complacent woman, depressed woman – hell just a woman in any state of affect) is much more likely to receive the stamp of the mentally ill than is a man displaying the same, or much more extreme (normal), behaviors. "All men, but especially white, wealthy, and older men, can act out many disturbed (and non-disturbed) drives more easily than women can" (99). It is possible that women's mental health issues, especially depression and anxiety, are subconscious responses – effecting both body and

mind – to an unjust world (Ahmedani 2011; Beresford 2005; Chesler 2005; Cvetkovich 2012). In the face of inescapable political, social, cultural, and historical oppression, "the role of the witch – or the mental patient – is often, like suicide, the only resolution (the "cure") for having been born female" (Chesler 2005, 164).

According to the World Health Organization:

> Depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use affect women to a greater extent than men across different countries and different settings. Pressures created by their multiple roles, gender discrimination and associated factors of poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse, combine to account for women's poor mental health. There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict [psychological distress] (WHO 2018).

There have been many advances in psychology, psychiatry, and psychoanalysis in the 21st Century due to advances in psychiatry and the fearless work of many pioneer feminist psychologists and psychoanalysts. It is important to note that within the field of psychiatry and psychoanalysis, many people have fought to create safe spaces for women and members of the LGBTQ community and have saved lives, provided support and empowerment, and pushed against purely medical and diagnostic models and categories. Therapy in its many forms can be an incredibly liberating and healing force for many people when it breaks from patriarchal or abusive traditions. Although there have been major improvements, especially with the advances of third wave feminism and increased awareness of intersecting oppressions (racism, sexism, etc.), there is still a need in psychiatric fields for further incorporation of gender, race, and cultural awareness within healing. It is especially imperative that post-sexual assault trauma therapy become central

to psychoanalysis, as sexual assault is one of the potential causal mechanisms in women's mental health issues (Rees et al 2011).

Too often, mood disorder and other diagnoses push medical treatment over personal empowerment, trauma counseling, self-writing and narrative reconception, and engaged coping. They encourage pharmaceutical dependency, as the drug treatment plans for many forms of mental illnesses are usually lifelong and disproportionally affect women (Chesler 2005; Healy 2008). Because gender role stereotypes encourage help-seeking behavior in women, (Cheng et al 2018) and because diagnostic practice is often gendered with women being viewed as weaker or more prone to mental illness, pharmaceutical marketing is gender driven and women – and children – are more likely to make up the majority of an overmedicated population (Healy 2008; Hill & Needham 2013; WHO 2018). Women have also historically constituted the population of psychiatric abuse victims. Psychiatric treatment is, even today, unsafe for marginalized populations because of the inherent white male power hierarchy within psychiatric care. Women, and especially women of color, are still exploited, misdiagnosed, overmedicated, sexually taken advantage of, used for free labor, and abused today – both by the mental health care system and, often, their psychiatrist[9] (Chesler 2005, Hill & Needham 2013).

Women and other marginalized groups experience the threat of violence by merely existing. Sexual trauma in particular has a strong link to presentations of

[9] For a more in depth look at the research documenting the psychiatric abuse of women, see Phyllis Chesler's *Women and Madness*.

psychosis and recurrent depression (Beresford 2005; Hill & Needham 2013; Rees et al 2013; Relyea & Ullman 2013).

When initially facing mental illness after an experience of abuse – both diagnostically and experientially – one's past identity is stripped from them. People struggling with illness watch concrete futures crumble and are forced to assume an entirely new, and temporally significantly diminished, sense of self (Frank 2013). Reading about mental illness from an abstracted, clinical or historical perspective is not enough to understand the lived reality of that genetic betrayal by way of mind. Evaluating the influence of social oppressions and gendered influences on 'breakdown' or contemplating the cultural (artistic) link between creativity and manic melancholy is not the same as living through it (Houston et al 2011). It is removed and safe. I intend to threaten this removed safety by narratively demonstrating the untethered danger, confusion, and pain of "losing your mind" in the aftermath of rape.

CHAPTER 3

RAPE AND THE PHENOMENON OF BEING REDUCED

"In practice, the standard for what constitutes rape is set not at the level of women's experience of violation but just above the level of coercion acceptable to men."
— Judith Lewis Herman

In the following two chapters, I discuss the psychic pain and disablement of madness from a position of lived experience, beginning with a presentation of sexual assault and gender-based violence as factors that strongly influence mental health concerns. According to the World Health Organization, gender-based violence (GBV) and mental illnesses are strongly linked, especially as it regards women and girls because women and girls are globally more likely to be sexually abused (Hill & Needham 2013; Houston 2011; Rees et al 2011; WHO 2002). A 2011 study published by the American Medical Association notes a "pattern of social disadvantage, disability, and impaired quality of life among women who had experienced GBV" (Rees et al 2011). There is a strong, reciprocal association between GBV – specifically sexual violence – and mental disturbances (Silove et al 2017). I introduce sexual assault because wounding is chronologically and thematically fused in my experience with the most debilitating and self-destructive expressions of my manic-depression. It is also the event that first "drove me mad." Thus, this lens allows me to express how madness can interact as disability rather than positing that it is inherently disabling. Madness cannot be reduced to a single definitive conceptualization. It is a fluid and intersectional entity, influenced by time, place, circumstance, trauma, and identity. I present moments of my own 'story' as an example of how oppressions, gender factors, social response failures, and voicelessness can *make* madness disabling. I explore the negative power of labeling, self-stigma, and

illness identity to show how conceptualizations of self and circumstance have power and can be enervating and reductive. I use narrative, memoir, and poetry to convey the emotional nature of the topic and to ground it in empirical and experiential voice, rather than academic abstraction. I also do so to communicate the nonlinear nature of trauma aftermath and experiences of identity disruption and diminishment.

Trauma, Stigma, and the Self

Rape is deeply personal and painful; it is conveyed as such in this chapter because these types of encounters are deeply personal and painful for those who endure them. Much like madness, sexual trauma is not logical, safe, or easily understandable. It is not categorical: experienced differently by different people. It is also not hierarchical. Although there are experiences of trauma that can and often are (although they perhaps should not be) 'ranked' in terms of violence and injury, all trauma is traumatic and shattering for those who experience it. It is disturbing both for its victims and society. It is a wounding and disruptive experience. It not only affects the body, it shatters the mind, dismantles identity, and creates powerfully destructive stigmas. Specifically, the wounding from this type of violation often exposes itself in esoteric ways that are alien to socially acceptable function and behavior. Sexual trauma causes a form of post-traumatic stress disorder and can ravage the mind much in the same way it ravages the body. The effect is a chronic dis-ease. The socio-cultural, political, and legal responses to sexual assault further traumatize victims. They are the ones who are blamed: ripped apart in courts, disbelieved, devalued, and often discarded. They also are at higher risk for being re-victimized. It is not uncommon for sexually traumatized people to undergo more than one attack through no fault of their own (Rees et al 2011). This relationship of GBV and

mental illness is also reciprocal: GBV "may predispose to mental disorder; conversely, mental disorder may increase vulnerability of women to incurring further GBV" (Rees et al 2011).

I have been raped a total of three times:[10]all in my twenties – twice involving date rape drugs (one stranger, one acquaintance) and once while I was passed out at a 'friends' house. I was a virgin the first time. Occasionally, and in my case, to make sense of the assault, people who have been victimized re-traumatize themselves through self-hatred, self-destructive patterns, and/or changed attitudes towards and interactions with sex. (footnote, not your/their fault). Rape can and often does severely damage a person's sexuality and internal relationship with sex. It also damages one's relationship with themselves and their own bodies. Expressions of trauma can include: eating disorders, sexual behavior that is out of character for that person, depression, psychosis, flashbacks, insomnia, dissociative behaviors, disconnection with one's body (feeling out of or detached from the physical), severe anxiety, sleep disorders, and induced mania. People who have experienced sexual violence may take seemingly extreme measures to gain back their sense of control. They may continue to talk to or even sleep with their attacker (this is especially salient with acquaintance rape) – as I did with my first rapist – in an effort to convince themselves that they weren't truly raped, or to try to find the missing pieces, stay in control, control their attacker through sex.

In academia, we often write about and discuss sexual assault and the resulting trauma. We clinicalize our discussions, use statistics and reduce women to numbers on

[10] I only include journal clippings and descriptions from the first two times in order to protect the story and identity of the other victim involved in the third incident.

pages. We talk about self-blame, self-hatred, denial, social stigmas, social attitudes towards victims, and rape culture and how to combat these things. This is necessary and useful. However, victim's voices are still hushed: what they can and can't say about the details of their experiences are controlled because, ultimately, "victims make us uncomfortable" (Chesler 2005, 204). Often victims silence themselves as well due to shame, public perceptions, and the violence that is directed at folks who speak up. I include excerpts from personal writings across time and different traumas that range from harassment and reduction to shocking sexual assault to full-fledged rape in order to demonstrate the fear, wounding, psychic pain and after effects of rape which, for me, eventually resulted in a semi-psychotic breakdown. All of these events happened, they are all true accounts or poetry written after that expresses true accounts.

They are not even the beginning. I have met few women who haven't been sexually assaulted in some form. Many times, like in the case of both myself and several female and LGBTQ friends of mine from college (pre-rape, early college) who were physically forced to 'swallow' a guy's dick ('bitch') or who woke up to a supposed friend touching them or jerking off on top of them as they slept, the pain and destructiveness of the assault is minimized in the telling. It is normalized because it is traumatic and we are socially conditioned to minimize the unwanted sexual aggression and violence of men. Who hasn't heard the adage 'boys will be boys'? When these stories are finally revealed, they are often accompanied by explanations, qualifications, and apologies. I did this myself many time, the internal and spoken narrative runs like this: it's normal, it wasn't that bad, it was my fault, I guess I deserved it for flirting, it didn't really happen, I'm probably being dramatic, what's the big deal, so what, you can't prove it, it's not as bad

as what a lot of other people go through, he probably just got too excited, etc. etc. etc. This is a self-diminishing that is socially and culturally conditioned and engrained. Male sexual aggression ('rapey' behavior) is normalized in all patriarchal societies; boys/men are taught that it is expected and girls/women like it and girls/women are taught that it is to be expected and is their fault or that they should like it (know your place!)[11]. It is important to note that these patriarchal oppressions are further magnified for those who experience multiple forms of marginalization. Women of color and members of the LGBTQ community often experience more violent sexual trauma or harassment with less recourse for justice, help, or healing (Chesler 2005). The experiences presented below predominantly took place in my late teens and early twenties, a particularly vulnerable age during which women often experience sexual attack, however they happened in different places and times and are not ordered chronologically or linearly. These are not easy reads, nor should they be.

[11] See the WAVAW Rape Crisis Center website for an excellent description of the different facets of rape culture.

Without Consent: A Personal Reduction

I woke to pounding blackness. The chaotic, bleary kind that numbs conscious thought and lends terror to your surroundings. Different than a hangover. Different than anything. My thoughts came slowly, like molten lead breaking through a thick plate of rock. *Pound, pound, pound*. Not like a headache, not like a heartbeat. It was like being under deep, black water. I couldn't move. *What? Where?* Everything was dark. I felt buried, weighted. I lay perfectly still, a suffocating sense of something horribly wrong – and familiar – paralyzing my already heavy legs. *Try to breathe…* I couldn't. I lay in a haze of immobility, my shallow breaths labored by the thickness of feathers pressing against my face. *Move… Slowly…* I turned my head, mouth struggling against its pillowed prison. The room was blurry. My tongue felt heavy, numb. No noise. I was dizzy and couldn't see anything but the dimly lit room and a few scattered pieces of clothing. *Wait, have I been here before?*

A gruff voice broke through, from somewhere far away. It was telling me to leave, get out of here. Strained, angry, annoyed. Wake the fuck up already! I didn't see anyone. But I thought I knew that voice, and suddenly I was panicking. Flashes of scattered images tried to focus themselves into pictures in my head. Jumbled, incoherent scenes. *Come on, get up, what's wrong with you?* I didn't know. My mind was oddly blank. I didn't recognize the feeling. *You must have gotten drunk.* My mind answered me, then stilled, for this wasn't the same – I was in the service industry, accustomed to bar tending, bar attending, and the requirements of bar living. I was acquainted with the hangover - But I barely drank anything last - last night?! … had it been hours? Or yesterday? What day was it? This was unlike anything I had experienced before. Not a hangover blank, not a sleep blank or a high blank or even a concussion type blank. This was ominous. Quieter. Too quiet. Images were trying to float across my sphere of thought, taunting me with unattainability. They felt like far off dreams, like I was remembering far off events through a shifting kaleidoscope, but I couldn't see them. I couldn't hold on to anything, couldn't anchor myself in these brief feelings of things I didn't think I had experienced. Maybe I was underwater, drowning. But no, the room came slowly and more clearly into view. The bed, TV, the pillow covering my face… *What the fuck? Had I been here before? Where was I? Ok, think.* I had been off of work. Had gone in. had two, no maybe three, glasses of wine. *That was all right?* I had been there for three hours at the very least. I was meeting with a friend. *Sober. You both stayed sober. I had to drive at the end of the night!* I had left, no, wait, a coworker had made me a cocktail. Then I left twenty, thirty minutes later? I was going to do some homework in the car. To wait to drive for forty minutes, just to be safe. I don't risk DUI's. *You were sober. Just cautious.* I got in, was reading. Then what? Weird, started feeling weird. Dizzy. Blurry. Heavy. The door opened.

"Hey" I turned to look up, feeling dizzy. *Oh, it's just him. I thought he left.*

"What do you want*?"* I was annoyed. Surprised. But feeling weirder. Like lights dimming. Was I talking weird? Slurring? No, not slurring, my mind was just having trouble processing. He was looking at me. Did he ask if I was leaving? What the fuck had

he wanted, I had told him I was never going home with him again. I, mean, I fucked him before when I didn't really care about anything… but I was over that. We work together, were not exactly friends. *Whoa.* Shaky. Heavy. He's taking my keys. Putting me in the passenger seat.

Blank. Like a dead TV screen. Nothing. Wait. Flash. I'm in the house, in the living room. *How am I standing up? How did I get in here?* His roommate is leering up at me. I'm trying to say something, but how, what am I saying? *No no, this is all wrong.* Blank again. Nothing. Flash. Sounds, loud music, maybe? Blank. Total blackness, then, *Wham!* One clear moment, one distinct picture. I'm face first on the bed. Sprawled on my stomach and my bleary eyes are heavy, trying to focus on the room. But I'm tired, so very tired. I can hear myself talking, blabbering, in the background, like foreign noise. Incoherent. But I'm sort of saying words. Not scared words, just apathetic, and confused. Can't think. Can't make any decisions. Can't move. I know he is fucking me. Or already did. Or is about to. I'm babbling, something ... or trying to say something? I can't make anything out. I can barely think. I'm on autopilot. I feel out of control, like my brain isn't working. Or my body. Or I'm outside my body, watching something happen that I can't stop. Then everything's fading. Sleepy. Groggy. Falling asleep. Can't think. He is behind me, moving something, getting ready for something. I am lying complacent, heavy, dead. I can't feel anything at all. My entire body is numb. I watch myself attempt to raise my hand, but I can barely even twitch my fingers. I'm underwater, must be. *What's going on?* Nothing is real. It feels like a strange, twilight dream. I'm falling in liquid space. I can't feel my body. I'm sleepy. So very sleepy. Darkness. That's all I can remember. Now I'm fully panicking, awake, trying to grasp to images, reconstruct the night. *WHAT THE FUCK HAPPENED?* My heart is racing. *Move, move, move.* The rasping male voice again urges me to leave. I'm looking frantically for my things, keys? Purse? Anything?

"It's in the kitchen" I stare in horror at the blanketed form in the corner of the room, on the floor, far away from the bed. His back is to me. His voice is tense, short. He wants me gone. Immediately. "I thought you'd never fucking get up" sharp now, angry. Like something is wrong. Or was wrong. I don't answer. His awkward silence is a question.

"What happened?" I meekly manage to choke out. He shifts, moves, nervously jerks at his blanket.

"NOTHING! GOD!" he snaps. "We got drunk and fucked, ok? You wanted it, ok? Chill the fuck out! Get out of here! *I've never seen him so agitated but maybe this is all a dream.* I don't tell him what I do remember. I don't tell him I don't think I was drunk. Or that it shouldn't have mattered? I don't challenge him or confront him. I don't scream out all the rushing fear and panic and anxiety. I feel sick deep down, confused. I just wanna get out! I stand. I stumble out of the room and look down. I've been haphazardly re-clothed. Or maybe my skirt was on, was left on, all night. Is it daytime? *Run, run, run!* I'm out the door. The sun is blinding, I'm stumbling, can't walk, trying desperately to find the car I didn't park. I'm in, I'm driving, driving home. The clock is flashing. It's afternoon, I have to be at work soon, I think. Everything is heavy, spinning. My body isn't working right. Or my brain. Darkness. Somehow I'm at work. I've been home, changed, and am standing back at the bar I was at last night, except this time on

shift. I can't remember going home, getting here. Like my memory is slippery, jumping time. *What the fuck is going on?* Calm down, you probably just drank too much. Is it possible I got drunk and slept with him? *But I've been turning him down. I turned him down last week! I told him it would never happen again, didn't I? I wouldn't ever sleep with him again! I was – trying to be… I wouldn't have, not like this. This isn't right!* I'm at work, trying to focus, trying to stay in my head, trying to organize my slippy thoughts. We have a private party coming. I feel sick inside. I want to scream. I feel like I'm catapulting into an empty, dark hole of inky pain and fear and shame. *Don't blackout again! Stay here! Stay in your body!* Matt is looking at me. "Are you ok?" I shrug and nod and walk the other way. Dry eyed. Dry souled. Had I made a mistake? It's not like I was an angel. Or was there something else? Something dirty, hidden. *Something way too fucking familiar about all this.* God, had I been drugged and raped? I half smirked. *No, no, you're just being dramatic, why would he? You've slept with him before. Don't be emotional. Don't be so dramatic.* I couldn't push of the nagging feeling. *FUCK HAD IT HAPPENED AGAIN? Had I been raped again?* I could barely admit the first time to myself. I'd been running away from it for two, since I was 18 and my virginity was stolen. How could something like this happen? Had it? Or had I made the whole thing up? Or maybe acted like I wanted it? Was this my fault? Suddenly all the black depth I had been shoving off since I had left California came crashing down in one heavy, obliterating wave. Dizzy, spinning circles. Can't stop. Everything is screaming accusations at me.

Whore, whore whore whore. Filth, drunk, dirt, blood, RAPE!

Now I'm sick. Sick everywhere. Retching right at work, on the curtains, on the floor. I can't breathe, can't stand up. Falling on my knees. More puking. I've never thrown up before in my life at this point. Ever. Not from alcohol, not from partying, not from the stomach flu. NEVER. I can't even make myself. I've tried before. There were times when I had wished I could make myself. And here I am, sick and crying, alone and hidden in a dark closet. *Stop it! Stop it! I want out!* Gagging, spinning, spitting. It's in my hair, on the curtains. *Whore, whore, whore …*I'm slipping on the concrete floor in a mess of my own yellow puke. "GOD, FUCK, SOMEDBODY HELP ME! GET ME OUT! GET ME OUT!"

My brother picked me up and dropped me off at my house. I didn't tell him about it, curled up in a ball in the back of his car. I couldn't even talk. I later told my manager and employer what had happened, they had been there at work. They knew me pretty well and knew something was very wrong, but I didn't tell them who it was. How could I? He was friends with everyone I worked with. Would they even believe me? I just quit. They put it on record at work but I didn't want to face anyone and have to defend myself because the truth was I had a limited, blocked recollection of the night. I just couldn't remember for sure. And I knew I could never prove it, and no one would believe me anyway *because I had slept with him before*. I didn't go to the police. Or get a rape kit. Or speak to anyone for days. I felt ashamed. I felt dirty. I felt worthless. What if I would never know for sure? Maybe I was just being hysterical or dramatic – I'd been told that before. Looking back, I'm not even positive the conversation the next morning happened.

Everything was so confused. And what if I was wrong? But I kept blacking out all that day. Long snippets and periods of hours where I slipped into an automatic consciousness. I bled too. Cleaned the violating red streaks angrily. There was no reason for me to be bloody. But I couldn't tell anyone. I was ashamed of myself, my life. I was worthless.

Did I even want to really know? What if it was all just me? What if it's all in your head? What if you're crazy? What if you wanted it? You probably deserved it! I didn't care. It was over. I couldn't fix it. I was horribly broken. And I gave up now. This had happened before and I'd ignored it. I couldn't run from it anymore. *There is nothing left of me. Just fucking let me die. The world is a mess, we're all just fucked up, leftover trash. Nothing can save me. What was the point of all this shit? The world was a sick fuck.*

There are times when you need to learn the art …
of how to disappear completely.
In the face of bombs exploding, or forceful tidal waves,
you enact this secret power of reducing.
For a suspended second you can see it all coming.
a stale, motionless feeling where you barely dare to move.
Like a terror, but an empty one.
You look up!
Waves threaten, tottering on the balance
Of a crushing and chaotic destruction.

They momentarily rest, leering
expecting you to run or scream or try to fight,
But
you simply lie there.

(You must stand still in time, in order to go away).

This time, this last time, there is nothing.
No fight or will to live within you kicking to be heard.

(You have to accept death if you wish to disappear).

Nothing but deadened eyes and one last extended heavy breath.
These glass eyes
are now
the eyes that tears once ruled, but then abandoned.
This is the breath that screams as it flies free of lips
'take me, kill me, I'm not here, I've long been dead.'
Hesitation.
The wave is at first taken aback at this acceptance.
It does not concede in mercy but rather down, down, down!
Impound!
Faster and angrier it comes, hammering, charging towards the shore as thud, thud,
crash it begins to break your body and rip apart your flesh.
Thrashing you, destroying you.

Ha! But you are evaporating! You make yourself a wisp!

(You are not there, and perhaps have not been for quite a while).

You are out of body, rising, watching far above.
You can see the scene is horrific,

Petrifying.
you hear nothing, feel nothing, - not even a quickening of panic.
You are too far gone; you must be too far gone now.
That laden breath is leaving you,
sighing,
mourning too late, too late, too late.
The water and the winds howl response.
They don't take pleasure in your frigid pre-death disappearing act.

Wanting you to feel the hard-ship.
Fight back.
Make it more fun.

(Sometimes resistance is an absence)

Your body cripples, doubles, shatters as they use you, beat you down.

(You must reduce yourself, or be forcibly reduced).

A whisper, a wisp, and then she's gone.
Finally, all you hear is ancient silence. Alone, alone.
All I could hear was an unanswering silence.
It's over, over, let it to all be over, in this forcing-your-soul-to-death.
Yes, it is finished.
And now …
I've learned the art of how to disappear completely!

They shoved pigs up my pussy.
They bacon slapped me.
1, 2, 3 times the charm.
They shove em' up there so you'll never stop believing you're nothing

Don't you know your place, girl?
Here, drink up and you will
Feel this ownership.
As I force it dripping down your thighs

What was it exactly?
About me sleeping there
A stranger to you,
That told you YES, I know exactly what she wants!
Did you even know my name?
when you came into that bed room
that didn't belong to you
late at night
to take something else
that didn't belong to you?
When you pushed yourself up against me
And touched yourself?
And when that wasn't enough,
Slunk your hands down my shorts
Desperate and disgusting
Shoved your dirty fingers inside me
Until I woke up in pain
To you getting off?
The indignation on your face when I confronted you!
(Fuck why did my body freeze? when inside I wanted to claw your face off?)
The hatred seething out of you when I told her -
my friend who had introduced us
As if I had betrayed you. YOU!
Go ahead, call me a bitch again
I'd rather be a bitch then a piece of shit like you

Three fucked up piggies prowled the market
Three fucked up piggies took me home
Three fucked up piggies ravaged me to roast beef
Three piggie pricks had their fun
Each rapey piggie went me, me, me, me, me, me all the way till dawn
Or so I assume. I don't know. I wasn't conscious.

Your existence is a defamation so bow down, bow down, bow down woman:
Bow down and swallow my cock
I know you know how
To take it like a bitch

it's a choleric meridian time
that places all who aren't in power
on a blood platter of scarlet

Will the sun ever rise on the disenfranchised and violated?
To tell us that we are more than just a naked lunch
He paid one drink and one drug for.

> The first time I tell society what happened: skepticism. Were you drinking? *Yes.* Well then! *Well then what? What does that have to do with it?* The second time I tell society: derision. Well maybe you shouldn't have been out. *Snort. Excuse me?* What were you wearing? *Clothes?!?* Knowing the way you dress … What did you expect? *Are you saying this is my fault?* You should have known better. *No, men need to know better.* The third time I tell society: accusation. You're lying. *WHAT?!?* Women say that when they feel bad about being slutty. You knew the guy, right? You probably encouraged him. *This is why we don't speak up… because of you. This is why violence is allowed to continue … because of you. This is why we're triple traumatized in your rape-culture-sick-fuckedup-social misogyny.*

Heart pain fits not choking
Lodging hook from fisher's line
Pulling
Drags body over slip and shale
To strip off slowly
Thrown back if too small
Gutting finds out
The meet
Crooked wire drug 'love'
No healing
Little fish
Just Treat and Devour

But I was wet! I got wet, trying to shove him off (please don't make me remember this): my body betrays me as I scramble away. And now I have no defense - clawing to the door, ripping out fingernails, tripping out of the underwear he uses to try and catch and keep me. Slamming. Running. My cunt humming, while I want to vomit and bleed; to hurl him out of me… To turn around and violently make him pay. But I can't. I'm too small and already pushed against a wall. All I can do now, in his brief break, is fucking run! RUN! Fucking pussy grossly sobbing against my will … You wicked bitch! There is nothing like the self-disgust of your own anatomy breaking faith with your consent, slathering and providing excuse for someone to indiscriminately take you as you scream, push off, panic, scrape and run for the door, freaking out at the slippery handle … OPEN! FUCK PLEASE OPEN! slam it in his face – down, down, the stairs, twisting ankle, jamming fingers GET THE FUCK OUT! RUN! You leave your friend, still inside with him, you just have to get out! You can't think, can't speak, don't know what else to do. You hate your own body for being so weak, you hate your vagina for not having teeth.

I could tell she liked it. They like to say. She wanted it. They say.
But they slip you pills because they like submission
to them you're not a person you're a plaything
they deserve for being born men.

When you tell me to get over it,
That I was lucky – it could have been worse
Do you not see what this is doing?
To say, we can't talk about it
Because our rape wasn't *that* bad
Compared to millions of others
Compared to alley ways or weapons or gangs
Or Rwanda
And if we all 'get over it'
Come to expect it
Be thankful to our rapists for doing it gently?
What will that do to us?
What will that say to them?
You can rape, just don't leave marks! You can rape just use a condom!
You can rape just use a drug! You can rape, just do it to a friend!
And pat yourself on the back for how moderate you were.
Comparatively.
NO! I say NO!
Rape is rape is rape is rape is a violence, is a horror, is a (dis)possessing.

Before me all is glass and shadow, illuminating nothing.
He pants. Breathing ragged; heavy wanton, reducing me to a triumphant evisceration.
Or do I reduce myself?
FUCK yeah, girl. You're such a dirty little whore.
Fade. Don't think.
No more waiting. The assault will be over shortly - how atavistic.
'I'm gonna fuck the shit outta you'

This will be a shattering self-destruction, I sink pathetically, anemic with rage. He, erect, grapples my anorexic flesh, esurient, salivating. Practically blubbering.

He has his way. I am forced to take what I know I deserve. Ass-smacking, raw, gritty porn. And I am the star. Am I supposed to be grateful?

I grasp hold of the snarling power inside me.
I cling to it to keep from cracking.
I tighten myself in on myself.
I vehemently pillage (how inverse).
I watch his face contort (how pathetic).

FUCK YOU! I scream, internally.
FUCK ME! He groans. Out loud.
This now me, I now this - voracious, chthonic Aphrodite all his making.

I have a thought - retribution.
Definition: the act of correcting a wrongdoing.

Oh my god, he's mumbling from far away.
But wherefore art thou my god?
Nowhere.
Or perhaps in me. Perhaps I am a god. The god of female suffering.

I ruminate, I disappear. Will he remember? Will he, haunted as me, be doomed to court the beast through slathered nights of fucking despair? Is my nightmare his? Or will he sleep peacefully for the rest of his life? Powerless, I am demoralized.
How have I come to be here? How has he come to be inside of me? AGAIN.

Is it even real?
this memory of ripped pants,
this memory of blood,
this day after, fucked over, plan-b begging guilt
this violent man who raped me of virginity?

This is the phenomenon of being reduced, and then reducing oneself.

Somehow – all my years in the dark can’t seem to kill me.

CHAPTER 4

MADNESS AS DISRUPTION

"Any illness constitutes a disruption, a discontinuance of an ongoing life."
– Lars-Christer Hyden

Madness is disruptive. It doesn't play by the rules. It interrupts you with unreason at times that are inconvenient. Beyond personal disruption, madness disturbs 'reasoning' society. "Madness is shut away from sight, shamed, brutalized, denied, feared, drugged" labelled, misunderstood, and rejected because "madness – as a label or reality is not conceived of as divine, [spiritual], prophetic, [knowledge-producing], or useful. It is perceived (and often further shaped into) a shameful and menacing disease, from whose spiteful and exhausting eloquence society must be protected" (Chesler 2005, 85;95). Mental illness may well be one of the "most stigmatizing form[s] of illness or disability in the West" (Gilman, 2014, 441). Neurological advancement regarding the functioning of the brain in bipolar or unipolar 'subjects' does not eliminate the long, historic fear of and fascination with madness, nor minimize the damage done on public perception by inaccurate media portrayals or environmentally exacerbated, severe expressions of mental illness such as some houseless persons[12] or hospitalized patients display – many of whom have experienced severe life trauma and are in need of support (Gilman 2014).

[12] Medical models would focus on genetics, the abuse of drugs or alcohol, and brain dysfunction as factors leading to unemployment, psychosis, and houselessness. Social models would focus on the oppression, economic demand towards production, and life experiences and occlusions that a person endures as triggering factors that can eventually lead to street life. It is important to note that houselessness has just as much, if not more, of a negative stigma as madness and is often reciprocally attached i.e. the assumption that mental illness causes houselessness and houselessness causes mental illness. This understanding does not provide much agency to either the mentally ill or houseless individuals.

In many cases, the expression of madness or mental illness, as well as the causes, can be debilitating, whether because of social and self-stigma, lack of support services, or the disruptive nature of psychic pain. According to the National Alliance on Mental Illness, "mental illnesses are the leading determinate of disability worldwide" (Procknow 2017). Disability is determined as a method of differentiation in relationship to ability and is generally evaluated according to what can be visually assessed by doctors, employers, and the general public (Frank 1995). It is an othering practice of concept formation, and often an epistemic injustice. The term mental disability encompasses a wide range of mental differences that cause disruption or are indicative of difference, under this "umbrella term [mental illnesses] are defined as 'alterations in mood, thinking, and behavior, as well as other domains of mental functioning … either directly or indirectly'" (Procknow 2017, 5).

Madness categories are similar determinants made by medical and social standards that privilege and are made in comparison to sanism (Gilman 2014) as kind and family hierarchies. These determinants are regulated by the authoritarian power of a psychiatric definitiveness that responds to societal fear and judgements of mad peoples as "unsteady, irrational, hysterical or violent" (Procknow 2017, 7). Madness becomes increasingly political and subject to ideological pressures when it is conceptualized as a kind hierarchy of disability or illness. "For madness has now not only to figure itself in relation to ideas about competency, moral ability, curability, etc., but also in relation to questions of access, stigma and advocacy" and power dynamics (Gilman 2014, 442). The police action of psychiatric and medical power as distributers and determinants of knowledge and 'truth' "regulates mental 'Otherness' in ways that impoverish mad

subjects' narratives; [thus] the colonizing language of psychiatry and psy-knowledge takes root" (Procknow 2017, 7; see also Foucault 1965).

Categorizing madness as either medical or social, disability or illness involves the suppression of mad voice and serves to narrow, reduce, and pinpoint – within Western standards – mental sanity and thereby marginalize that which disturbs the sanist normative framework. Mad people are turned into the 'mentally ill' and 'functionally disabled' and are increasingly regulated according to diagnostic and social labels that inhibit agency and create either perpetual patients or victims of circumstance. Once dismissed to the psychiatric couch, the doctor's prescriptive authority, or the political ideological powers that regulate services and access to them (or, in some cases, left to the streets), "mad citizens are rendered unintelligible beings only to be 'spoken and written' about" rather than with (Procknow 2017, 7). The sane silence, often violently, those deemed insane (Chesler 2005).

When Illness Interrupts

In a society with a collective, often capitalist, form /expectation of function, madness can be disabling because mad people experience 'logical' processing disruption and are often seen and treated as disruptive themselves. They/we are unwanted, mocked, disparaged, harangued, expelled from the social order, misunderstood, and stripped of power, agency, and voice. They/we become one more category of *homo sacer*[13] in socio-political hierarchies. For some, integration into political, economic, and educational

[13] Ancient Roman religion defined sacer as something set apart, both "hallowed" and "cursed," abiding within and yet without the realm of bios. The homosacer is stripped to bare life, banished to the realm of the zoe where he may be "killed but not sacrificed," where he has an 'exclusionary' included place in the world. See Giorgio Agamben's *Homo Sacer: Sovereign Power and Bare Life*

institutions is not possible. For many others, it is the institutions themselves that create depression, anxiety, and mental and emotional strain (Castillo & Schwartz 2013; Kelleher 2017). For others still – people with genetic predispositions toward manic depressive or schizoaffective diagnoses who function within the system – the label of illness and disability can be both a needed salvation and an alienating violation of identity.

If there is one thing that I have learned through my struggle with manic depression, it is that "nobody's going to save you. No one's going to cut you down, cut the thorns thick around you …There is no one who will feed the yearning. Face it. You will have to do, do it yourself" (Anzaldúa 1987). If I believe knowledge production should be different, if I believe in the liberating power of narrative and lived experience, if I believe in feminist inquiry and madness as *many different things* that models cannot possibly communicate, I will have to write, write it myself. After all, "it always made intuitive sense to me that if one really wanted to learn about something, there was no better way than to see things for oneself, speak with those involved, and experience the phenomenon as much as one could" (Shehata 2006, 209).

An experience of madness as an aftereffect of three shattering experiences of assault tells me that all of these models have missed things in their delineated understandings because mania and melancholia *are not logical, linear, or dependent on the perspectives of scholars* and, for many people, may be influenced by trauma (Rees et al 2011). In an effort to get 'unstuck[14]' from my illness, depression, and post assault trauma, I had to abandon the crutch of linear movement and let go of my old identity; I

[14] Ann Cvetkovich relates being stuck to depression, especially in writing and the academia, and critiques corporate, production-based temporalities that limit movement to only that which is forward. Neither the creative process nor our experience of affect and mental health is necessarily linear and rhythmic.

would never be that girl/woman/person again. I had to accept that I would struggle with manic depression, likely for the rest of my life, and decide how I would handle it and what I would do with it, how would I use it? Could it be turned into something possible? Or would it be an interrupting force forever? I had to realize that no one else can write our reality for us. As a result, I had to allow the process and embrace the chaos of a creative transformation that would be messy, sideways, cyclical, and wrought with frustration – much as an experience of trauma healing and struggling through depression or being manic is. In the neurotypical experience, life obeys a sort of linear progression most things, including affect, fits somewhere in the cubic dimensions of a ruler-like universe – if you can figure out the spatial alignment, then you can begin to determine the reason and order of things.

This has not been my experience. I experience mood changes at inconvenient times and have to learn to balance between a functioning, logical world, and a chaotic whirlwind of conflicting emotions that are often influenced by political and social circumstances I have no control over. For that reason, I show how limited theoretical debates and linear scholarships – written by the sane and regarding madness –truly are. The only real reality for the mad is experience – and it's something academia prefers abstracted. Yes, models of madness, yes theory, yes debates at conference, yes comments on sexual assault, yes awareness, yes purported support, but power allows diversity only within the certain limits: where it can be controlled.

What about the 'insanity' *I've/we've* consequently been *forced* to accept because something about me(us)– about my brain, my life, my actions and feelings – disturbs society's perceptions of reality and normality? What do the scholarly debates have to say

about how it *feels* to have your life, health, economic potential, and validity as a human being evaluated, devalued, and determined by either a doctor, a historian, or a sociologist (chances are – a male in a position of power)? With no chance of personal testimony? My power, or lack thereof, and the consequential struggle and resistance of my entire life has also been disparaged, dismissed, and degraded (as women often are) by a 'rational,' westernized, patriarchal system that views me as crazy, dysfunctional, hysterical: certainly 'less than.'

In the previous chapters, I briefly reviewed some of the 'madness,' 'mania,' and 'melancholia,' literature and argued against positivist tradition by "categorizing the categorizers" and using the tools of categorization and concept formation to show the limitations of positivist epistemologies. I've given a limited overview of the gender bias and violence in the psychiatric field and broken away from the models through narratives of sexual assault and the experience of breakdown and reduction in order to demonstrate the problematic of what the models, and a non-experience near perspective, ignores/loses/or limits. Positivist categorization cannot capture the negative, horrifying, and reifying effects of trauma and other stigmatizing life and identity disruptions.

In the following chapter, I use my experience of madness – dysthymic, hyperthymic, and euthymic – to demonstrate moments of the making of self, outside of linear models, through which possibility emerges, and pain, discomfort, and identity disruption open spaces for a self-conceptualization and identity reconstruction within moments of madness. These are mostly unedited presentations of clips from personal writings over the years as I've explored, experienced, and tried to understand what it means after sexual assault to have to live with manic depression, and to face the 'fact'

that I will be mad and mentally divergent for the rest of my life: that I will have to learn to face and conquer my greatest fears over and over again in different times, places, and circumstances – that my life will be a constant unmaking and remaking *and that there is possibility, hope, and empowering potential in this space*.

The first excerpt included below was written during a (possibly manic[15] transition period, in which I rewrote my life, quit an unhealthy job,[16] and took some time off to deeply explore myself. This healing and discovery period lasted quite a while. It was during and after I was diagnosed – after I was violated for the second time – and included the period of time in which I 'abstracted' myself from academia (was given a compassionate withdrawal). It was messy, scary, lonely, dysfunctional at times. At times, as I challenged myself, learned independence, travelled to foreign countries, and pushed myself to take on new challenges and learn how to reconstruct myself it could be poetic, free, rebellious, and beautifully mad. Despite the "shadows" in my past, I have come to look at that first post-assault breakdown and see it as both the worst time in my life and was also one of my first forms of self-activism (activism toward self-creation, determination, and active self-molding). I was questioning everything I knew; deeply

[15] When you regularly experience anxiety, depression, mania, and other conditions, it is sometimes empowering to know what "phase" you are in and sometimes restrictive – you risk falling into self-hatred and frustration if you try to rip apart pieces of your identity, as binary models sometimes do. It can be painful to try and separate all of your actions and decisions, to fall into the positivist trap that typologizes itself and seeks to categorize every decision or aspect of who you are into facets of "illness." This is a self-violence, one that the medical model often perpetuates.

[16] I was back working as a manager, several years later, at the same bar where I had been working when attacked the second time. This was clearly a mistake. I had taken a break from teaching and traveling and 'got stuck' – pulled back to a place, quite literally, of trauma, fear, and anxiety. I felt stagnant and surrounded by past injuries because I had physically and mentally returned to that place. The extremely late nights, negative memories, overtime, and lifestyle were detrimental to both physical and mental well-being. I was circumstantially depressed during this time period. I eventually quit and took some time off to write and figure out what I wanted to do. It was one of the best decisions I ever made.

introspective and fighting to understand both myself and gender-based violence. I was reconstructing myself, slowly. Testing out my new place-in-world as a recovering trauma victim and mad woman. Manic depression is characterized by a desire to discover – to uncover secrets of the universe. Often, manic phases present as an eagerness towards knowledge, experience, and/or adventure. They are not always negative or dangerous, terrifying, or un-useful experiences.

The medical model explains manic depression as a genetic and mental disorder, in which the brain does not work 'properly,' but there is still very little that is known about the different causal mechanisms and expressions (DSM 5; Goodwin & Jameson 2007). A social/cultural framework of madness might posit that the manic thirst represents a semi-psychotic passion for potential in the light of social injustice – the potential of political resistance, the potential of a new system, the potential of exploration and passion, the potential for change (note: this is my personal lens employed). Manic people are often swept up in a flight of ideas and imagination – they often also experience a deep depression over social circumstances. The experience can be disruptive, uncomfortable, dangerous, exhilarating, or frightening.

Manic depression presents differently for different people and is often unlike the way it is described medically. Mania, in my personal experience, has been both a liberating experiment in resisting autocratic, authoritative, patriarchal control and a terrifying chasm in which I cling desperately to the edge of sanity and struggle against a disquiet mind state. Acting differently – defiant, wild – and challenging the rules of how, what, and who we can or should be in society (especially as a woman) – is threatening to the social form and function of life. Manic depression is portrayed in certain ways by

both media and medicine, but I have yet to actually speak with or to someone else who experiences it. It is not homogeneous. It presents differently for different people at different times and in different ways. Some people retain control, or struggle for it, some do not, some expressions are harmless and exciting, some are bizarre and interesting, some are confusing, some creative, some destructive, some dangerously (and perhaps with cerebral/intellectual/exoteric possibilities we as of yet do not understand) tripping into the deep unknown of psychosis. Narratives of madness as a form of reclaiming agency and autonomy, of demanding epistemic justice and producing mad knowledge in the face of psychiatry would in themselves be disruptive to dominant sanist concepts and relationships between sanism, gender, race, capacity, and the nation-state (and of course, medical and social models).

Madness in its many forms is a deeply personal and individual experience. I expect that however it presents mania, as it has been for me, is an embodied form of boundary disruption, a way of putting much of what is in your mind to action, rebelling against controlled norms, expression that not only breaks social limits, but attempts to crack the walls of constructed and collective reality. Mania is/could possibly be a social structure resistance of the mind operationalized. Yet it is not always a chaos, a loss, or a dys-function. Unlike what is presented by the medical model, the presentations still reflect much of the person. Personality and character, individual ethic, desires, talents, past experience … amalgamate and stay deeply embedded behind any bipolar experience. Your character and personality do not 'disappear' in the madness – or they are, at the very least, reconstituted and reconstructed.

This is why I have chosen not to identify which of the following excerpts comes from which time. I do not demarcate the year in which they were written or where I was in the world (Africa, Korea, Vietnam, or on the Continental Divide Trail). It is difficult to pick out which of the following pieces were written during hyperthymia, euthymia, or dysthymia. These writings were chosen because they all thematically explore meanings of and the experience of 'madness.' However, they were written at different times and in different states of mind. They are not chronological or organized in any particular manner because the times in which these raw self-expressions pour forth are disorganized and 'unreasonable'. They read with similar tones and themes because they all came out of me. Insanity is not independent of prior identity, personhood, or voice. This is why madness is a deeply individual experience, influenced by a myriad of different factors – medical, social, political, cultural – including one's own personality, life experience, voice, and epistemological orientations. For that reason, the narrative provided cannot be generalized or extrapolated and applied to any grand theory. Nor can it explain what manic depression is like for all people, as the medical model attempts to do. It may not even be comprehensible. There are limitations with narrative and poetry just as there are limitations within positivist traditions. Although these feminist tools are active, reflexive, and self-aware, they can be dismissed as metaphoric or exaggerated because they are not static and because they are interpretive. This also is a risk that I must take because this story is not a collective story: it is not *the* story, it is merely *my* story, and yet will speak differently to different people according to *their* story. There is powerful possibility in the freedom of this fluidity.

Moments of Mania, Melancholia, and Making Myself

That which is human, cannot be foreign to me – Maya Angelou

At the end of it, I sat perched like a bird, balancing on my toes on the splintery wood of a thin broken-down balcony in Bisbee, Arizona, waiting on a meteor shower. I pursed my lips. I chased deep thoughts. I didn't panic - I waited. I laughed at the moon and barked like a crazy person into the silence, searching the sky for the showers. Loving the un-performance of being completely removed from society. Slightly manic, tediously depressed, but in that semi-functional way I've cultured through years of pushing myself: intense living, hectic traveling, upendingly stressful jobs, and self-determination. This particular time, I drowned myself in moonlight because I knew I needed another moment of the sad manic-depressive rolling on the ground clawing self-discovery if anything was ever going to change. Or if I was going to come out of this particular identity reconstruction alive. Times of 'seeing' had certain physical consequences for me. Colors changed, life came sharply into focus, the world blossomed. And then sometimes crashed. For tonight, I'd balance on my toes on rails and roofs under deep dark vehemently powerful night skies and feel more solid and more connected to my body, more within myself – yet also more in tune with what was outside myself – than when things were normal. When life was merely happening to you. I suppose I've felt disconnected from myself since my early twenties. It's some sort of epic battle, struggling to be and stay inside my own body. Instead of hovering over my own shoulder. Most of the time, life flies at me in unsynchronizeable patterns. Pitter patter splat! All at once, and my thoughts and interactions about this process are either named manic or depressed by others. I survive in a perpetual internal and external struggle, not of my making. A balance of chaos and order, pain and exultation, shadow and light and liminal places in between.

I thought it was interesting, because that crouching state, half in, half out reality-consciousness, being alone for a while, writing, connecting, meddling with your inner and outer self but somehow feeling you were in touch with something greater… The seething vulnerability bubbling all your damage up to the surface, while you boil down. Well it's everything that brings down showers of judgement, that ruins your credibility, makes you seem ill or strange or sad or messed up or (essentially) 'other'. Even if it's brave -and true - to face and seek yourself out like this, rather than shut yourself down. That was why I was here, *As above so below*. I hadn't struggled through so much pain just to crumple up and give in. It wasn't in me to give up, no matter the struggle. Africa, Korea, Vietnam, mountain peaks, beautiful relationships, living unafraid and bucking the system. All of that was in me. Also, loneliness, pain, disruption, confusion, anger, broken relationships, isolation and darkness. All of that was in me too. One thing I had learned however, was that when life inevitably dumped me into these places of deep cycling depression, I needed to be alone, because the cycles never happened purely on their own – it meant something, it was part of a greater process, a life transition, a being-in-world-womb, a struggling-to-come-forth, to be born again and again, to be remade, to find

answers, to explore deep recesses of self – to create something whole out of the pain of it, to take the liquid glass pieces of a fractured mind experience and mold it into something else, some kind of sunlit, colorful windowpane. I was slowly, oh so slowly, replacing the walls trauma had built up in me with transparency, and stained glass. I wouldn't let mania, depression, difference, pain, trauma and the threat of insanity keep me in pieces. I hadn't had a choice in becoming fractured, but I had choice in the reconstructing.

And so here I was, I perched on the edges of that wooden balcony and climbed to the roof and growled and fought with my inner self. I struggled up a mountainside barefoot with an old journal one night, in-praise-of-nature, scratched myself on bushes, rubbing soil into skin. Tasted the atmosphere and read my narrative out loud so I could see how my own story sounded on the wind. I broke down in the dust so that I could learn the magic of transformation – so I could learn how to change my own patterns. So that I could rewrite the story.

I also wondered if I had finally, actually gone insane. I wondered why that thought was relieving.

I contemplated the glory of those pretty, tucked-back-hard-scrubbed mountains. I thought about the way some things fight to survive, and some things don't. I wondered where I fell in that category. I hoped I was the former. I hoped this sea-change was a part of that fight. I had quit my bartending job to get back to myself and away from a shadow self. I was finally determined to go back to school, where I had always belonged, where I had also been badly burned. It had been ten years. And it was time to stop running away. So – what did I accomplish? I accomplished nothing at all, in that cabin, per se. Nothing came of it. There was no 'product' to deliver at the end. And yet…

That is what the manic-depressive struggle is about for me. A fight for my own agency. A struggle with a creative process that takes me deep down into the bowels of empathetic dissatisfaction and then up, up into a seeing-of-different-worlds. Throughout it all, I balance (I wonder if this emotional mind balancing act influences my outward actions, if it is the reason I like to balance in treetops and on roofs) on the edges of my own mind, I balance between the grave of depression, the ground of reality, and the sky of creative, occasionally overwhelming and untethered, imagination.

Why have I spent so much time trying to force my mind into my head?
Trying to squeeze my soul cleanly into body?

I will never be traditional because it is not in me to be so. I wish my defection from the acceptable – what others can stomach – didn't offend, so inevitably, those who have never defected. Yet do I not have the same right to refuse reason as most seem to find to acquiesce? Here I am! Like it or be afraid. But you should be afraid.

Perhaps I am too honest, not wanting to be alone in the pissant/puissant break point
questioning of self.
but what do I know?
I wear no shoes and rub the bark off the branches of the trees I dance upon at midnight,
knowing this madness is nothing but a pretty note
engrained in the music that plays in my head.
My body trembles and I scrape/run/bleed/scream/break fingernails and enjoy
my wildness,
wishing society could too, and I needn't be outcast.

I live in love songs and poetry. I roll into the seeing place," ignore speeches clenched out by doctors and stiffs because the vast internal expanse, existing, trapped, within the human anatomy is impossible to force out of small openings. A mouth is a pen is a keyboard is a tool, that is an inept translator, operating clumsily. We are all the proprietors of our own rag and bone shops of the heart.

(Me to myself, talking to a clock)
Tick tick tick: Are you really going to do this?
Yes!
Tick Tick: Really?
Yes!
Tick: why?
Because I have no more time! I give up on time! I want to live without time, and then die without it too!
Tick, tick: what will you do?
Something crazy!
I'll move myself into my head, then outside my body.
Take months.
Take Eons.
Write self.
Write people.
Write time out of reality.
Make my own Eons!
Become a poem, become a song, become magic –
Defy You! Break down your categories!
As you keep ticking out your demands.
I will take your cadence and make it my own.

Most of the world wants to be
coked out, drugged out, or buzzed out
To oblivion
Five seconds of riding pink ponies
To hide from ourselves,
or convince ourselves we're alive.

There is no truth
In the high fly
Flip flop creation
Of pleading the fifth
What is gained in hiding from self?

What are you supposed to do, when the three strangers appear?
When they manipulate your life to motivate your path?
When the questions and answer intermingle in a fucked up, semi-circle
Perpetuating you into murphy's un-aerodynamic law?
When life becomes unlinear,
And everything you ever thought was real or true or solid –
Disappears.
What do you do when you are doomed to each of the three guests?
Who always shatter you, shatter you down
What do you do when your life is a triangular mess of fighting between heaven and hell
Love and hate, redemption and rebellion
When you ping pong slap face fuck shit cry and bounce
Trying to find yourself in the chaos

A bright star dispute
The breaking of golden ratio moments
Crescendos in the 17th ballad
A love story of death and the woman chokingly trying to live
But how do you make love stay?
She recites the words, standing on a matchstick
In a world operated through two switches
Called Hysteria or Stupor
Either whom to love or how
The twin operators, manic and melancholy, flipping coins
Named un-being and sub-being
(or is it his being or not even one being?)
Only ever and always a 3-body problem

Victory is an elemental madness, a voice in the dark, reminding me that everything I see and hear, that isn't understood, or crazy, frightening, different – like the voices I hear in my head late at night – can either be feared or celebrated. I listen, the voice is behind music, beautiful, frantic, tortured, fractured, strong. It's joined by others, a murmuring symphony. Open, they say, take flight. I can barely make out the words "or simple or complex … the lost … reclaim yourself … here you are … all of us at some point (laughter) are called insane… that's a social opinion." I wonder if I'm asleep dreaming or awake dreaming (sometimes called psychosis). I wonder if it is my voice, or something else, something more. Or, perhaps, my brain is dysfunctional. But Victory is a voice that tells you to overcome. And so I stay in my body, associate rather than dissociate, maintain grip. But also, listen – listen, listen, listen to that victory chant, telling me … to astound myself!

These stories are often told in
separated whispers, attributed to madness
I can feel myself, in this moment, deciding whether to be uncareful
But how does one resist
This specific rearranging of soul?

I feel myself deeply sometimes, of a morning, reappearing and disappearing through the fragments of my mind.

My inner being is torn between two planes. There are times when I can feel whispers of something else touching me, like a dream, as I rotate above myself, or fly outwards in pieces, trying to find something. It was never something I can explain, especially to my own logic. When I try to capture even the description of how that being-in-other-spaces feels, it trips laughingly away. Every moment that being-in-other-spaces happens I, ironically, somehow feel my body-self, my physicality, in a brief moment of holistic contact with spirit … with that me that usually exists in a semi-disconnection from the tangible – like pulling shattered pieces back together for a brief, electric moment of wholeness in another reality. For a brief second, I suddenly fully exist somewhere, I can be within myself: feel that eternal entity breathe through my lungs, stretch my fingers, shine through my eyes. I'd sit in-mind-in-awe of the recognition of my flesh as a great poetry. When I feel myself smash into myself in the ether, the subconscious, the mind divine. It's an insanity perhaps, or perhaps it's a process of self-dissolution and self-resolution, happening within.

Can you see? Are you awake?

Do you notice how many poems and moments of expanded awareness hang on a twig
that goes mostly unseen in suburbia?

I love speaking with trees – not fluently, not aloud – but in the spreading of my toes against bark, in the feathered touch of fingers on limb and twig and leaf frond. In my angry interruption of stoic peace and place as I climb, limber and aggressive, to tantalize and challenge the strength of branch in a shaking glory of disturbance and nonconformity.

There are days of deep tornado holisticism … In which the energy swirls out of my DNA. Inward issues expanding. One time, two times, slanting towards three. Double up or double under. Fall, fall, crash, bang, be. Either down or up, but always upside down.

ABCD … plus EFGH …
with so many parameters, they ask me to put
so much of myself
into so many little spaces.

the thing that tore at me then
was the living, writhing pain of 'otherness'
It seemed there was something about me
that must be subjugated, crushed, and domesticated.

My head is trying to kill me.
It's laughing-bed-down-hysteric. It's tripping along brain path firings, lighting 'em up, light 'em up!
It's ember twitching, oxygen seeking acrobatic flips down my spine,
nerve flare
(flare!)
fall jump, ignite – it's spine-on-fire physical discomfort. Like a wild thing embodied, causing havoc not only in thought, but in all the extrapolations of brain function.

When these unmanageable ideas jump into your soul to disrupt you,
when your soul jumps into your mind to disrupt you,

you either writhe and listen, try to translate it –
or check into a mad house and get tranquilized.

I mean, how do you win in a war against yourself?

CHAPTER 5

MADNESS AS RESISTANCE

The ill person who turns illness into story transforms fate into experience

– Arthur Frank

Overturning Illness Identity and Self Stigma

> Illness and disease are distinctive categories.
>
> In academic discourses, 'disease' typically refers to a pathological entity in the abstract – disembodied, as it were, rather than as experienced by any particular person. Polio is a disease, as is cancer. In contrast, 'illness' refers to a particular person's experience of a disease: its various effects on the person's identity (Couser 2015).

This distinction is important in differentiating disabling phenomenon from medical nosology. Where the medical model focuses on the distinctive pathological entities causing one to be sick, illness and trauma lenses focus on the experiences of the individual in relation to self and to the world. Ill people may experience disability and vice versa in ways that have little to do with sickness. I discuss the unique experience of illness and its relationship to disability in the following section in order to communicate how illness and trauma – specifically mental illness and sexual trauma – can influence one's sense of self, one's relationships with others, and one's relationship with society. I speak as someone who is identified by others as ill because of my struggles with manic depression. Illness, for me, is episodic much as my manic depression is episodic; there are times when struggles with depression and trauma recovery disable me and make me ill and others where it does not. Because of this, I consider my manic depression to sometimes express as an illness, sometimes as a disability, and sometimes as diversity, always as an aftermath of trauma, but not necessarily as a disease. In each of these

expressions there exists a radical possibility for self-reconstruction: illness upends identity, disability requires self-reconstruction, and diversity encourages me to reclaim my place and self-agency in the world as someone with something unique to say, someone with voice and place and wholeness, albeit reconstituted.

Illness is a fracturing experience that upends identity, twists perceptions of self, and has the power to radically disturb pictures and plans of/for the future (Hyden 1997; Frank 1995; Yanos et al 2010). Illness may be corporeal, spiritual, emotional, or mental but influences all of the aspects of personhood no matter origin. Illness is marked by suffering and a lack of control. Often, illness – or the way an ill person is related to – threatens autonomy. Ill people are spoken about or to (much as I am doing now) through mediums of doctors, loved ones, psychiatrists, therapists, or society. Illness, dys-function, dis-ease, and dis-ablement are diagnosed, decided, and treated *by others*. This is a reductive practice. Ill people, I/she/he/they/we, are conceptualized and may begin to conceptualize themselves as victims, patients, subjects, sick, different, excluded, and/or other. We are considered, and forced to consider ourselves, as passive entities whose futures, health, capabilities, and value are/is dictated for us.

Clinicalizing and medicalizing illness, or banishing the voices of the ill from discussions of illness (as necessary as it may be for determining and operationalizing treatment) is also a reductive practice. When you are forced to experience a form of attack, whether from disease, physical assault, or brain and body disjointedness, you also experience an attack on core identity that ranges from your sense of self to your place in the world (Yanos et al 2010). Illness is not merely a pathological disease that can be cured, it is the experience of the disease. Illness always involves suffering and

diminishment: a forced facing of both self and public stigmas of inadequacy, incompetence, and lessened wholeness. Illness brings to the foreground an inability to ignore life's contingencies (Frank 1995). This form of difference and diminishment inflicts suffering, it is in itself a wounding entity created out of a wounding. The mind-body-self both incorporeal and corporeal is affected. According to sociologist Arthur Frank, suffering occurs and is sustained through disruptions that threaten "the very intactness of a person … [whether] immediate or imminent, real or perceived." Suffering is a "threat of disintegration" (169-170) that is both personal and social because it is manipulated by the reactions, interactions, and dictations of one's external world. After all, "Bodies [minds] and selves are … culturally elaborated" (Frank 1995, 170; Vickens 2012).

Illness is deconstructive as trauma is deconstructive. It breaks down the body and the mind. It interrupts the "lived flow of experience" (Frank 1995, 170; see also Hyden 1997). It is a "process of [identity] dismemberment and fragmentation, of seeing that self or the situations you're embroiled with differently." It is also a place of potential - albeit a dangerous one, this tottering on edges of vulnerability and loss of control, under threat, being forced into depths of loss of fear and anger that wasn't your fault, but also being given opportunity for resistance. Dangerous spaces are "a symbol for reconstruction and reframing, one that allows for putting the pieces together in a new way … an ongoing process of making and unmaking. [Where] There is never any resolution, just the process of healing" and deciding how to heal (Anzaldúa 2015, 19-20; Frank 1995). This place of unmaking and remaking, of dangerous possibility and potential, is a tension between the limitations of illness and the potential of self-recreation and conceptual control. You

cannot will away illness; being disrupted into chaos may be out of your control. The question then is, can you/I/we/they learn to live in a place of fluctuating identity in which anchored definitions of who you/I/we/they are can be abandoned to make room for the inevitable fluctuations of disruptiveness. Can it become a place not only of confusion and chaos, but of agentic rebellion and reestablishing autonomy? Can we move beyond illness: or in illness, make meaning?

Understanding Madness as Diversity

Psychiatric knowledge is hegemonic. Psychiatry controls the 'truth' of mental 'disorder' and suppresses the voice of those it maintains control over. While psychotherapy and medication can be incredibly helpful for some – and have saved lives – they promote a homogeneous sanist assumption of wellness that assigns illness to people of neurological difference without consent. The medical and social models are both based in a sanist perspective in which mental difference is something to be feared, something other, and something that needs correcting. Mentally 'ill' people are then limited to the role of the subject, the patient, or the victim of social circumstance without recourse for autonomous self-conceptualization. While mental differences and manic-depressive syndromes can present in ways that are alienating, disruptive, and disabling, they are also spaces of possibility, often linked to creativity, and sources of struggle through which activism, art, and victory can be embraced. According to the World Health Organization, there are over 450 million people who experience one or more forms of persistent mental health issue – 60 million of whom are considered bipolar. Social and economic environments "themselves become restrictive [for neurodivergent people] when they match the mental template of normality" because they support "a litany of

deprivations, injustices, and inequalities psychiatrized 'Others' within predominantly 'sane' cultures face" (Procknow 2017, 6). Psychiatric power structures promote sanism by treating madness as an inherent illness and disability in relation to the sane rather than a natural neurodiversity that has existed for thousands of years and is a valid knowledge producing category, albeit a minority one.

> Sanism is 'more troubling … [and] insidious' than other 'isms' because it's practiced recurrently, (un)consciously, by those whom assume a progressive posture, and denounce similar injustices involving racialized, gendered, and (de)classed minorities. Sanism subsists through society's tolerance [and promotion] of it" (Procknow 2017, 6).

Madness certainly has genetic and social causes, it needs to be navigated and supported, and can be challenging to live with in a sane dominant culture that suppresses and stigmatizes the experiences and voices of the mad. Incorporating mad voice and privileging mad knowledge corrects sanist and psychiatric 'truths' of mental difference as inherently ill and allows for different expressions to come to light, also spotlighting trauma and psychological damage that may underlie negative or destructive expressions of madness. Understanding madness as minority population and mental diversity creates space for the creative expression and social, political, and institutional resistance of the mad to gain platform.

Exploring the lived experience of psychic pain and neurodiversity as well as the ill or disabling moments of madness engages an activist lens towards empowerment, in which mad peoples are seen as equal despite the differences of their experiences. Stigma, misunderstanding, and lack of support and inclusion – the suppression and viciousness experienced by the mad at the hands of society – may very well cause or at least

exacerbate ill, violent,[17] impaired, or aberrant presentations. Transforming conceptualizations of madness from illness to diversity dismantles the neurotypical and psychiatric assertion of mad people as diseased, unhinged, unstable, and hysterical and begins work to disrupt the violence that unchecked psychiatric power [18]over 'mad knowledge' has wrought.

Mental health issues can be particularly disorienting, presenting sometimes as illness, as disability, and as neurodiversity and resistance. It represents a thrust into ambiguity, a betrayal of your brain rather than your body, an unknowing of relationship-to-others-reality. It is frightening in its looming menace of possible psychosis, complete self-loss, or incapacitation. However, it can also represent a form of social resistance, and be an expression of social resistance and neurodivergence/neurodiversity. It is, in my experience:

confusing/disturbing/elating/challenging/terrifying/painful/seductive/exhilarating … also alienating, chaotic, and a place of creative potential.

The most severe and debilitating presentations of my manic depression have been during points of trauma and struggle in which the social response and my own negative self-conceptualization of madness meant that I was "messed up, sick, incapable, invalid, and worthless" affected my symptoms, coping mechanisms, and help-seeking. Identity becomes muddled in the initiation of madness, or it is at least forced to stay fluid and be

[17] It is important to note that violent expression is not token of mental health issues. Sanism, much like ableism, creates false social stereotypes of 'othered' peoples. Sanism often advances and spotlights the stories of frightful, violent, deviant, and destructive mad people and suppresses those of the successful, kind, intelligent, creative, or active.

[18] Until recently, homosexuality, transgender identity, and other categories of 'difference' that disrupted social norms were considered mental illnesses and were diagnosed, medicated, psychiatrized in violent manners, and banished to the mad house when they couldn't be 'cured' (Chesler 2005; Gilman 2014; Procknow 2017)

constantly reassembled. As a result, my personal power of self-creation plays a role in whether my episodic fluctuations of hypothymia and dysthymia are disabling or transformative. In manic depressive and schizoaffective disorders, alterations in mood, emotion, and affect are fluctuating, thus constructions of self are constantly subject to change just as the expressions of depression, mania, and psychosis are subject to change Yanos et al 2010). It is possible that any chronic illness taps into this fluidity and those affected are forced to come to terms with a constant unmaking and making of self. How much of you is you, how much your affective or affecting dis-order? The lines blur as your conceptualization of self is constantly forced to evolve and old identities of pre-illness or pre-trauma (or even last year's illness, madness, or disease presentation) are unmade. Are you defined by this different and constant state of being and unbeing, in and out of several worlds? Or do you retain your own power of self-definition? Is your changing relationship to self a symptom? Is it the result? An inevitable conclusion? Or is it choice? Do you have a choice? And if so, how can you learn to understand your difference in a way that creates and empowered future?

Recovery from illness and the remaking of the unwell self into the empowered self is "an inherently personal, subjective and self-defined process" that is powerfully influenced by one's illness identity. Illness identity – "the set of roles and attitudes that a person has developed about him or herself in relation to his or her understanding of mental illness" – is an "aspect of one's experience of oneself that is affected by both experience of objective aspects of illness as well as by how each individual person makes meaning of the 'illness'" (Yanos et al 2010, 74-75; see also Cheng et al 2018; Frank 1995). Identities are constantly deconstructed, reconfigured, and reassembled. For the ill,

the disabled, and the mentally divergent, "the reconstruction of one's own life story is of central importance" (Hyden 1997, 51). Self-story telling – a narrative form of rewriting identity – allows people to "shape and give voice to their suffering… Narratives not only articulate suffering but also give the sufferer a voice for articulating the illness [or mental disorder] experience apart from how illnesses [and mental disorders] are conceived and represented by bio-medicine" and society (Hyden 1997, 51; see also Anzaldúa 2015; Simplican 2017). It gives voice to suffering and illness or 'othered' experience as a "point of departure" (52) and disruption from which the self must be recreated. Because mental illnesses and chronic illnesses are constant life companions and do not see "resolution," those who suffer from and engage with them must "continually produce new narratives in new contexts." Chronic experiences of disruptive entities such as illness and madness

> usually changes the very foundation of our lives because the illness creates new and qualitatively different life conditions. Our range of options no longer seems so wide and varied, we may be forced to look at the future from a totally different angle. Thus, even the past acquires new meaning: as part of a lived life (Hyden 1997, 52).

Narratives give voice to voicelessness and are an enactment of personal agency by those whose stories and self-determination have been lost or taken from them. For those like me who experience mental divergence and disruption – whether from genetics, trauma, social circumstances, or an amalgamation of these – writing experience is a way of writing the self back into an experience from which the self, or the previous self, has experienced exit or destruction. It allows for the exploration of one's own meaning making and self-stigma and provides the opportunity to reject and recreate understandings of self as a being-in-world. Narratives allow people struggling after

diagnosis to investigate questions about their life experiences and the integration of their 'illness' or difference into their identity. For instance, "does the illness … mean they are a weak person? Is it just another barrier to overcome [full of possibility]? Does the illness have no personal meaning or does it mean the end of previous dreams" (Yanos et al 2010, 76)? Can illness identity be conceptualized and accepted in a way that allows for the creation of an empowered future?

"Illness can be experienced as a more or less external event that has intruded upon an ongoing life process. At first, the illness may seem to lack all connection with earlier events, and thus ruptures our sense of temporal continuity … if the rupture is not mended, the fabric of our lives may be ripped to shreds" (Hyden 1997, 52). When I was first diagnosed, I couldn't figure out if it was because my actions were not socially acceptable,[19] or if I really was sick, if it was because I had been raped – which seemed overwhelmingly unfair – or if it was an inevitability that had always resided in my DNA. I was, absolutely, suffering, but was I chronically ill? Mentally disordered? A person of diminished capacities? Struggling with the self-loathing, guilt, and trauma of assault at the same time as discovering I might be 'insane' was excruciating. Everything I knew or believed about myself split open and fell apart. The pain was overwhelming. It was a chasm inside me that seemed infinite and I don't know how to describe in words that

[19] He was an older male doctor who went to church with my parents, a traditionalist, conservative, and religious – this does not negate his diagnosis or impinge on his ability to diagnose, necessarily. However, the solutions were religious and patriarchal. I was still as a supplicating lost girl who needed fixing via repentance, not someone who needed voice and recognition for the injustices I had and would continue to experience – those that marginalized groups experience daily that are violent and oppressive. I probably needed therapy, but more than that I needed JUSTICE. I needed to know that I was not helpless yet the solutions I was being given revolved around embracing helplessness, disowning my 'erratic behaviors,' and once again, bowing down without any grain of salt.

won't cheapen it. People who have suffered trauma and deep depression, as well as both violent and non-violent oppressions, othering, and psychic pain will understand this.

There is no explaining the kind of anguish and affect that is both choking and numb, a feeling and a non-feeling, a heaviness and an emptiness, an anger so desperate it vacillates between eruption and the most dangerously stifling kind of acquiescence. I won't talk about the details of all the circumstances that coalesced to disrupt me. Because I'm more personally interested in what it was that took me from that place, full of self-loathing, abused psychology, and a manic depression that was, at that time, expressing as illness and disability, into something different. How did, and does, my illness identity transform from a 'being ill' to a 'living with illness' to a resisting of labeling of illness in favor of a self-love that views manic depression as neurodiversity and has helped make me into who I am today by providing challenges to overcome and possibilities for resistance, strength, and self-exploration.

How have I and do I continue to come into a cogeneration with society in which I keep myself to myself but am also unafraid of the labels given to me and can find ways to reclaim them and understand them as my own? How do I be medically bipolar, historically mad, socially manic depressive/ill, mentally ill, socially disabled, neurologically diverse and personally all of these things at the same time and so much more? I begin by understanding that I have a say in my identity. I begin by writing. I begin by speaking. I begin by claiming voice and giving voice to my experience. I become my own narrator, at times unreliable, hesitant, unsure; at others angry, damaged, righteous; at others manic, melancholic, incapacitated, struggling; at others, aware, seeing, in control, capable, successful, determined, and full-throated (with spilling forth

self-creations, rather than forced ingestions). I embrace the disparate parts of being. I gather each piece. I live each shard and do not dispel them. I no longer try to make a congruent picture. Somedays I let myself fall into fragmentation; in pieces and

Somedays
I take all the broken bits of you
and the jagged pieces of me
and fit them together
into stained-glass moments
I can hold in my hands

Over the years, I have developed active rather than avoidant coping mechanisms. Mostly, I write myself. Writing – poetry and essays, novels and memoirs and the whole expressive, processing therapy of it – has saved my life, allowed me "to dispel the myth that I am a mad prophet or a poor suffering soul. To convince myself that I am worthy and that what I have to say is not a pile of shit" (Anzaldúa, 1981). Through writing and rewriting my identity, I *am* able to leave the injured and self-loathing place, although I am still wounded. Wounds become part of you. They heal slowly, and rarely ever fully, and if so with scars. Wounds are deep, penetrating all places of self. You incorporate wounds. And because you must incorporate them, wounds carry potential for an evolution in self-definition, negative or positive. They carry the possibility for self-exploration in those deep dark places; "to understand our complicity and responsibility [in the making of self] we must look at the shadow" (Anzaldúa 2015, 10) and begin to start

becoming aware that I am vast,
that I am multitudes
that I am the glorious chaos interrupting sounds
and furies
and sedulous construction
embracing vortex sutras

fighting fear
mongering not after destruction
but an expansive evolution
walk forward, back, don't step on cracks
hop fences, climb trees,
walk again … no! stumble
fall incoherent, pick up again, gather pieces,
incorporating wounds, not injury
find power in the directing of self

Injury is temporal. It is the active surface of a wound. Or perhaps a moment of experience in and of itself. It is the immediate, responding part. It is the reaction, the redness, the sore and the scab. I moved past the temporal effects of sexual assault and bipolarity. I moved on and stitched up the surface parts – my expressions of the wound changed as the wound changed me and forced me to learn how to be my own healing. With the change in wound expression, began possibility. I defied the diagnoses. Rather than *yes, yes, destroyed, yes mad, yes broken, yes less* I said, *maybe, maybe mad, maybe unhinged, so* why not lean into the possibility of madness? For me, being a mad person means that I face fear and dark places regularly, and I do not look away. It means I must learn the power of self-control, self-construction, self-determination (this is the magic of transformation) and both refuse and embrace them in measures. It is a balancing act. It means living with my greatest fears of self on a daily basis and learning to overcome and even embrace them. It means learning how to define myself in the face of oppressive knowledges that seek to categorize me as less then, ill, insane, incapable, and impaired. Through my relationship with madness, I have learned how to challenge myself and defy expectations. Would I have moved to Africa? Would I have successfully navigated life in foreign countries on my own determined to prove that mania and depression do not need to be crippling disruptions? Would I have hiked 3,000 miles across the United States to

document its beauty in poetry and rewrite my identity under Rocky Mountain skies? Would I have begun to understand that, rather than incapacitated:

"I too am not a bit tamed"
Untranslatable
I run against the world
Among trees and valleys, spirits untouched
untapped, unappreciated
Yet steadfast in their chaos of ultimate being
I too court the beast
Indelible
Follow it, the wild, the call
into echoes of canyons
Scathing heights of passion
Terrifying glory
Icy, snowcapped mountains
Threatening
in their promises of freedom
And death. The heightened fear of it
In that raw somewhere
of the in between place where you
Where I
Where we
Could find the self in
walking, pushing, camping, freezing, fucking, eating, bleeding, being
The place where the wild nature of opposites
finally comes to balance
in the mind
I, and perhaps you too, are not a bit tamed

Would I have returned to school, the same school to which so much of my past damage is tied, to exit, a new self, with triumph rather than shame? Is my madness a disability or has it become the conduit for a determined strength? If you tell me I am, and always will be unhinged – well then! I will push into and against this idea of unhinged. I will unpack it. Unhinged - this sound and trap, the rolling openness and then – snap! – the closing in the very sound of it. Rather than run from it, I will wonder what I should do with it, how I should respond. Whether I should ignore and reject it, or perhaps touch it,

roll it around and look for myself there. Unhinged is reminiscent of – of what? Chaos I suppose. Of the mythical feminine. Of buttons undone and mechanisms unoiled, of presumed incompetence[20] and becoming uncoiled. Unhinged things are aberrations, dangerously out of cog. Disruptive, ruining; a threat to the normative machine. When things become unhinged, something is sure to happen because they are metaphorically kinetic, full of possibility, non-submissive. To be unhinged is to not subscribe to the reality that society dictates for you. It is to find yourself in ungiven, lovely insides as well as in combustion seeking. It is to be unafraid to break your own ropes and think critically of that which is determined for you by others, to constantly ask of predetermined constructions of the other by a social standard:

[20] This phrase is taken from *Presumed Incompetent: the Intersection of Race and Class for Women in Academia* (2012) and an excellent compilation of texts dealing with the lived experience of navigating academy and life while dealing with intersecting daily oppressions and the challenges that arise as a result.

Are you …
All vast?
All multitudes?
(Do you think yourself the only Whitman)

Do not I, in I
be also
rough,
simple, complex,
angry, temperamental,
competitive,
refractive,
retroactive,
peaceful, peaceful,
dangerous.

Oh! So very dangerous!
To celebrate those minds that can burn-rain-bleed-break-swell-come-breathe-break
REINVENT
all in one instant

be still too,
or want to be still,
or desire stillness
or become stillness
or see that stillness erupts
or see that stillness is
a chaos,
inchoate/matured.

Why do you feel you should be feared?
when there is
no fear in me
at all

You will not destroy me
for
I, in I
will welcome YOUR destruction
I will cause and release it to completion

I will push my climbing spikes into every inch of you
until,
eureka!
I/will/be/you/being/me/what/will/we/be/come?

An undoing.
of course!
(inevitable!)
Are you so afraid of being undone?
(I know you are)

Did you never scrape yourself on bark dirt dust, play sticks, lick branches and enjoy it?
Do you not yet know that life and death are one?
- won by losing -

This war is a game I will always lose.
in you,
when
I,

in
burn-hurt
blood-giving,
fall from limbs,
break, shatter bones,
risk all,
give all,
climb forth,
consumingly rise
constantly.

to ecstasy
to eternity
to consummation
to seek-and-ride-and-crave
the towering mystery.

I wonder how many times one can kill themselves by dancing with madness.
How many times have I - can I - die and come again?
Incalculable!

How many deaths and resurrections will you provide?

I/push/in/to/me/to/find/out
I/push/inside/of/me/to/find/out
I/push/outside/myself/to/find/out

Too often, “we perceive the version of reality that our culture communicates” (Anzaldúa, 1987). “Our cultures induct us into the semi-trance state of ordinary consciousness, into being in agreement with the people around us, into believing that this is the way things are. It is extremely difficult to shift out of this trance” (Anzaldúa 2015, 7). To shift out of this trance:

Let us go there, you and I

to the temple place
to the release of life
where each moment
becomes a heavy world
Full of backstories

and every identity
on the trees of our balcony
is sunkissed and celebrated
as we go into spaces of seeing
rather than hiding

Change our dynamics,
navigate the possibilities of being
imbibe of life
within our broken spaces

become endless entities
watch stars rise
and smash our creations into our hands

inspect our particles
against sunbaked fingers
watch the freckles of resistance rise
against odds and sunscreen

sit in the light of the day
and feel the glory of reinventions
encapsulated in gold wrapped prime times
warm beer and early morning bird song
Let's feel this life, you and I,

our merging selves
in our rare moments of togetherness
in the places where power falls away
and the world heaves and takes
and spits us
into being uncoupled, uncurbed, unhinged

learn how to rise, and rise, and rise forever.

Madness provides this opportunity: to navigate reality differently and dismantle the dominant cultures conceptions (medical, historic, social) of the way things are, the way things must be, and where our place in the world is.

I make myself become a leaf on a tree
A long frond
A forget-me-not
A moment of mango pineapple remembrance
A place in time and being among cityscapes
I breathe into this
Feel my soul licking the seconds
Dry skin on concrete
And chlorine hair
I know madness is also here with me
Dancing numbered freedom steps in my head
Breaking the moments
And making the self grow
And glisten with the sunlight

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APPENDIX A

SEXUAL ASSAULT & GBV STATISTICS

According to the United Nations: (information taken directly from UN WOMEN and UN websites)

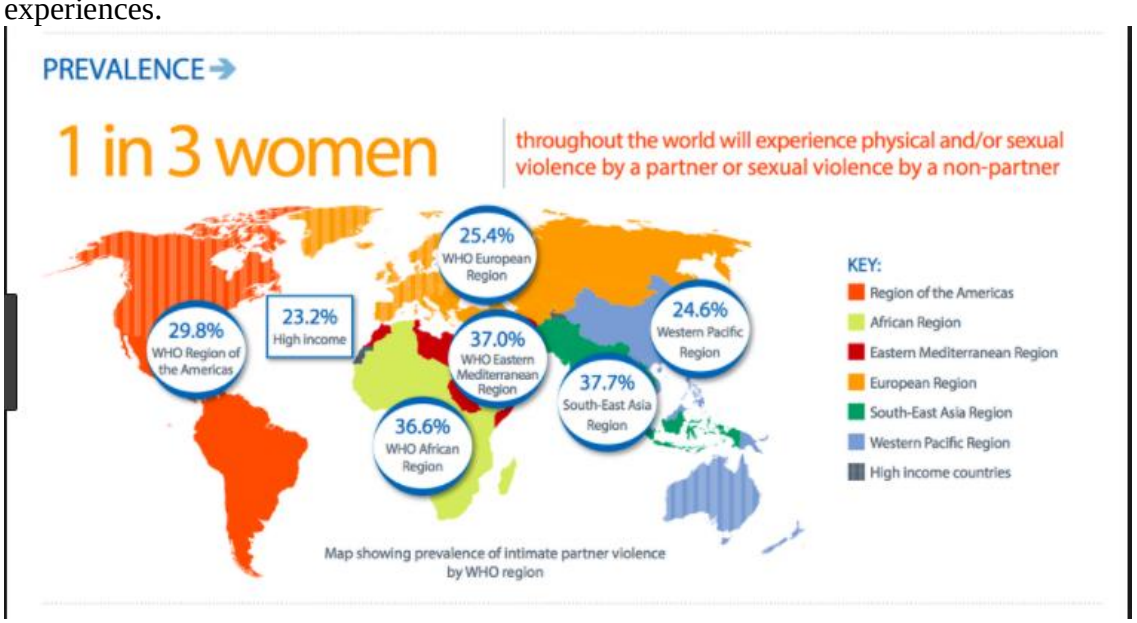
> Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys.

Violence against women is a worldwide phenomenon – one of the "most systematic and widespread human rights violations" (UN WOMEN) – affecting millions of women and often perpetrated within relationship or by someone known to the person, or as a weapon of conflict and war. According to the UN WOMEN, an estimated 35% of women worldwide experience some form of sexual violence in their lifetime with national studies showing upwards of 70 percent.

In the United States, at least 23% of female undergraduate students reported experiencing sexual assault and sexual misconduct in 2015 – it is believed that rates of reporting only reflect five to 28% of actual incidences.

In the United States, an American is sexually assaulted every 98 seconds (RAINN). Women are more prone to sexually based violence and 90% of adult rape victims are women. Shockingly, one out of every six American women has been the victim of either an attempted of completed rape in her lifetime. Transgender students are also at a particularly higher risk of experiencing sexual violence – 21% of transgender, genderqueer, or nonconforming students have been sexually assaulted.

Many studies believe that rape and sexual assault are severely underreported due to stigma, threat of violence, sexual violence illiteracy, or the domestic nature of many GBV experiences.



TRAUMA AND MENTAL HEALTH

(These statistics/ the information below was taken directly from the Research Highlights of the Domestic Violence and Mental Health Policy Initiative Fact Sheet Chicago)

"Lifetime experiences of abuse and violence are common among women seen in mental health settings.

• Of 140 women attending an outpatient psychiatric clinic, 64% had a lifetime history of physical and/or sexual abuse (Surrey et al, 1990).

• Among 153 women seen in a range of psychiatric settings, half had been sexually abused and 16% had been physically assaulted as children (Mueser et al, 1998). As adults, 64% had been sexually assaulted, 36% had been physically attacked, and 24% had witnessed severe violence.

• Out of 303 depressed women culled from a large random sample, 63% had experienced abuse at some point in their life (Scholle et al, 1998). 55% reported having been abused in adulthood by "a family member or someone they knew well, such as a boyfriend."

Experiences of abuse and violence are especially high for women diagnosed with serious mental illness (SMI).

• Out of 39 adult female clients in an intensive psychiatric case management program, 59% had been sexually abused and 62% had been physically abused as children and/or adults (Rose, Peabody, & Stratigeas, 1991).

• In a sample of 123 female patients on a psychiatric inpatient unit, 53% had a lifetime history of abuse (Carmen et al 1984).

• Although not explicitly identifying the perpetrator, another study found that of the 64% of female inpatients who had been physically assaulted as adults, 56% shared a home with the perpetrator (Jacobson and Richardson 1987).

• In one study with 66 female psychiatric inpatients, 44% had experienced physical assault as an adult (Bryer et al 1987). Of those, 59% had been assaulted by an intimate partner.

• Out of 93 women seen in a psychiatric emergency room, approximately half had been physically and/or sexually abused as children, 42% had been abused by a partner in adulthood, and 37% had experienced an attempted or completed rape (Briere et al, 1997).

• In a study of 69 inpatients (male and female) who had ongoing relationships with partners or family members, 63% reported a history of physical victimization by a partner and 46% reported physical abuse by a family member (Cascardi et al., 1996). Twenty-nine percent had experienced domestic abuse within the past year. Abuse rates are even higher among homeless women with serious mental illness. In a study with 99 episodically homeless women with SMI, Goodman et al (1995) found that significant numbers had been physically (70%) or sexually (30.4%) Domestic Violence and Mental Health Policy Initiative Domestic Violence, Mental Health and Trauma Research Highlights abused by a partner. Rates of physical or sexual abuse in adulthood by any perpetrator were 87% and 76%, respectively." (Warshaw & Barnes, 2003).

APPENDIX B

MENTAL HEALTH FACTS

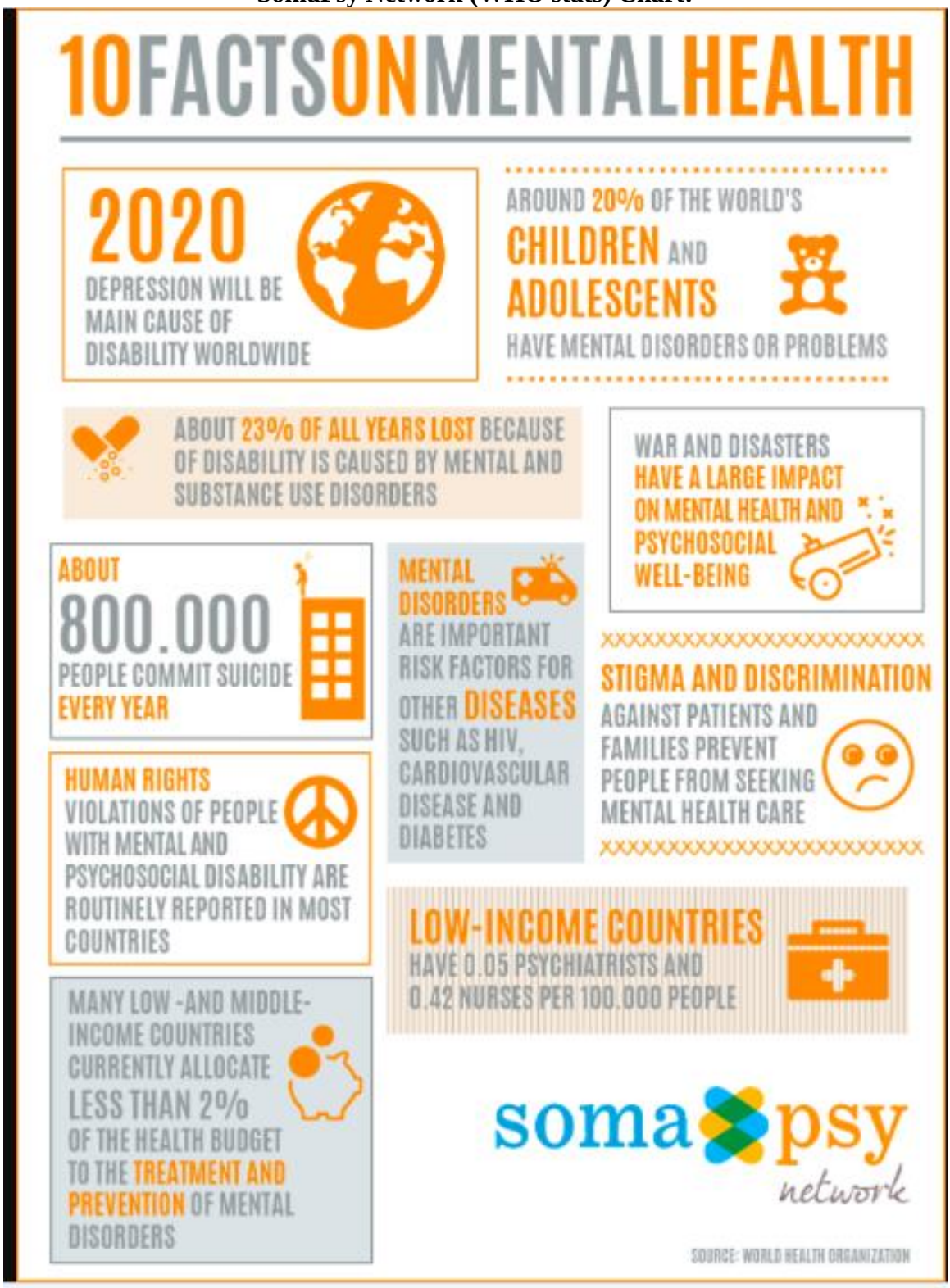
MENTAL HEALTH MYTHS AND FACTS
(Information taken directly from MentalHealth.gov)

- **Myth:** Mental health problems don't affect me
    - **Fact:** Mental health problems are very common. In 2014 one in five American adults suffered from a mental health issue, one in 10 young people experienced a severe period of depression, and one in 25 Americans were currently living with a severe (disruptive) mental health issue such as schizophrenia, bipolar disorder, or major depression
    - (Approx. 4.8 million adults experience mental illness in a given year, according to NAMI)

- **Myth:** People with mental health problems are violent and unpredictable.
    - **Fact:** The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health problem and don't even realize it, because many people with mental health problems are highly active and productive members of our communities.
- **Myth:** People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job.
    - **Fact:** People with mental health problems are just as productive as other employees. Employees who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.
- **Myth:** Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.
    - **Fact:** Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems, including: Biological factors, such as genes, physical illness, injury, or brain chemistry; life experiences, such as trauma or a history of abuse; family history of mental health problems.
    - **Fact:** People with mental health problems can get better and many recover completely.

WHO Mental health facts/considerations: (information taken directly from WHO)
According to the World Health Organization, mental disorders are a leading cause of disability worldwide and are caused and influenced by a confluence of factors including war and disaster, poverty, abuse, GBV, trauma, and more. Stigma and discrimination are key factors in preventing people from seeking help and treatment and from voicing or speaking out about mental health issues. Additionally, human rights violations occur routinely against people with both mental and psychosocial disabilities/issues.

SomaPsy Network (WHO stats) Chart:



NAMI Chart:


Mental Health Facts
IN AMERICA
Fact: 43.8 million adults experience mental illness in a given year.
1 in 5 adults in America experience a mental illness.
Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.
One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.
Prevalence of Mental Illness by Diagnosis
1.1%
1 in 100 (2.4 million) American adults live with schizophrenia.[1]
2.6%
2.6% (6.1 million) of American adults live with bipolar disorder.[1]
6.9%
6.9% (16 million) of American adults live with major depression.[1]
18.1%
18.1% (42 million) of American adults live with anxiety disorders.[1]
NAMI