



“Crippling the Fuck Out:” A Queer Crip Mad Manifesta Against the Medical Industrial Complex

Lzz Johnk and Sasha A. Khan

The Medical Industrial Complex (MIC) frames pathologization as “care” in the best interests of the patient. This is a performance piece that theorizes the rhetoric of pathologization through a scripted conversation between Doctor and patient. Drawing on our lived experiences as disabled, Mad, and/or neurodivergent people, we offer this exchange to resist compulsory able-bodymindedness that pathologizes non-normative bodyminds and interlocks with other systems of oppression. By bridging our experiences, we craft a coalitional resistance to the MIC that is grounded in genealogies of women of color feminisms, queer and trans of color critiques, Two-Spirit critiques, and Disability Justice.

[T]hey seem to remain ignorant of the fact that we have histories and cultures and skills and visions, and that if we’re going to survive the Trumpocalypse and make the new world emerge, our work needs to be crippled the fuck out.

—Leah Lakshmi Piepzna-Samarasinha (2018, 124)

Introduction

The Medical Industrial Complex (MIC) refers to medicine under capitalism. Queer Korean Disability Justice activist Mia Mingus (2015) explains that the MIC is inextricably linked to ableism/sanism: a system of oppression targeting disability, Madness, and neurodivergence. Working with and through other oppressive logics, ableism/sanism reifies the ideal bodymind of the settler colonial imaginary. The ideal bodymind is imagined to be rational, logical, articulate, capable, competent, healthy, well adjusted, normal, and productive. These characteristics are coded through what Audre Lorde refers to as “the mythical norm,” which is “defined as white, thin, male, young, heterosexual, christian, and financially secure” (2007, 116). Expanding on work by crip theorists Robert McRuer (2006) and Alison Kafer (2013), along with Mad scholar-activist Margaret Price (2015), we define the imperative of this ideal as “compulsory able-bodymindedness.” According to Mingus,

[The Medical Industrial Complex] is a system about profit, first and foremost, rather than “health,” wellbeing and care. Its roots run deep and its history and present are connected to everything including eugenics, capitalism, colonization, slavery, immigration, war, prisons, and reproductive oppression. It is not just a major piece of the history of ableism, but *all* systems of oppression. (2015)



We understand that the MIC, like the Prison Industrial Complex (PIC), cannot be fundamentally reformed because it functions as it was designed to — by maintaining settler colonialism through state killing (Stanley et al. 2015).

The United States is an ongoing settler colonial project (Allen 1986; Tuck and Yang 2012; Arvin et al. 2013; Simpson 2017). As such, this nation-state was created and is maintained through the genocide, devaluation, and dispossession of Indigenous people. The settler colonial project produces eugenic practices that aim to “cure” or kill nonnormative bodyminds, as we discuss below. Pathologization is one eugenic tactic that constructs and polices bodyminds along the intersections of race, sexuality, gender, class, nationality, language, disability, Madness, and neurodivergence. Within oppressive logics and systems including the MIC and PIC, pathologizing rhetoric justifies “rehabilitation,” confinement, and other forms of violence that enforce compulsory able-bodymindedness (Ben-Moshe et al. 2013). Through pathologization, nonnormative bodyminds are funneled into carceral systems as well as consumed to fund the MIC and PIC.

This piece emerges from our lived experiences as disabled, Mad and/or neurodivergent people coming up against the wall of pathologization inside and outside of the MIC, to borrow Sara Ahmed’s metaphor of the brick wall (2017). We first analyze interconnected examples that demonstrate how “ableism is colonial” (Morales et al. 2012, 84) before turning to interrogate pathologizing rhetoric in a manifesta that takes the form of a scripted exchange between Doctor and patient. We offer this exchange to resist compulsory able-bodymindedness that pathologizes nonnormative bodyminds and interlocks with other systems of oppression.

“Ableism is Colonial”

As poet Amy Berkowitz asserts, “doctors are cops” (2015, 52). Doctors engage in policing and cops in pathologizing via systems of oppression that unevenly impact nonnormative bodyminds. People of color, especially queer/trans folks, experience the effects of policing doctors and pathologizing cops more than their white counterparts (Ritchie 2017; Sharman 2016; Stanley et al. 2015). Disabled, Mad, and neurodivergent people of color also experience intensive policing and pathologizing (Ben-Moshe et al. 2013; Ritchie 2017). In the following examples, we trace how doctors and cops work in tandem to police the boundaries of the ideal bodymind by targeting people who embody difference. Eunjung Kim uses the term “curative violence” to describe this “exercise of force to erase differences for the putative betterment of the Other” (2017, 14). This section examines several tactics of pathologization within the settler colonial state that target non-normative bodyminds in interconnected ways.

First, pathologization functions as a tactic of settler colonialism to clear stolen lands of “insane Indians” (Driskill 2011). In the poem “(Auto)biography of Mad,” Cherokee Two-Spirit scholar-activist Qwo-Li Driskill indexes this tactic under the terms “craziness,” “eugenics,” “forced sterilization,” and “Hiawatha Asylum for Insane Indians” (2011, 108). Hiawatha Asylum, located in South Dakota and operational from 1898 to 1934, was one colonial apparatus to take possession of Native people’s lands and bodyminds.¹ For instance, settler judicial courts declared a Cherokee woman, Josephine Rider, insane on the basis of claims made by her white son-in-law and law enforcement (Walker 2015). Rider was then committed to the Hiawatha Asylum, which enabled her son-in-law to gain possession of her land. This example indicates



how, as a practice of genocide, the settler state weaponizes ableism/sanism against Indigenous bodyminds whose very existence troubles the settler colonial imaginary. As Driskill remarks,

Ableism is colonial. It is employed to maintain an ideal body of a white supremacist imagination. The ideal body is heterosexual, male, white, Christian, non-disabled, and well muscled. It is an ideal with a long and troubling history inseparable from racism, genocide, misogyny, and eugenics. (qtd. in Morales et al. 2012, 84)

Second, settler colonialism flexes the power of pathologization to eliminate Indigenous existence as it employs that same power to gain possession of Black bodyminds. Early colonial psy scientists created the diagnosis "drapetomania" as a "mental illness" that caused enslaved Black people to attempt escape (Clare 2017; Snorton 2017).² In this way, Black people who were seen as overtly resistant to chattel slavery were pathologized and subject to "treatment" in the form of physical punishments. Mobilizing the supposedly objective scientific method, eugenicists claimed proof of the subhumanity of Black people to further justify enslavement and control of Black populations (Clare 2017). Within this framework, Black people, especially Black women, were not only objects of scientific inquiry, but they became the test subjects of colonial medicine for the sake of improving the health of white settlers. For instance, gynecology was "founded" by J. Marion Sims, a slave owner who developed surgical techniques to "cure" fistulas by conducting experiments without anesthesia on enslaved Black women including Anarcha, Betsey, and Lucy (The Olimpias 2008). These techniques were framed as beneficial to slave owners, who profited from the labor of the "cured" enslaved Black women, and to wealthy white women, who could afford procedures with the benefit of anesthesia (Snorton 2017). The legacy of pathologizing Black bodyminds as sick and subhuman continues to fuel the white supremacist Medical Industrial Complex. Scholar-activists point to how this history shapes the contemporary lived experiences of Black people under the MIC (Roberts 2017; Judd 2014; Christina 2018). To provide one example, Black women today are three to four times more likely than white women to die in childbirth in the United States (CDC 2018; Hill 2017).

Third, pathologization shifts dramatically in order to be politically expedient for the settler colonial state. In the early 20th century, psy scientists diagnosed white women with schizophrenia, which was defined as a mild "mental illness" affecting white women who "failed" as mothers and wives (Metzl 2010, xv). However, the latter half of the century saw a significant shift in the diagnosis. Amidst the growing efficacy of the Civil Rights Movement, psy scientists targeted Black men by adjusting the symptomology of schizophrenia from a mild "mental illness" to a severe and dangerous one affixed to politically-active Black men, thereby removing potential educators and organizers from Black communities (Metzl 2010). Today, schizophrenia retains these racialized connotations with Black people disproportionately diagnosed with this "disease" (Schwartz and Blankenship 2014). Such medicalization subjects Black people to state-sanctioned violence such as removal from schools, incarceration in psychiatric and prison facilities, and forced medical treatment (e.g., psychiatric drugs and electroconvulsive therapy) (King 2016).

Writing in this spacetime known as "the present," we engage with these histories of settler colonialism not as bygone but as ongoing. The violence done to pathologized ancestors of color continues to unfold in "the present," and remains salient within the structures of the MIC and PIC, which target people of color in ways that reveal a continuity of white supremacist settler colonial logic across spacetime. It is not only because we, too, are affected by



sanism/ableism that we feel compelled to dismantle it. More importantly, we recognize our responsibilities to disabled, Mad, neurodivergent kin who have been, are being, and will be impacted by sanism/ableism. In this manifesta, we join a genealogy of Indigenous and Two-Spirit people, Women of Color Feminists, queer/trans people, and disabled, Mad, and neurodivergent people who resist oppression and pathologizing rhetoric.

Rescripting the Rhetoric of Pathologization

This manifesta weaves together our respective positionalities and commitments to craft coalitional resistance to the everyday enactments of ableism/sanism in the Medical Industrial Complex. To introduce our positionalities, Sasha is a queer non-binary disabled Mad mixed-race diasporic/settler desi Pakhtun femme. Lzz is a bi/pan agender crazy white kid from a eurodescended settler family. We are cohort siblings in a doctoral program where we are both settlers on Chepenefa Kalapuya lands. In our work, we trace "uncanon" genealogies in Queer Studies, Trans Studies, Disability Studies, and Mad Studies, centered on Women of Color Feminisms and Two-Spirit critiques.³ We are bridging these (and other) fields to critique the MIC.

Below, we offer a script of conversations inside, and outside of, the MIC involving three characters: the Doctor; the patient or Kay; and B., who is Kay's friend.

The script is comprised of quotations, paraphrases, and subtext from and of conversations we and loved ones have had with doctors and with each other. This Mad and neurodivergent method shares resonances with "echotextia, an autistic poetic form where others' words echo in our own and are in conversation" (Piepzna-Samarasinha 2019, 11). Our manifesta chronicles oppression, while revising the MIC script, to confront oppressors and catalyze resistance. Our response resists the policing of our nonnormative bodyminds inside and outside of the MIC. Through this exchange, we interrogate pathologizing rhetoric, challenge the assumed authority of the Doctor and assumed passivity of the patient, and consider alternative "modes of care" that can manifest in and beyond the MIC.⁴



The Script

Characters: The Doctor; the patient or Kay; and Kay's friend, B.

****The Doctor Is In****

The Doctor

Hi! I'm Dr. Such-n-Such. Or if I'm feeling magnanimous, I'll even let you call me by my first name. What brings you in today?

patient

I want to—

The Doctor

Hopefully, it's something you can explain in brief; the sum-total allotted to your visit today comes to fifteen minutes. My, my, we really need to clean up that affect of yours. How long has it been like this? Have you been experiencing a persistent feeling of sadness and loss of interest in things you once enjoyed on a daily basis for more than two weeks? Admittedly, I'm not a psychiatrist, but the great shortage of psychiatrists means I treat people with depression and anxiety all the time now. But I draw a very strict box for myself; I only treat simple cases.

patient

I'd best make it simple, then. There's something about constantly experiencing violence and trauma instead of care when I interact with agents within the Medical Industrial Complex that tends to get me down—

The Doctor

How about an antidepressant? Or maybe an anti-anxiety med? That tightness in your shoulders and neck that smooshes you into a noticeable C shape isn't the overwhelming weight of settler heteropatriarchy and neoliberal capitalism bearing down on you, that's just your poor posture and negative self-talk. Consider getting a rolling backpack. Knowledge is a heavy burden. Alternatively, muscle relaxants can do the trick. How am I to know that I'm prescribing you the same recipe that killed your sibling? It's not as though this system has time to account for personal histories.

patient

Why do you bother collecting my medical history if you're not—

The Doctor

Anyway, where was I? Ah yes, no doubt your current situation is of your own making. If only you weren't so negative. If only you'd comply with the treatment plan. If only you'd told us sooner. If only you'd taken time off from work. Come now, let's get you back on your feet. Sick days account for \$225 billion in lost productivity in the U.S. alone. It's okay to ask for help. Stigma kills. Compliance saves. Only you can bootstrap your way to wellness by following my instructions to the letter. It's very important that you swallow this pill every day with breakfast.



patient

You say you don't have time for "personal histories," yet you've developed a whole creation story for why I am sick. You call me "non-compliant" because I deviate from your expectations and a creation story of your own invention. You say that your diagnostic criteria are universal, but you focus on the individual devoid of sociopolitical context. You tell me that I "have the unreasonable expectation that I shouldn't be in pain," but you're fixated on cookie-cutter cures. You write "non-compliant" in my file because I do not follow a treatment plan to which my consent is conjured, assumed, and expected.

The Doctor

Um...where was I? Bipolar disorder is hereditary. We make our own destiny. Manifestly—

patient

Manifestly, schizophrenia isn't hereditary until it becomes convenient to pathologize generations of radical and resistant people of color (Metzl 2010).

The Doctor

Listen, *you are in control* of your health and your body. Take charge of your life. You need to change your outlook. *Are you listening to me?*

patient

The problem is not my ability to listen. In fact, I will hear the echo of your words many years from now. Will you recall this conversation the next time you overprescribe drugs? Will you regret that I was forced to pay for the privilege of your abuse? Will my face haunt you late at night as you think about the harm you caused? Will you, dear doctor, remember my name? I know you will not, because you do not hear me now.

The Doctor

It's clear from the look on your face that you're acutely unwell. A small battery of tests may pinpoint the cause. There is no treatment that can cure you but let's test to see—for science. Trust me, I'm a doctor. I saved this special medical side-eye just for you. Are you sure? Maybe you slept on it funny. "Funny," that's medical terminology. I made a joke, you should laugh. That you don't laugh is proof of your pathology. It's only natural that women laugh at men's jokes. But not too hard, otherwise it's unfeminine. Anyway, all of my patients are the same: I don't let race or gender interfere with my scientific rationality, my objectivity. Objectively, women of color have a higher tolerance for pain. That's why they make excellent test subjects.

patient

I'm not your guinea pig. I did not come into this death trap to be experimented on, yet I've been taken off of life-saving medications that there was no reason to stop, withheld for the purpose of "objective observation" and "diagnosis," as a doctor watched imperviously, and told me that I would always suffer, that I was meant to writhe in pain. I've been held down as a doctor stabbed me repeatedly with needles and shot electricity through my body and then sneered: "Why is a big girl like you crying?" Objectively, I don't find sexist and racist medical abuse "funny."



The Doctor

Objectively, emotions are irrational. Objectively, medicine is science. Objectively, we Know Things. Objectively, humans are dimorphous—there is only “male” and “female,” simple as that. What did you say your preferred name was again? Everyone is welcome in this clinic. We have special sensitivity trainings, as evinced by the rainbow pin I wear on the lapel of my lab coat.

patient

It’s clear that your training has been very successful...at teaching you how to successfully overlook your complicity within a violent and oppressive system. Were my gender and sexuality not covered in the “special sensitivity training?” Or, did they just not teach you how to deal with crip and brown Mad Queer Muslims (Patel 2014)? Am I too niche?

The Doctor

But where was I? Ah yes, your face—what’s wrong with your face? What’s wrong with your lips? Pretty girls should smile. No one likes a Negative Nancy. Guys don’t make passes at girls who wear glasses. What’s wrong with your hair? What’s wrong with your hands? What’s wrong with you? What’s wrong?

patient

What is wrong is that the Medical Industrial Complex is working precisely as it was designed. We are targeted for violence within a system that strives to mold us or dispose of us in accordance with settler colonial, white supremacist, heteropatriarchal, sanist/ableist standards of “normality.”

The Doctor

Talking to you right now is almost like talking to a normal person. You’re a complex case—outside of my area of expertise. I draw a very strict box for myself. Let me write you a referral. It’s important that you have reasonable expectations—

patient

I expect you to do your job, but that must be another one of my unreasonable expectations. I came here to access resources that I desperately need, but I shouldn’t have to be subjected to violence in order to get them. This is why we need Disability Justice and Mad Pride. It is why we’re seeking and crafting models of collective care outside of the Medical Industrial Complex. Because, I must inform you, this system kills.



****The Patient is Out****

B.

Hey, Kay. How did it go?

Kay

Not great. Let's go. I'll explain on the way out.

B.

[Collecting their things from the waiting room] OK.

Kay

I didn't even have a chance to explain what I needed from the visit. He kept interrupting, making assumptions, and trying to force me to comply.

B.

Ugh. That's frustrating.

Kay

Yeah, it made me angry. I challenged him and he faltered a bit but kept talking. I don't think any of the things that I said sunk in.

B.

You said something, though. That's hard to do and not always possible.

Kay

It was obvious that I wasn't going to access what I needed, so it felt like there was nothing to lose. I'll admit it felt good to talk back and name the fact that this system is fucked up.

B.

It is fucked up! That naming is so important, and by doing that, you're "living and speaking those truths which [you] believe and know beyond understanding" (Lorde 1980, 22).

Kay

Thank you for coming with me. It took me a long time to work myself up to coming, and it really helped to have you here with me.

B.

Of course! This is what it means to be part of a "care web" and to support each other in the ways that we can (Piepzna-Samarasinha 2018, 33).



Afterword

We understand ourselves as having roles and responsibilities that arise from "relational accountability" in our relationships with each other, our communities, and the scholarship-activism with which we are in conversation (Wilson 2008, 7). For instance, the work of *Queer Indigenous Studies* calls on "all people linked by the border-crossing potential of queer Indigenous critiques to study their locations in the power relations that [Two-Spirit and queer Indigenous] critiques disrupt" (Driskill et al. 2011, 214). We respond to this call to situate ourselves as settler scholar-activists living and working on stolen lands, and to decolonize our methodologies in relation to Indigenous scholarship-activism. We have a responsibility to seek out "decolonial options" (Mignolo and Walsh 2018, 224), and to enact those options in support of Indigenous sovereignty and to end "colonial domination" (Maracle 2015, xiv). We understand the MIC as part of settler state violence and oppression and thus view its abolition, along with the PIC, as part of the decolonial option. This is vital coalitional work.

From Women of Color Feminist scholar-activists, we understand bridging as a mechanism for mobilizing difference as a resource to build coalitions (Lorde 1984; Moraga and Anzaldúa 2015; Sandoval 2000; Hong 2006). As Vivian May writes: "Intersectionality invites us to take up a radical *coalitional political orientation* grounded in solidarity, rather than sameness, as a basis for working collectively to eradicate inequalities" (2015, 34). Our manifesta as scripted exchange articulates a coalitional critique of the MIC that bridges scholarly and activist movements including Disability Justice, Mad Pride, Women of Color Feminism, Two-Spirit critiques, and queer and trans of color critiques.

One beginning for the story of this manifesta takes place in a nearby chain restaurant, where the two of us were preparing for a conference presentation that would eventually become the script you have just read. We knew we wanted to do something creative and that we wanted our creation to disrupt and talk back to psychiatric and medical systems. This goal proved more challenging than either of us had anticipated, and the surprising resolution to the impasse manifested differently for each of us. Lzz realized that they could finally get words on the page by writing from the position of the pathologizer/Doctor, in the second person. Many of the Doctor's utterances are things that have been said to Lzz or Sasha "in real life." Sasha felt that they needed to write as the patient in the first person in order to stay grounded. The patient's words are drawn from both Lzz and Sasha's experiences and critiques of the MIC.

This manifesta, scripted from the material realities of our lives, is a practice of "theory in the flesh" (Moraga and Anzaldúa 2015, 19). We carry the violent effects of pathologizing rhetoric in our bodyminds as flashbacks, memories, shivers, nightmares, stories. Theorizing from lived experience makes legible the power of the MIC and enables us to find words that will validate its victims/survivors, including ourselves, especially when considering the intense gaslighting of pathologized subjects. Theorizing our flesh, finding words, and speaking them does not always feel like a cathartic or healing process; oftentimes it feels terrifying and painful. Perhaps this insight is unsurprising, for as Audre Lorde (1980, 21) tells us, "the transformation of silence into language and action is an act of self-revelation and that always seems fraught with danger." By placing the pathologizing rhetoric wielded against us in the Doctor's mouth, we can speak back to and refute its power, as well as reclaim some of our own.

We locate transformative possibilities, not predicated on the MIC, but emerging from the scholarship-activism of Disability Justice and Mad Pride. Disability Justice is a disability-



centered approach to justice, community, and relationships that arises from the scholarship-art-activism of disabled people of color. Specifically, gender/queer, poor, and/or diasporic disabled people of color are at the heart of Disability Justice movements, ideas, and intentions and they constitute some its most vocal and prolific knowledge-makers and advocates (Sins Invalid 2016). A Disability Justice framework enables us to see how “ableism helps make racism, christian supremacy, sexism, and queer- and transphobia possible, and that all those systems of oppression are locked up tight” (Piepzna-Samarasinha 2018, 22). Mad Pride is a transnational movement that validates and celebrates the lives, identities, and communities of Mad and neurodivergent people, including people who identify as crazy, psychocrip, neuroqueer, Autistic, Borderline, Bipolar, ADHD, and mentally ill.

Within these movements, disability, Madness, and neurodivergence are not devalued in line with the MIC’s deficit model; rather, they are celebrated as part of the diversity of human perception, interaction, and experience. Disability Justice scholar-activists call for the abolition of borders, carceral systems, and capitalistic health “care” that quantifies the costs and benefits of human life (Mingus 2015; Piepzna-Samarasinha 2018; Sins Invalid 2016). Dismantling the MIC is one move toward Disability Justice that helps shift our understandings of care away from logics that devalue bodyminds to perpetuate ableism/sanism and other systems of oppression. But what follows dismantling? Piepzna-Samarasinha offers a vision for Disability Justice-centered futurity in which the access needs and stories of disabled, Mad, and neurodivergent people of color are centered in “resistance communities” of the future where they are leaders guiding us “towards cocreating the decolonial living future” (2018, 135).

For our readers, we offer our stories in keeping with the intention of Cherokee scholar-activist Thomas King, who writes that “[t]he truth about stories is that’s all we are” (2003, 2). Our hope is that readers will join us in recognizing the vital necessity “for each one of us to establish or examine [our] function” in the collective transformation of silence into language and action, and how the sharing and receiving of stories plays a critical role (Lorde 1980, 22). As we have been invited to consider our relationships to Indigenous scholarship-activism, lands, and communities, we invite readers to dream pathways to decolonial options through which we can realize Disability Justice, Indigenous sovereignty, and the end of colonial domination.

Notes

1. Hiawatha Asylum was also known as the Canton Indian Insane Asylum.
2. Following the work of psychiatric survivor and Mad scholar-activist Phil Smith, we deploy “psy scientist” in reference to psychiatrists, psychologists, neuroscientists, and other psy agents who perpetuate and profit from the Medical Industrial Complex through exercising ableist/sanist power.
3. Following Cherokee Two-Spirit poet-scholar Qwo-Li Driskill (2011), we take “uncanon” to mean scholarship-activism that has been marginalized within the whitestream academic canon but which for us constitutes the center of, and thus reshapes, these (inter)disciplines.



4. We borrow "modes of care" from Ashkenazi/Sephardi crip femme mama-scholar and intellectual sibling Cassandra Hall.

Works Cited

- Ahmed, Sara. 2017. *Living a Feminist Life*. Durham, NC: Duke University Press.
- Allen, Paula Gunn. 1986. *The Sacred Hoop: Recovering the Feminine in American Indian Traditions*. Boston, MA: Beacon Press.
- Arvin, Maile, Eve Tuck, and Angie Morrill. 2013. "Decolonizing Feminism: Challenging Connections between Settler Colonialism and Heteropatriarchy." *Feminist Formations* 25 (1): 8 – 34.
- Berkowitz, Amy. 2015. *Tender Points*. Oakland, CA: Timeless, Infinite Light.
- Ben-Moshe, Liat, Chris Chapman, and Allison C. Carey. 2013. *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*. New York, NY: Palgrave Macmillan.
- Centers for Disease Control and Prevention. 2018. "Pregnancy Mortality Surveillance System." August 7, 2018.
<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>.
- Christina, Dominique. 2018. *Anarcha Speaks: A History in Poems*. Boston, MA: Beacon Press.
- Clare, Eli. 2017. *Brilliant Imperfection: Grappling with Cure*. Durham, NC: Duke University Press.
- Driskill, Qwo-Li. 2011. "(Auto)biography of Mad." In *Sovereign Erotics: A Collection of Two Spirit Literature*, edited by Qwo-Li Driskill, Daniel Heath Justice, Deborah Miranda, and Lisa Tattonetti, 107 – 109. Tucson: University of Arizona Press.
- Driskill, Qwo-Li, Chris Finley, Brian Joseph Gilley, and Scott Lauria Morgensen. 2011. "The Revolution is for Everyone: Imagining an Emancipatory Future through Queer Indigenous Critical Theories." In *Queer Indigenous Studies: Critical Interventions in Theory, Politics, and Literature*, edited by Qwo-Li Driskill, Chris Finley, Brian Joseph Gilley, and Scott Lauria Morgensen, 211 – 221. Tucson: University of Arizona Press.
- Hill, Zahara. 2017. "#BlackMamasMatter Draws Attention to Racial Disparity in Maternal Mortality Rates." *Ebony*. August 22, 2017.
https://www.ebony.com/news/gender_sexuality/blackmamasmatter-draws-attention-disparity-maternal-mortality-rates/.
- Hong, Grace Kyungwon. 2006. *The Ruptures of American Capital: Women of Color Feminism and the Culture of Immigrant Labor*. Minneapolis: University of Minnesota Press.
- Judd, Bettina. 2014. *patient*. New York, NY: Black Lawrence Press.
- Kafer, Alison. 2013. *Feminist Queer Crip*. Bloomington: Indiana University Press.



- Kim, Eunjung. 2017. *Curative Violence: Rehabilitating Disability, Gender, and Sexuality in Modern Korea*. Durham, NC: Duke University Press.
- King, Colin. 2016. "Whiteness in Psychiatry: The Madness of European Misdiagnosis." In *Searching for a Rose Garden*, edited by Jasna Russo and Angela Sweeney, 6 – 76. Monmouth, UK: PCCS Books Ltd.
- King, Thomas. 2003. *The Truth About Stories*. Minneapolis: University of Minnesota Press.
- Lorde, Audre. 1980. *The Cancer Journals*. San Francisco, CA: Aunt Lute Books.
- Lorde, Audre. 2007. "The Master's Tools Will Never Dismantle the Master's House." In *Sister Outsider: Essays and Speeches*, 110 – 114. Berkeley, CA: Crossing Press.
- Maracle, Lee. 2015. *Memory Serves: Oratories*. Edmonton, CA: NeWest Press.
- May, Vivian M. 2015. *Pursuing Intersectionality, Unsettling Dominant Imaginaries*. New York, NY: Routledge.
- McRuer, Robert. 2006. "Compulsory Able-Bodiedness and Queer/Disabled Existence." In *The Disability Studies Reader*, edited by Lennard J. Davis, 301 – 308. New York: Taylor & Francis Group.
- Metzl, Jonathan Michel. 2010. *The Protest Psychosis*. Boston, MA: Beacon Press.
- Mignolo, Walter and Catherine Walsh. 2018. *On Decoloniality: Concepts, Analytics, Praxis*. Durham, NC: Duke University Press.
- Mingus, Mia. 2015. "Medical Industrial Complex Visual." *Leaving Evidence* [Blog]. February 6, 2015. <https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/>.
- Moraga, Cherríe and Gloria Anzaldúa. 2015. *This Bridge Called My Back: Writings by Radical Women of Color*. New York: SUNY Press.
- Morales, Aurora Levins, Qwo-Li Driskill, and Leah Lakshmi Piepzna-Samarasinha. 2012. "Sweet Dark Places: Letters to Gloria Anzaldúa on Disability, Creativity, and the Coatlicue State." In *El Mundo Zurdo 2*, 77 – 97. San Francisco, CA: Aunt Lute Books.
- Patel, Shaista. 2014. "Racing Madness: The Terrorizing Madness of the Post-9/11 Terrorist Body." In *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*, edited by Liat Ben-Moshe, Chris Chapman, and Allison C. Carey, 201 – 216. Basingstoke, UK: Palgrave MacMillan.
- Price, Margaret. 2015. "The Bodymind Problem and the Possibilities of Pain." *Hypatia* 30 (1): 268 – 284.
- Piepzna-Samarasinha, Leah Lakshmi. 2018. *Care Work: Dreaming Disability Justice*. Toronto, CA: Arsenal Pulp Press.
- Piepzna-Samarasinha, Leah Lakshmi. 2019. *Tonguebreaker: Poems and Performance Texts*. Vancouver, CA: Arsenal Pulp Press.
- Ritchie, Andrea. 2017. *Invisible No More: Police Violence Against Black Women and Women of Color*. Boston, MA: Beacon Press.
- Roberts, Dorothy. 2017. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Vintage Books.
- Sandoval, Chela. 2000. *Methodology of the Oppressed*. Minneapolis: University of Minnesota Press.



- Schwartz, Robert C. and David M. Blankenship. 2014. "Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature." *World Journal of Psychiatry*, 4 (4): 133 – 140.
- Sharman, Zena, ed. 2016. *The Remedy: Queer and Trans Voices on Health and Health Care*. Vancouver, CA: Arsenal Pulp Press.
- Simpson, Leanne Betasamosake. 2017. *As We Have Always Done: Indigenous Freedom Through Radical Resistance*. Minneapolis: University of Minnesota Press.
- Sins Invalid. 2016. *Skin, Tooth, and Bone: The Basis of Our Movement is Our People: A Disability Justice Primer*. Sins Invalid.
- Smith, Phil. 2018. *Writhing Writing: Moving Towards a Mad Poetics*. Fort Worth, TX: Autonomous Press.
- Snorton, C. Riley. 2017. *Black on Both Sides: A Racial History of Trans Identity*. Minneapolis: University of Minnesota Press.
- Stanley, Eric A., Nat Smith, and CeCe McDonald. 2015. *Captive Genders: Trans Embodiment and the Prison Industrial Complex*. Oakland, CA: AK Press.
- The Olimpias. 2008. "Anarcha Anti-Archive." *Liminalities* 4 (2).
<http://liminalities.net/4-2/anarcha/>.
- Tuck, Eve and K. Wayne Yang. 2012. "Decolonization is Not a Metaphor." *Decolonization: Indigeneity, Education, & Society* 1 (1): 1 – 40.
- Walker, David Edward. 2015. "'A Living Burial:' Inside the Hiawatha Asylum for Insane Indians." *Indian Country Today*. November 9, 2015.
<https://newsmaven.io/indiancountrytoday/archive/a-living-burial-inside-the-hiawatha-asylum-for-insane-indians-7NZ2CDyrfo2QuQZxUZBKgg/>.
- Wilson, Shawn. 2008. *Research is Ceremony: Indigenous Research Methods*. Winnipeg, CA: Fernwood Publishing.

LZZ JOHNK is a Mad agender Ph.D. student in Women, Gender, and Sexuality Studies with a graduate minor in Queer Studies at Oregon State University. Their research interests include Mad Studies, critical and feminist disability studies, decoloniality, and Indigenous methodologies. Their current project is a reimagining of the genealogical roots of Mad Studies through Women of Color Feminisms.

SASHA A. KHAN is a queer non-binary disabled mad mixed-race desi Muslim femme. They are a Ph.D. student in Women, Gender, and Sexuality Studies at Oregon State University with a Trans of Color Critiques concentration and Queer Studies minor. Sasha's research interests include Two-Spirit critiques, South Asian Indigeneity, queer/trans Muslim and desi critiques, Women of Color Feminisms, and Disability Justice.

ACKNOWLEDGMENTS Thank you to the guest editor for her labor to bring forth this issue and the anonymous reviewers for their thoughtful, generous feedback. This piece was crafted with the support and wisdom of many intellectual relatives. Leah Lakshmi Piepzna-Samarasinha's activist-scholarship continues to sustain and invite us to dream queer, crip, Mad futures. Wado to Dr. Qwo-Li Driskill and Dr. Patti Duncan, who were the first to identify this as a performance piece and encourage us along the path to publication. Thank you to our intellectual sibling Cassandra Hall for their generative and nourishing friendship.