Living with (Manic) Depression as a Racialized Woman: Women's Memoirs about Invisible Dis/abilities

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In her memoir, *Haldol and Hyacinths: A Bipolar Life* (2013), Melody Moezzi describes herself during a manic episode as "Tigger on crack."[1] By mixing humor with social critique, the author compares the discrimination she experiences as a Muslim woman of Iranian descent and as a woman living with bipolar disorder I in the U.S. Gayathri Ramprasad's *Shadows in the Sun: Healing from Depression and Finding the Light within* (2014) offers insights into Ramprasad's childhood marked by chronic depression in India and her approaches to managing her mental health that combine Hindu culture and Western medicine after migrating to the U.S.[2] Both women expose and criticize exclusionary practices that dehumanize and isolate people with invisible dis/abilities. Their life writing urges that only when we understand psychological dis/ability as a social construct shaped by a web of oppressive forces, can we create more opportunities for effective and just treatment and inclusion.

This article investigates how women use memoir to discuss the negative ideological notions that patriarchal society has historically attached to dis/ability, femininity, and non-whiteness. My comparative reading—informed by life-writing theory, feminist concepts, and dis/ability and critical race studies—offers an intersectional perspective on how society perpetuates the oppression of women with a mental dis/ability based on their bodies, gender, race, ethnicity, nationality, and religion. My article adds to essential current issues within the field of American studies as it focuses on conversations and lived experiences around (invisible) dis/ability in an intersectional and interdisciplinary manner. My analysis takes to heart Jasbir Puar's admonishment that "intersectionality

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always produces an Other, and that Other is always a Woman of Color . . ., who must invariably be shown to be resistant, subversive, or articulating a grievance."[3] Through my comparative approach, I hope to avoid "racial essentialization;"[4] and in focusing on national background and migration influence, I add one of the "least theorized and acknowledged of intersectional categories" to my discussion about gender, race, and dis/ability.[5]

Unless quoting someone else's words, I use the spelling dis/ability (relying on Subini Ancy Annamma's expertise) to refer to the term's reliance on social context and its fluidity. I write "disabled" when implying that the act of disabling is being done to someone. I further refrain from using the terms "illness" and "impairment" as they might connote deficiency or abnormality. In line with Alison Kafer, I, too, understand dis/ability as "political, as valuable, as integral," and I see this conviction in Moezzi and Ramprasad's works.[6] As a person not living with a dis/ability, I am acutely aware of my privilege in and the power of naming, and I respect every person's right to choose words that capture their bodies and minds the most accurately. Moezzi and Ramprasad use the terms "bipolar" and "depression"/"postpartum" depression respectively to refer to their conditions. While I understand that more medically accurate and precise terms are available, I have decided to use the terminology the authors have chosen as I believe it reflects the rhetorical choices they have made to reach their audience more successfully. Lastly, it is not my intention to make essentialist claims in this article as I adhere to Annamma, Connor, and Ferri's recognition "that having a dis/ability is not universal and in fact, is qualitatively different for individuals with the same dis/ability depending on cultural contexts, race, social class, sexuality, etc."[7]

Robert McRuer sets the tone for any discussion about dis/ability: "A system of compulsory able-bodiedness repeatedly demands that people with disabilities embody for others an affirmative answer to the unspoken question, 'Yes, but in the end, wouldn't you rather be more like me?'"[8] Alison Kafer phrases this common devaluing of dis/ability in a more pungent way when she argues that many hold the belief that "disability is a fate worse than death or that disability prohibits a full life."[9] Moezzi and Ramprasad work with the understanding that the U.S. very much condones a "system of compulsory able-bodiedness" in which "able-bodied identities, able-bodied perspectives are preferable and what we all, collectively, are aiming for."[10] Their works support the demand on the part of the dis/ability rights movement as well as dis/ability studies for "access to a newly imagined and newly configured public sphere where full participation is not contingent on an able body" or,[11] in the case of the authors analyzed here, on "compulsory able-mindedness."[12]

The women whose memoirs I discuss do not declare their lives unique. They emphasize how common mental dis/abilities are among women. In doing so, they present an essential intersectional portrayal of the lives of many women with neuroatypical minds that reveals, in Kimberlé Crenshaw's seminal words, the "multilayered and routinized forms of domination that often converge in . . . women's lives, hindering their ability to create alternatives;"[13] they express a political stance and push for social justice as they challenge autobiography's reliance on a stable sense of self to convey the 'truth' and connect discourse about dis/ability with other systems of oppression, most notably sexism, racism, xenophobia, and Islamophobia.

Dis/ability related to one's mental state is a social construct that limits the opportunities of those living with it. (Manic) depression constitutes a bodily phenomenon which not all people consider a disease but rather a symptom expressing a psychological need; it is, as Susan Wendell theorizes, most societies' demand that physical and mental conditions deemed out of the ordinary be fixed that turns bodies and minds into a socially-constructed dis/ability carrying a negative connotation.[14] This "medical model" presents dis/ability as a strictly personal problem and "frames atypical bodies and minds as deviant, pathological, and defective."[15] Kafer's political and relational model of dis/ability, on the other hand, challenges the ideologies that inform what constitutes "normalcy and deviance" and removes blame from individuals to put it on the stigma created by social environments that create exclusion.[16] While these approaches also capture the "social model" of dis/ability, as promoted by scholars like Wendell, Kafer refines it by emphasizing that impairments, too, are socially constructed—in that assessments of them shift across time, cultures, and socioeconomic status. The relational/political model also specifically refrains from excluding those who find comfort in medical cures, meaning that it does not shame people for wanting to have what are perceived as "normal" bodies.[17]

I find Kafer's model applicable for my discussion since the memoirs I analyze are in line with her call for "cripped politics of access and engagement."[18] Kafer uses the term "crip" for its ability to shock people into questioning their understandings of ability and to capture how many disabled people feel belittled in public.[19] She connects crip with "queer" as she sees deviance in both identities, which mirrors the intersectionality women memoirists with an immigrant background employ. For gender and mental dis/ability are decidedly connected. Andrea Nicki explains that "[c]alling someone 'crazy' keeps that person and her differences away, but it also reinforces the belief that 'crazy' or mentally ill people are less than fully human and not deserving of respect."[20] The word "crazy" is gendered as it is freely used to describe women's behavior as erratic and hysteric. Labeling women "crazy" has proven an effective rhetorical tool to disregard their opinions and needs and to dehumanize them. Similar to how dis/ability is associated with infancy and childhood, women, too, are reduced to a childlike state (whether it is by calling them irrational or demanding they remove all body hair).[21]

Women have produced much life writing about their experiences with sexism; similarly, dis/ability life writing serves as a powerful venue to challenge the ableist and oppressive worldviews the scholars above criticize. According to G. Thomas Couser, "disability has become one of the pervasive topics of contemporary life writing."[22] This constitutes an important accomplishment as writers with dis/abilities might be culturally conditioned to believe that their lives do not offer the kind of positive "success stories" inherent in mythologies of the American Dream, and internalized oppression might prevent them from thinking of "their lives worthy of autobiography" since, as Couser reiterates, "autobiography as traditionally conceived, with its inherent valorization of individualism and autonomy, presents its own barriers to people with disabilities."[23] Individuality, autonomy, and success are concepts that can look different for someone living with a dis/ability than the socially sanctioned norms. Moezzi and Ramprasad challenge such underlying assumptions. It is less important to them to establish themselves as heroines; instead, they show how dis/ability is socially constructed and how one's experiences with privilege and oppression based on one's identity influence the trust and care one receives.

Susannah B. Mintz's groundbreaking *Unruly Bodies: Life Writing by Women with Disabilities* (2007) demonstrates how life narratives by women with physical differences, such as multiple sclerosis, negotiate the relationship between body and identity.[24] According to scholars like Mintz, many life writers identify an incongruence between depictions of dis/ability as a sign of weakness and a reason for shame and their own lived experiences. My case studies are crucial as they put a spotlight on mental dis/abilities, which have received less literary and scholarly attention than visible dis/abilities. In addition, the particular memoirs in this study attend in specific ways to intersectionality in discussions of dis/ability, which many books marketed by bigger presses achieve on a lesser scale due to the persistent lack of minoritized voices in the U.S. publishing industry.[25] Particularly, the authors' immigrant backgrounds from non-European/non-white-majority countries add meaningful perspectives to research about mental health. In an effort to reclaim the authentic voices of racialized women with dis/abilities, Ramprasad asserts the "power of stories to touch and transform lives" as well as, ideally, institutions and systems of power (240).[26] Together with feminist dis/ability rights advocates, the writers in this article proclaim that the stories of women with invisible dis/abilities matter.

Gender: Stereotypes, Norms, and Mental Health

Gayathri Ramprasad, a mental health advocate who immigrated to the U.S. from India in her twenties, started experiencing intense periods of anxiety and chronic depression after failing the final exam in her second year of college. It became impossible for her to keep food down, which resulted in immense weight loss. Because failing the exam made her fear for her chances of acceptance into medical school, Ramprasad was convinced that she was "destroying [her] parents' dreams" (36). Her worry is rooted in working-class anxiety to not disappoint her parents' hopes for a better future for their children. Her concerns about how she would be perceived if she shared her fears are also decidedly gendered: "I am scared they will think I am crazy" (44). Historically, women have been called 'crazy' more frequently than men. The term has been used to silence women and to gaslight them into questioning their feelings. Family members and health care professionals fully justify Ramprasad's suspicions when they reprimand her for being "weak and hypersensitive" (43). Both adjectives are variations of "crazy" and mark women as emotional, overreacting, and irrational. Additionally, patriarchal rhetoric associates femininity with (intellectual, physical, and emotional) weakness to further devalue women's judgments.

The facts that Ramprasad's knowledge about her own body was not taken seriously and that her sickness was located in an excess of feelings culminate in a doctor's 'diagnosis' of her as a "drama queen asking for undue attention instead of navigating the road bumps of life with maturity and grace" (45). Those words denote the doctor's refusal to take a young woman's pain and knowledge of her own body seriously. This assessment by the patriarchal medical complex brings to mind the diagnosis of hysteria; "[s]tretching back to at least as early as 1900 B.C., when ancient Egyptians attributed hysterics to the misplacement of the womb, women's reproductive systems have been linked with irrational emotions."[27] Only in 1980 was hysteria taken off the Diagnostic and Statistical Manual of Mental Disorders (DSM). Due to such inherent sexism in medicine, which is a global phenomenon, Ramprasad's condition is misdiagnosed as a character flaw rooted in the fragility of her female body.[28] Labeling women as crazy and irrational has proven an effective tool to prevent them from empowering themselves and changing the status quo. While both Ramprasad and Moezzi find relief in eventually being diagnosed—because that diagnosis is accompanied by therapy and medical assistance—they insist that a sanctioned diagnosis by the medical industrial complex does not validate their suffering; instead, they underscore the social, political, and economic reasons that cause and perpetuate their distress.

In hindsight, Ramprasad is not at all surprised by the lack of support she faced. She now sees it as a symptom of her "powerlessness in a society where girls and women were sexual objects routinely victimized by men who got away with their crimes" (48). As a patriarchy, India is invested in the oppression of women and abuses mental dis/ability as a tool to support this goal. Pushpa Parek reminds readers that all conversations about gender, race, and rationality need to consider India's history as a British colony. The Hindu philosophy of the "undivided" self was replaced by Western rationality that insisted on "acceptance of hierarchies of male, female, as well as embodied constitutions," which fed into ableism and sexism.[29] At the same time, British colonizers' fears about diseases fueled by "pseudo-scientific race theories" bolstered "race and gender stratifications."[30] Colonialism as a driving force behind ableism, sexism, and racism has left lasting marks on marginalized communities globally.

As a result of her experiences in India, Ramprasad becomes an immigrant in hopes of more opportunities for mental healing. Via an arranged marriage with an Indian man living in the United States, she is able to obtain a green card; "cut loose from [her] family and its cultural expectations, [she] loll[s] in bed as long as [she] want[s] and linger[s] in the shower, singing to [her] heart's content" (103). Separated from the pressures of being a dutiful daughter and a traditional Indian wife, Ramprasad's mental health improves substantially. She feels that the "very things that made me a misfit in India help me acculturate in America—my independent spirit; my untraditional looks; my love of jeans, short hair, and makeup" (104). When she has to negotiate fewer daily restrictions stemming from her gender, the author is able to recover slowly. Years later, after she finally received a diagnosis, an American therapist tells her that her "'addictive need to please [her] family and gain their approval at all costs, coupled with the shame and stigma associated with mental illness, and [her] desperate need to safeguard [her] family's honor, is threatening [her] health and well-being'" (179). Ramprasad's depression was able to intensify under deep cultural pressure to hide mental health issues in order to preserve archaic notions of honor which stipulate that mental dis/ability within the family line constitutes a deficiency that lowers the familial social standing and reputation.

At the same time, values such as honor are gendered as they demand women in most cultures to perform conformity and nothing less than perfection to meet patriarchal gender norms that prize women's acquiescence; so Ramprasad, for years, hides "behind a façade of normalcy" (79-80), getting "tired of pretending [she is] okay when [she is] not" (75-76). Even later on in life, she receives advice about how to handle her diagnosed condition that is, at its root, steeped in sexist understandings of women's psychological dis/abilities. For example, her mother admonishes her that if she "only . . . prayed with a purer heart, [she] wouldn't be depressed the way" she is (197). While many people struggling with their mental health are not taken seriously, this emphasis on purity specifically targets women whom patriarchal societies tell that their worth and value lies in their innocence and chasteness.

Sexism contributed to the fact that for three years "nobody believe[d Ramprasad's] pain" (91). Instead of receiving help, she was shamed into silence and compliance. This pattern still holds true for many women seeking help with psychological and physical conditions. Diane E. Hoffman and Anita J. Tarzian's much-cited article, "The Girl Who Cried Pain: A Bias against Women in the Treatment of Pain," brings together research suggesting that female patients are more often perceived as anxious rather than in pain.[31] Studies further indicate that women "experience disbelief" when encountering medical personal.[32] Overall, women who "seek help are less likely than men to be taken seriously when they report pain and are less likely to have their pain adequately treated."[33] Stereotypes about women being overly emotional as well as able to endure more pain due to the ability to give birth have severe consequences for those seeking adequate treatment for their mental dis/ability. For example, Lauren Mizock and Megan Brubaker found that women with severe mental health issues "experience doubts and questions as to the legitimacy of their symptoms and concerns by their mental health providers" and face "mental health providers who either overfocused on the effects of their mental illness or minimized their symptoms, often through the misattribution of the symptoms to something other than what they reported."[34] Importantly, Moezzi and Ramprasad did not only navigate sexist mental health care systems but ones heavily influenced by racist stereotypes. As Thomas McGuire and Jeanne Miranda outline, in the U.S., racialized people "have less access to mental health services" than white people, "are less likely to receive needed care, and are more likely to receive poor-quality care when treated."[35] This disparity is caused by providers' bias, differences in access to health insurance, a shortage of a diverse mental health care workforce, and a lack of culturally sensitive education for personnel.[36] Through their writing, Ramprasad and Moezzi speak out forcefully against this persistent sexism and racism in psychological care.

Like Ramprasad, lawyer and mental health advocate Melody Moezzi, whose parents are immigrants from Iran, was misdiagnosed for a long time. She begins her memoir, *Haldol and Hyacinths*, with the shocking assertion that there "are plenty of respectable reasons to kill yourself, but I've never had any" (4). She recounts her stay at a psychiatric unit after a suicide attempt, which she labels "pathetic" because it was not generated by "actual problems" like having been raped, an experience which brought many female patients to the unit (3). By this point, Moezzi has internalized the oppressive notion that only when women are physically violated are they allowed to feel mental pain. The author's self-doubts about her right to seek treatment are likely rooted in her having to wait years for an accurate name for her condition, bipolar disorder I—also known as manic-depressive disorder or manic depression, which causes manic episodes during which patients demonstrate high levels of energy, mood swings, and irregular behavior that can be life-disrupting followed by periods of depression. Even after a longer stint at a psychiatric institution, Moezzi leaves "without a proper diagnosis and without a long-term treatment plan" (160). At that time, she did not have "even a rudimentary understanding of what bipolar was, besides a pejorative reserved for *really* crazy people" (160; emphasis in original). While, initially, Moezzi is afraid of being labelled crazy, she later reclaims the term and uses it frequently throughout her memoir to create community among those who have been ostracized because that adjective has been attached to them.

In her reclamation of "crazy," Moezzi stands in solidarity with minoritized communities and activist movements who have reclaimed derogatory terms like "queer," "bitch," and the n-word. In particular, the "Mad Pride" movement has fought the stigma against psychological dis/ability on a global scale since the 1990s and has recovered power over descriptors like "crazy" and "mad." As Stark Raving points out, if "you have only scientific terms to understand your brain, your identity can feel like it is being reduced to a problem which needs to be cured" and "until society changes its vision of mental illness, even medical words will be used against those suffering."[37] Raving proposes that taking back "crazy" "is also a way of refusing to be divided: to have a line drawn between good mental illnesses and bad."[38] Language has power over our perceptions of others, and if a community takes back control over a term that has been used against its members, oppressive systems will lose one more instrument in their toolbox.

Further using the power of language and description, Moezzi details the symptoms of her mania, which she experiences in addition to her depressive periods, to showcase her extreme and untypical behaviors. For example, she decides to become a circus artist, to purchase an ocelot, to stop walking in favor of skipping everywhere, and to embrace the calling of a prophet. While she emphasizes that she "really *believed* that nothing [she] was doing was remotely irrational" (206; emphasis in original), readers might be confused why medical professionals did not diagnose Moezzi correctly despite these extreme moods. A lack of concern about mania is a leading cause for the misdiagnosis of bipolar disorder. Gender stereotypes that label women as exaggerating, overreacting, overly emotional, irrational, and, above all, hysterical likely played a significant role in Moezzi's treatment. Studies suggest that health care professionals tend to see women as complaining more than men and as incapable of accurately describing their conditions.[39] The situation can be even more dire for women of color whom racism has stereotyped as "aggressive, unfeminine, undesirable, overbearing, attitudinal, bitter, mean, and hell raising."[40] Wendy Ashley exhibits how myths about the "angry black woman" can cause mental health care providers to "miss or misinterpret data, symptoms, and observations," which can compromise the "assessment, diagnostic formulation, and treatment for this population," resulting, for example, in the premature termination of therapy.[41]

Ashley's observations confirm that sexism and racism in dis/ability health care create what Miranda Fricker calls epistemic injustice, which "wrongs someone in their capacity as a subject of knowledge, and thus in a capacity essential to human value[;] where it goes deep, it can cramp self-development, so that a person may be, quite literally, prevented from becoming who they are."[42] Because hospital staff and doctors had not seen her as a knower of her own body and mind, they missed that Moezzi "wasn't sad. [She] was suffocating" (24). This silencing of women has huge implications considering that "[a]ccording to the World Health Organization, bipolar disorder is the sixth leading cause of disability in the world" (49). Stigma against dis/ability as well as sexist forces likely keep that statistic smaller than it actually is.

Experiencing epistemic injustice is an especially prevalent phenomenon for women living with invisible dis/abilities. Moezzi speculates that if "you could diagnose bipolar with a CAT scan or a blood test, I expect it would be both easier to treat and much less likely to evoke so much shame and embarrassment in its victims" (216). In comparison to how people tend to treat a cancer patient, if "you survive a mental illness, most people consider you a feeble-minded degenerate and an embarrassment" (216). A severe stigma is attached to mental conditions that marks people living with it as intellectually and emotionally weak and responsible for their own mistreatment since their atypical minds are seen as something to be ashamed of that make others around them uncomfortable. While the disbelief about invisible dis/abilities does not only affect women, it is heightened by stereotypes as the Western "medical model overemphasizes objective, biological indicators of pain and underacknowledges women's subjective, experiential reports.[43] Women are not seen as experts regarding their lives, which puts their survival at risk.

In addition to affecting their treatment negatively—by, for example, ignoring self-reported symptoms or disbelieving levels of pain as Serena Williams' experience with life-threatening postpartum complications in 2017 captured—labeling women as crazy can make them vulnerable to being seen as bad mothers and, ultimately, to having their children taken away from them.[44] Thus, dis/ability is intimately connected with reproductive justice. The stakes are especially high for women of color who are more likely to be judged as "angry" and incompetent caregivers. Persistent racist and sexist depictions of the "mammy" trope have established especially black women, but by extension also brown women, as obedient caretakers of white children at the expense of their own children.[45] Based in this historical context, mothers of color are more likely than white mothers to be undeservedly targeted as cheating the social welfare system, as lazy, and as only bearing children to receive government money; they are accused of holding "inferior cultural beliefs and values," which individualizes their struggles instead of critiquing the systematic negative impact that classism, racism, sexism, ableism, and other forms of oppression have on these women's lives.[46] As a horrific result, children of color (particularly African American and Native American children) are disproportionately placed in foster care. In 2000, black children counted for 16% of the U.S. child population but made up 38% of children in the foster system.[47] In fact, statistics show that child protective services will check in on 53% of African American children before they turn eighteen years old, compared to 37% of all children.[48] A broken foster care system, unfortunately, generates abuse in far too many cases, and adoption often permanently breaks connections with biological relatives. Fearing such outcomes, women of color are particularly inclined to overlook hints at a lack of mental well-being in their bodies, which lowers their chances of receiving adequate treatment.

These intersections of sexism, racism, and ableism put strain on Ramprasad when she learns that she is pregnant and anxiety about being a bad mother to her unborn child paralyzes her. While she believes that having her mother with her in the U.S. for the birth would bring her relief, her husband decides to bring his parents instead, and, thus, the "rules of patriarchy that bind [them] force [her] mother and [her] to honor the wishes of Ram and his parents" (114). Indian custom dictates that the husband's wishes come first. Combined with the stigma that prevents Ramprasad from speaking out openly about her struggles, sexism keeps her from receiving the comfort she desperately needs.

The birth of her daughter enhances Ramprasad's mostly managed chronic depression and triggers it to manifest as what she now knows was postpartum depression (PPD)—which materializes itself as extreme hopelessness, anxiety, and exhaustion that can last for long periods of time if not treated; Ramprasad was not diagnosed even though a previous history with depression should have functioned as a strong indicator for medical staff to check her for PPD.[49] Ramprasad's national origin likely influenced the treatment she received as Katy

Kozhimannil, et. al.'s research indicates that only half as many women of color and low-income women, who are actually more at risk for PPD, received treatment than white women did.[50] Looking specifically at the connections between migration status and PPD therapy, Marina Morrow et. al., who studied the experiences of South Asian and Chinese immigrant women in Canada, suggest that "exclusively using . . . Western psychiatric clinical diagnostic category may obscure important situational and social features of women's lives and limit our understanding of the kind of mental health care needed."[51] Researchers found that women's migration experiences put stress on them as they disrupt cultural rituals and gender norms and remove family members that would have traditionally provided mental and physical support.[52] In treating PPD, and any form of mental health issue, it is vital to take an intersectional approach to understand and value women's experiences in order to offer effective healing.

To make other women aware of the symptoms, Ramprasad uses a sidebar about PPD in her memoir and shares that "the initial euphoria after the birth begins to dissipate under a cloud of agonizing pain" and that she experienced feelings of "worthlessness, hopelessness, guilt," "emptiness," and "nothingness" (125, 126, 132). Devastatingly, Ramprasad feels "guilty for being a bad mother" (127). She lives in fear that she might hurt her baby and have her taken away from her. Ready to give up, "death becomes an alluring presence" as she is convinced that her daughter will be better off without her (149). Ramprasad is disabled by the lack of a support network, to the point where suicide seems the only option. While in India extended family members and neighbors offer new mothers help, Ramprasad is isolated and "lonely" in the U.S. (134). Pressure to be a perfect mother makes her regret her migration despite her initial feeling that living in the U.S. was a liberation: "I am tired of this stupid country! I have to do everything myself" (128-9). Recalling her panic about her parents' reaction to the early onset of her condition, she is gripped by dread that she "might be labeled crazy" (132). Patriarchy tells Ramprasad that she needs to excel in her roles as daughter, wife, and mother without regard for her own well-being. In a sexist system, mental dis/ability is used to punish women into complete dependence; the shame women are made to feel for failing to live up to artificially constructed notions of perfect womanhood is debilitating and weakens their resolve to speak up for their right to bodily autonomy and access to adequate care.

When Ramprasad is hospitalized in the U.S., she is relieved of her patriarchal duties as maternal and spousal caretaker for the first time. At that moment, she understands that she "was brainwashed into believing that, as a woman, [she] needed [her] husband and family to protect [her] honor and well-being. Now, [she] realized that in battling mental illness, [she] stand[s] alone" (201). This rather forceful emancipation comes at a high price as she feels "violated [and] dehumanized" having to wear a hospital gown (204). But she also appreciates meeting, for the first time, "people that truly understand my pain" (212). Unfortunately, Ramprasad's condition worsens after she has a miscarriage at the hospital for which she blames herself. As a result, she is taken to an isolation chamber. In preparation for her relocation, medical staff remove her wedding necklace, not knowing its cultural significance. Even when Ramprasad explains that without the necklace, she is no longer considered married as per traditional customs, the staff insist on taking it, thus ridding her of an essential part of her identity: "I had grown up believing there were only two measures of success: marriage and motherhood. Convinced that I have lost them both, I completely lose control" (217). Made to feel like an utter failure in two of the most defining purposes that patriarchy has impressed on her, Ramprasad exemplifies how the intersection of sexism and cultural ignorance can negatively affect women's mental well-being.

Instead of building on cultural sensitivity training for employees, many mental health facilities use supposed physical safety concerns as a common justification for the, at times severe, treatment of patients. Moezzi claims that popular culture is complicit in creating preconceptions about mental health clients as violent. She critiques how TV shows and movies stigmatize the mentally different as violent even though, "[d]espite what you'd expect from watching *Law & Order*, research has shown that the mentally ill are, in fact, no more likely to commit violent crimes than their otherwise 'sane' counterparts" (72; emphasis in original). Popular culture sends powerful messages about various communities and affects how viewers perceive the members of these communities off the screen. Scott Parrot and Caroline Parrot's study, which coded 983 characters in 15 crime shows, reveals that those characters who were identified as "mentally ill" were more likely to commit violent crimes than other characters, feeding the "inaccurate stereotype about mental illness that associates mental disorders with unpredictable, random, and violent behavior."[53] Importantly, in real life, "the majority of persons living with mental illness are not at an increased risk of violence in comparison to the general population."[54] Yet, such misleading portrayals may heighten biased behavior against people with mental dis/abilities, negatively affect their support systems, and shape laws and policies in ways that reduce access to housing, medical care, and work opportunities.[55] At its extreme, the "dangerousness stereotype" leads to the disproportionate incarceration of the mentally dis/abled. According to Risdon N. Slate, Jacqueline K. Buffington-Vollum, and W. Wesley Johnson, mental dis/ability has indeed been criminalized so that neuro-atypical persons are more likely to be trapped in the U.S. prison system than find help in the mental health care system.[56]

This pop culture disparagement and its adverse consequences have concrete influence on whether people feel comfortable asking for help with mental health issues and on the treatment they will receive. These issues are infinitely more complicated for racialized people in the U.S. as Moezzi and Ramprasad make it clear that gender is not the only factor affecting their psychological dis/ability, but that their cultural backgrounds and their status as perceived foreigners in the U.S. contribute to the intersectional oppression they experience.

Culture and Nationality: The Fight against Stigma

While gender, arguably, functions as the main focus for much of Ramprasad and Moezzi's memoirs, they connect the oppression they experience based on their gender and dis/ability with the layered forces of domination they live with because of their ethnicity, religion, and national background. Similar to how invisible dis/abilities provide some people with the privilege of avoiding discrimination, invisible religious identities can afford a person the means to "pass" and avoid judgment about their creed. Garment (like the kippah), facial hair or marking (like the bindi), and practices (such as prayers at a specific time of day), on the other hand, may make religious identities visible in ways like a wheelchair or seeing-eye dog might make a dis/ability, which can create immediate negative reactions. Yet, visible markers also tend to offer legitimacy for a religion and its members, much like a visible bodily difference can make a dis/ability "real" and "acceptable" for those not living with it. In the absence of visible markers for either religion or dis/ability, how people's religious identity and dis/ability status are *perceived* by others can shape how they are treated, as is the case with Moezzi and Ramprasad.

While Moezzi does not wear a hijab, she is still perceived as "different" and foreign. In support of her claim that she was not taken seriously by medical personnel, she shares that when she arrived at a hospital during a psychotic break, her ethnicity was listed as Indian and the people admitting her refused to believe that she was a lawyer, likely because they were influenced by sexist and racist biases that keep people from associating a woman of color with a successful legal career. While it is important to note that Moezzi's higher socioeconomic class (stemming from her family and profession) provides her with the privilege to receive medical care—which is not a given for many people, especially people of color living with mental health issues—her gender and ethnicity intersect to create barriers hindering her treatment.

The medical staff did not see Moezzi as a credible reporter of her own life, and they distorted her emotions, which is common for women who are observed as non-white.[57] Sexism in the health industry is exacerbated by persistent racism, especially when related to dis/ability health care. A plethora of studies and reports has established "pervasive racial inequities in health" in the U.S.[58] For example, persons of color are less likely to have adequate insurance than their white counterparts. Structural discrimination does not only affect access, it also inhibits quality of treatment. For example, African Americans are denied pain medication at a higher rate than white patients reporting the same pain level, and if they do receive medication, quantities are lower.[59] As Hoffman et. al. found, these decisions are rooted in racist myths about biological differences between black and white individuals.[60] Evidently, stereotypes based on gender and race collide and deteriorate the relationship and trust between medical teams and those in need of bias-free care.

Drawing a powerful connection between ableism, racism, and Islamophobia, Moezzi implements the "Dis/ability Critical Race Studies" framework for which Subini Annamma, David Connor, and Beth Ferri call.[61] Building on diasporic and dis/ability studies, a DisCrit approach recognizes that race and dis/ability are socially constructed to support the domination of one community over others and that they interconnect.[62] Racism and ableism collaborate to create oppressive notions of "normalcy" that label some individuals "deficient."[63] DisCrit aims at analyzing how these processes work in people's lives on a daily basis. While Annamma, Connor, and Ferri focus on educational settings to comply with this demand, I argue that the life writing genre can present an effective means to collect more diverse information on the intersections of dis/ability with other forms of domination such as xenophobia and anti-immigrant nationalism.

Kafer draws enlightening parallels between the rhetorics of feeble-mindedness and degeneracy used to marginalize people with dis/abilities and to deny citizenship to specifically non-white immigrants.[64] Douglas Baynton elaborates that since U.S. immigration has historically been focused on bodies "as material for labor," people with dis/abilities have been judged as unproductive and not worthy of becoming American.[65] Similarly to how people with dis/abilities are supposed to want to find a cure and assimilate to "normal-bodiedness and -mindedness," immigrants are pressured to cleanse themselves of any cultural vestiges (especially visible ones) of their nations of origin and assimilate to white U.S. society. Annamma, Connor, and Ferri point out how race and dis/ability affect notions of ideal citizenship, "including who is allowed to represent or signify a nation, how nations pursue 'building' a strong, healthy population that is ready for competition in work and war, and ways nations seek to reproduce and expand."[66] White supremacy and ableism feed into nationalism.

Perhaps not surprisingly then, Moezzi sees clear similarities between feeling humiliated on account of her bipolar disorder and being discriminated against as a Muslim woman in the U.S. She compares the stigmatizing of people with a psychological dis/ability, "especially those of us who've been hospitalized" (4), to the intense Islamophobia in the U.S. after 9/11. Moezzi explains that as "an Iranian-American Muslim in the buckle of the Bible Belt," she has been "intimately acquainted with stigma, scorn and isolation for quite some time" (4), which manifests itself in people asking her numerous times about her involvement in the terror attacks. Moezzi, somewhat tongue-in-cheek, sums up her outsider status in the statement that it is "a colossal bitch to be Muslim in America" (136). Yet, she sees the discrimination she experiences because of her religion exceeded by the oppression of the mentally disabled, for it is "more suffocating, this scorn more subtle, this isolation more literal" (4). In Moezzi's experience, ableism has even more severe detrimental effects on people's well-being than Islamophobia, racism, and xenophobia; while ableism is more hidden, it is also more tolerated, insidious, and harder to escape, eventually leading to Moezzi's actual psychiatric confinement.

The liminal status Moezzi inhabits because of her dis/ability is mirrored in the rootlessness she feels due to her cultural heritage and family's migration background, which caused her "bipolar identity [to be] born long before any mental malady" (7); as a child of immigrants who had to leave the U.S. after the Iranian Hostage Crisis and move around Europe until they were able to return to the U.S., Moezzi, a U.S. citizen, is excluded from both cultural and national parts of her identity. Targeted in America for her cultural and religious roots and unable to go to Iran due to the current political regime, she "remain[s] a hybrid, with [her] mind and body in America and [her] soul in Iran. Perhaps insanity is inescapable when you separate a soul from its vessel. Like eggs outside a nest, we must improvise to survive" (276). Mere survival becomes the goal. When you are "not free to feel fully at home anywhere" (128), it is a difficult task to nourish one's psychological health. Indeed, studies show that stressors which people with a migrant background experience—such as lack of support networks, isolation, and anxiety—take a toll on their mental health.[67]

In addition to explaining how being treated as an (assumed) immigrant can be a burden on one's mental well-being, Moezzi and Ramprasad clarify that ostracization is not merely externally imposed, but one's own ethnic background is often complicit. The authors' outsider status is heightened from within their own communities. Moezzi writes, there "isn't even an agreed-upon label for bipolar disorder in Farsi. . . . The stigma surrounding mental illness in the States is bad, but it's beyond measure in Iran. People are about as likely to discuss their psychological issues as they are to discuss their bowel movements" (12). In Iran and the Iranian diaspora, psychological issues are ignored, regarded as Western, or attributed to character flaws. Her life writing offers Moezzi the opportunity to "shed[ ] shame and to [] speak[] out against a heavy cloud of suffocating stigma" coming from multiple fronts (264).

Ramprasad's experiences with mental health in the Indian context are similar to Moezzi's: "In a culture where the emotional aspects of a human being are rarely talked about or addressed, my family and physicians focus only on my physical symptoms" (45). In addition to the sexist belittling she experiences, a cultural silence around psychological conditions keeps Ramprasad from being diagnosed successfully. She recognizes that the failure to consider depression as a possible finding is not malicious; "it isn't that [her] parents and physicians don't care; they are utterly ignorant about mental health issues" (45). A national refusal to take mental health problems seriously functions as an enormous contribution to dis/ability as a social construct. As Anita Ghai explains, religion is complicit in this process as it marks "disability as an essential characteristic of the individual that has to be endured to pay back for all the sins committed in the past."[68] Instead of merely having to manage one's symptoms, mental health patients are, according to Ramprasad, disabled by a society that makes them believe they will "be shunned by [their] own family and ostracized by [their] community" (51). In the face of such a possible fate, denial and suffering in silence seem like more viable options even if they can cause disastrous consequences;

Ramprasad's father was actually diagnosed with depression himself, but the shame instilled in him—which, certainly, was influenced by stereotypes of men with a mental dis/ability lacking masculinity—kept him from providing this information to his daughter's doctors. Ramprasad is certain that had she "been suffering from diabetes, heart disease, or even cancer, . . . [she and her husband] would not have kept it a secret" (193). Because psychological dis/abilities are not arbitrarily socially-sanctioned diseases, people who live with them and their experiences are pushed into the shadows. Via their memoirs, Ramprasad and Moezzi encourage others to break the silence to save lives.

Because of nationally authorized muteness, Ramprasad only receives a diagnosis after almost seven years of the first signs of her condition. Trained by her gender and culture, her reaction is predictably negative: "*Depression . . . mental illness* . . . the doctor might as well have handed me a death sentence" (154; emphasis in original). Confusion grabs her as she is torn between the fear that she will be institutionalized for the rest of her life and the "relief, knowing that my illness has a name" (155). In an insertion in *Shadows in the Sun*, Ramprasad stresses that while depression is the "leading cause of disability worldwide," India has one psychiatrist for every 400,000 people so that 50-90% of people with depression remain without treatment (156). While unlikely that the presence of psychiatrists will alleviate the social, political, and economic distress that causes depression in India, Ramprasad's note is crucial as it adds socioeconomic class to her intersectional portrayal; she explains that even if a trained doctor might be close, many Indians are unable to afford visits. In acknowledging her class privilege, Ramprasad draws attention to the fact that the mental health situation for people in slums and members of oppressed castes in India is even more appalling.[69]

More recent research on mental health care in India corroborates Ramprasad's claims: India's suicide rate is higher than most other nations', and among 15-29 year-olds in India, suicide as cause of death is only surpassed by car accidents.[70] While a 2016 survey showed that 150 million Indians urgently need mental health care, merely 30 million can access such care,[71] mainly because, across the subcontinent, only 40 psychiatric institutions are in operation, including only nine that treat children.[72] As Ramprasad describes, stigma against mental health needs and ostracization of those who have them are still widespread in India, mainly because the 1987 Mental Healthcare Act pushed mental health patients into isolation and criminalized suicide.[73] Since the publication of *Shadows in the Sun*, a new Mental Healthcare Act was passed in 2017, which provides access to and protects the rights of people undergoing mental health treatment.[74] Despite the new law, as in many other countries—such as certainly the U.S.—"[p]oor mental health in India is strongly associated with poverty and social deprivation," which makes an intersectional discussion of dis/ability that includes socioeconomic status essential.[75]

Due to the cost and pervasive stigma, many Indians are likely to seek help from unqualified spiritual healers. Ramprasad's mother-in-law asks a priest to exorcise her stepdaughter. In a most cruel intersection of sexism and ableism, this priest sexually harasses Ramprasad by touching her all over her naked body during his so-called examination (161). Ramprasad is unable to defend herself because "[h]aving never met anyone who has recovered from depression or any other mental illness," she does not believe that she will ever be able to lead a normal life (159), so she accepts the fate a sexist and ableist society has imprinted on her.

Because of her past, Ramprasad recognizes that representation matters when it comes to understanding and accepting one's individual state of health. It is crucial to note that the stigma Ramprasad experienced in India is also present among Asian American communities in the U.S. and that stereotypes about Asian Americans affect the attention and care they receive with regard to psychological dis/ability.[76] First marked as a "yellow peril" that allegedly brought disease to the U.S., people of Asian descent today are lauded as a "model minority." While the term sounds like a compliment, it not only makes people of Asian descent complicit in racism against other minoritized groups (who are depicted as less "adaptable" and less "hard-working"), but it also holds Asian Americans to high standards of exceptionalism that make "disabled Asian American bodies hard to see" as "[c]ompliant subjectivity[,] hard work," and "hyper-ability" are made mandatory.[77] This mythical perception of Asian Americans directly results in problematic care; Quyen Ngo-Metzger, Anna Legedza, and Russell Phillips found that doctors are less likely to ask Asian American patients than white patients about their mental health status despite high rates of depression and posttraumatic stress disorder especially among Southeast Asians; additionally, Asian Americans report the inability to find care-providers who know and respect their cultural heritage.[78]

Ramprasad's personal storytelling contributes to filling a gap in public health resources for Asian Americans. Asian Americans have a three times lower rate of reaching out for mental health help than their white counterparts. Causes for this lack of reporting include family pressure for "success," cultural perceptions about mental health as a taboo topic, discrimination, and the hardship of developing a bicultural sense of identity.[79] In its specific concentration on Asian immigrant women's mental dis/ability, *Shadows in the Sun* joins efforts with other powerful artistic and activist output like *Wong Flew over the Cuckoo's Nest*, a performance by Kristina Wong, who effectively uses comedy to bring attention to the high rates of depression and suicide among Asian American women.[80]

Wong, Ramprasad, and Moezzi attempt to educate their audience and, in turn, shorten the period of gnawing uncertainty for other patients. While it is difficult to assess accurately how well particularly Ramprasad and Moezzi's readers are perceiving the authors' messages, a look at the reviews posted online on such sites as Amazon offers insights into the books' perception. Overall, reviews of both works are positive. On Amazon, *Shadows in the Sun* received a scoring of 4.3/5 by sixty-nine reviewers and *Haldol and Hyacinths* 4.5/5 out of one hundred reviews. A reader on Barnes and Nobel's website writes that *Shadows in the Sun* was "very helpful to [them] in understanding more about mental illness from the afflicted person's perspective." Another "highly recommend[s] this book for anyone who loves anyone who lives with depression, for professionals who work with people in depression, and others who want to expand their understanding of heart/brain/emotion/intellect issues." On Amazon's page for the book, someone commented that if "you feel alone in your suffering, read this book! If you know someone suffering with depression and need insight into what they are experiencing, read this book!" Recurring vocabulary used to describe Ramprasad's book includes "inspiring," "hope," and "overcoming." The latter is especially interesting as Ramprasad does not express in her memoir any indication that she conquered her depression. Instead this interpretation might represent readers' conditioning to see defeat of dis/ability as the only viable success.

While comments on *Haldol and Hyacinths*, too, are overwhelmingly positive—for example, the "one thing that makes this book stand out from the rest is how relatable the author is to people who have this illness," and a person with bipolar disorder asserts that they feel adequately represented—negative assessment of Moezzi as "offensive," "racist," and a "narcissistic diva" is hard to ignore. Perhaps it is not surprising that Moezzi's humorous and satirical approach to writing about mental health and her insistence on offering an intersectional analysis of how dis/ability and other identity markers connect might not resonate with all readers that are used to a Euro-white-centric focus in portrayals of psychological health.

Going beyond the Texts

In offering models of women who are successfully living with their neuroatypical minds, Moezzi and Ramprasad's life writing texts, which do not shy away from showing their subjects hit rock bottom, make a crucial contribution to dis/ability activism. The women encourage active solidarity with disabled communities in their writing and beyond. Ramprasad is the founder of ASHA International, a nonprofit wellness organization, and Moezzi started Hooping for Peace, a human rights and peace organization. In line with Annamma, Connor, and Ferri's postulation that DisCrit "requires activism and supports all forms of resistance," Moezzi and Ramprasad's life writing supports their non-textual activism.[81] *Shadows in the Sun* and *Haldol and Hyacinths* contain concrete political messages to improve the lives of people with dis/abilities.

In addition to challenging persistent stigma against certain mental differences, the authors demand mental health care reform. *Haldol and Hyacinths* disparages the "perpetual degradation" of the psychologically disabled, "thanks to the American health care system and its often inhuman training methods and protocols" (90). Moezzi criticizes the for-profit approach to mental health services, which robs patients of their dignity; since "insurance companies . . . pay significantly more for fifteen-minute 'med checks' than they do for forty-five-minute therapy sessions[], psychiatrists have little financial incentive to do much more than dole out scripts" (170). Instead of employing holistic healing methods, drugs are prescribed indiscriminately with “side effects about which patients are frequently uninformed” (170). Ramprasad concurs that “Western medicine is focused on controlling symptoms instead of fostering systems change. . . . [W]ellness does not come encapsulated in a pill that can be patented by pharmaceutical companies and traded for profits” (226). Neither author denies the effectiveness of some drugs and certain treatments for patients with mental health concerns. Yet, they advocate against a persistent neglect or discrediting of traditional, non-Western healing approaches, which are often seen as primitive and ineffective due to cultural stereotypes.

One such method is pranayama, an ancient Indian meditation and breathing practice, which has been fundamental in helping Ramprasad control her depressive and anxious episodes (226). While large-scale studies on the benefits of pranayama and yoga are scarce, a number of investigations suggest that coherent breathing can decrease depressive symptoms,[82] that mind-body exercises may improve depression,[83] and that breathing-based meditation might serve as an effective intervention for patients with depression who do not respond to medication.[84] In referring to a potential healing technique that is indigenous to a non-Western culture, Ramprasad exhibits a diasporic identity that cuts across monolithic understandings of cure. She resists the portrayal of Indian culture as always oppressive and critiques the exceptionalist assumption that only Western medicine can generate healing. Additionally, Ramprasad’s advice captures the fact that one of the most pervasive barriers keeping people from adequate mental health care is cost. Ramprasad and Moezzi critique financial inaccessibility to treatment and suggest ways to reform the care system through respectful and effective methods that are not tied to the power of large companies.

In addition to critiquing the complicity of pharmaceutical businesses in the mistreatment of people with dis/abilities, Moezzi and Ramprasad condemn the practice of solitary confinement. Moezzi decries it as “cruel” (221), and Ramprasad describes feeling “like a convict on death row being led to the execution chamber” when she is brought to her seclusion room (218). This simile is matched in intensity by Moezzi’s statement that “little difference [exists] between the power structure of the so-called ‘Islamic’ Republic of Iran and so-called ‘treatment’ facilities” with guards and leaders that are “just as brutal” (235). Moezzi insinuates that the isolation of those deemed “mentally ill” in the U.S. is similar in viciousness to the human rights violations—such as “censorship . . . clampdowns on freedoms . . . floggings, arbitrary arrests, protracted imprisonment, disappearances, executions, and torture”—perpetrated by the Iranian regime.[85] As Kafer reminds us, for many people with dis/abilities, “[e]rasure is not mere metaphor.”[86] The comparison is especially poignant as the U.S. has long admonished Iran’s abuses of its people, when, as Moezzi claims, the U.S. dehumanizes some of its own citizens in similarly destructive ways. In linking dis/ability rights with a debate that is political in nature, Moezzi clarifies that dis/ability is very much a political and not just a private issue.

In their call for abolishing solitary confinement, Ramprasad and Moezzi add an intersectional component focused specifically on women with an immigrant background to the work activists against the mistreatment of people with mental health issues have performed. For example, Elyn R. Saks, a professor of Law, Psychology, and Psychiatry, who lives with schizophrenia, has pushed for respect and autonomy for people with mental dis/abilities. In her autobiography, *The Center Cannot Hold* (2007), she illustrates her experiences of having been physically restrained in hospitals even though she had never been a threat to others to show how degrading the practice is and to delegitimize the use of any force as psychiatric treatment.[87] Saks, Moezzi, and Ramprasad use their life narratives to push for the rights of people with mental dis/abilities. In an activist voice, they demand that mental health patients be "treat[ed] with basic human dignity and respect" (Moezzi 235) and "promise [themselves] to restore [their] dignity and the dignity of others around the world" (Ramprasad 219). With such force, these women's memoirs encourage activism to educate a wide audience and to raise self-esteem in those affected. The intersectional lens through which they narrate their lives challenges medical norms, ableist blame, and stigma and celebrates neuroatypical people of all backgrounds.

Notes

1. Melody Moezzi, *Haldol and Hyacinths: A Bipolar Life* (New York: Avery, 2013), 186.
2. Gayathri Ramprasad, *Shadows in the Sun: Healing from Depression and Finding the Light within* (Center City: Hazelden, 2014).
3. Jasbir K. Puar, "'I Would Rather Be a Cyborg than a Goddess': Becoming-Intersectional in Assemblage Theory," *philoSOPHIA: A Journal of Continental Feminism* 2, no. 1 (2012): 52.
4. Ibid, 64.
5. Ibid, 55.
6. Alison Kafer, *Feminist, Queer, Crip* (Bloomington: Indiana University Press, 2013), 3.
7. Subini Ancy Annamma, David Connor, and Beth Ferri, "Dis/ability Critical Race Studies (DisCrit): Theorizing at the Intersections of Race and Dis/ability," *Race, Ethnicity and Education* 16, no. 1 (2013): 19.
8. Robert McRuer, *Crip Theory: Cultural Signs of Queerness and Disability* (New York: New York University, 2001), 9.
9. Kafer, *Feminist*, 2.
10. McRuer, *Crip Theory*, 9.
11. Ibid, 30.
12. Kafer, *Feminist*, 16.
13. Kimberlé Williams Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color," *Stanford Law Review* 43, no. 6 (1991): 1245.
14. Susan Wendell, "Toward a Feminist Theory of Disability," *Hypatia* 4, no. 2 (1989): 104-124.
15. Kafer, *Feminist*, 5.
16. Ibid, 6.
17. Ibid, 7.
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19. Ibid, 15.
20. Andrea Nicki, "The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma," *Hypatia* 16, no. 4 (2001): 87.
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22. Thomas G. Couser, *Signifying Bodies: Disability in Contemporary Life Writing* (Ann Arbor: U of Michigan Press, 2009), 203.
23. Thomas G. Couser, "Conflicting Paradigms: The Rhetorics of Disability Memoir," in *Embodied Rhetorics: Disability in Language and Culture*, eds. James C. Wilson and Cynthia Lewiecki-Wilson (Carbondale: Southern Illinois University Press, 2001), 79, 88.

24. Susannah B. Mintz, *Unruly Bodies: Life Writing by Women with Disabilities* (Chapel Hill: University of North Carolina Press, 2007).

25. Julie Rak, *Boom! Manufacturing Memoir for the Popular Market* (Waterloo: Wilfrid Laurier University Press, 2013), 133.

26. Going forward, direct quotations from the two primary texts analyzed will appear as in-text citations for reading comfort.

27. Cecilia Tasca, Mariangela Rapetti, Mauro Giovanni Carta, and Bianca Fadda, "Women and Hysteria in the History of Mental Health," *Clinical Practice and Epidemiology in Mental Health* 8 (2012): 110–119.

28. For a detailed analysis of how sexism in the medical industrial complex creates a gender data gap that adversely affects women, see Caroline Criado Perez, *Invisible Women*: *Data Bias in a World Designed for Men* (New York: Abrams, 2019).

29. Pushpa Naidu Parekh, "Gender, Disability and the Postcolonial Nexus," *Wagadu: A Journal of Transnational Women's and Gender Studies* 4 (2007): 146.

30. Ibid, 153.

31. Diane E. Hoffman and Anita J. Tarzian, "The Girl Who Cried Pain: A Bias against Women in the Treatment of Pain," *Journal of Law, Medicine and Ethics* 29, no. 1 (2001): 13-27.

32. Ibid, 17.

33. Ibid, 19.

34. Lauren Mizock and Megan Brubaker, "Treatment Experiences with Gender and Discrimination among Women with Serious Mental Illness," *Psychological Services* (2019): 3-4, http://dx.doi.org/10.1037/ser0000346.

35. Thomas G. McGuire and Jeanne Miranda, "New Evidence Regarding Racial and Ethnic Disparities in Mental Health: Policy Implications," *Health Affairs* 27, no. 2 (2008): 396.

36. Ibid, 398-399.

37. Stark Raving, "To Fight Mental Health Stigma, We Need to Reclaim the Word Crazy," *Medium*, January 28, 2019, https://medium.com/invisible-illness/to-fight-mental-health-stigma-we-need-to-reclaim-the-word-crazy-dec3a3cda70f.

38. Ibid.

39. Hoffman and Tarzian, "The Girl Who Cried Pain," 13.

40. Wendy Ashley, "The Angry Black Woman: The Impact of Pejorative Stereotypes on Psychotherapy with Black Women," *Social Work in Public Health* 29 (2014): 28.

41. Ibid, 28.

42. Miranda Fricker, *Epistemic Injustice. Power and the Ethics of Knowing* (Oxford: Oxford University Press, 2007), 5.

43. Hoffman and Tarzian, "The Girl Who Cried Pain," 20.

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51. Marina Morrow, et al., "Shifting Landscapes: Immigrant Women and Postpartum Depression," *Health Care for Women International* 29 (2008): 594.

52. Ibid, 606.

53. Scott Parrott and Caroline T. Parrott, "Law and Disorder: The Portrayal of Mental Illness in U.S. Crime Dramas," *Journal of Broadcasting and Electronic Media* 59, no. 4 (2015): 640. 51% of mentally ill characters were violent compared to 18% of characters from other populations, and 60% of the former group perpetrated a crime compared to 19% of the latter (650).

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Ibid, 641, 652.

56. Risdon N. Slate, Jacqueline K. Buffington-Vollum, and W. Wesley Johnson, *The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System* (Durham: Carolina Academic Press, 2013).

57. Ashley, "The Angry Black Woman," 30.

58. Kelly M. Hoffman, et al., "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites," *Proceedings of the National Academy of Sciences of the United States of America* 113, no. 16 (2016): 4300.

59. Ibid, 4296.

60. Ibid, 4299.

61. Annamma, Connor, and Ferri, "Dis/ability Critical Race Studies." In her award-winning 2018 *The Pedagogy of Pathologization: Dis/abled Girls of Color in the School-Prison Nexus* (New York: Routledge, 2018), Annamma powerfully applies the Dis/Crit approach to the lived experiences of disabled women of color in juvenile detention. Through the use of these young women's voices, Annamma exposes the systemic practices, such as lack of care and hyper-punishment, that paved their way to prison.

62. Annamma, Connor, and Ferri, "Dis/ability Critical Race Studies," 6.

63. Ibid, 11, 12.

64. Kafer, *Feminist*, 30, 32.

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73. Ibid, 68.

74. Ibid, 68-69.

75. Vivek, "Bridging the Gap."

76. I purposefully use the collective term Asian American to denote that stigma about dis/ability and willful invisibility of dis/ability are issues that affect all people of Asian descent in the U.S. due to the historic racism against Asian immigrants.

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