Yale RebPsych Speaker Series

Mad Folx and Activist Spaces: Tensions, Challenges, and Opportunities for Radical Inclusion.

Speaker: Laura Cornwall

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Sreeja Kodali: Thank you for hopping on. We're letting folks trickle on and we'll start soon.

How do you feel about getting started? Great. Welcome, everyone, to another session of RebPsych 2020, decolonizing mental health. I am Sreeja. I use she/her pronouns. I am a Med student. I am a South Asian woman. I have a long Black braid and a navy shirt.

We have live closed captioning available. Instructions have been posted in the chat for accessing this. To do so, you can select "show subtitle on the closed captioning or more menu.

To view the full transcript, in a separate browser, there is a link in the chat.

I want to acknowledge that Indigenous peoples, have stewarded through generations the lands and waterways what is called the state of Connecticut. We honor and respect the enduring relationship that has existed. This is but one step, recognition. We look forward to using this platform to further decolonize.

We explore what decolonization of mental health looks like. Last week we looked at this in terms of mental health. There will be a link to the recording last week.

I'm thrilled to introduce Laura, who will be presenting tonight. Laura Cornwall is a performing arts manager, theater producer, and dis/ability advocate and activist. She has a BA from Oberlin in Dramaturgy and Stage Management, and an MFA from the Yale School of Drama in Theater Management. Between degrees she worked in New York, managing Mercury Glass Theatre in New York, managing Mercury Glass Theatre and other indie groups. While at Yale, her efforts shifted increasingly towards disability work, , leading to the formation of the group DEFY: Disability Empowerment for the Yale school of drama. That strain of her work is what brings her here today.

We have a feedback form. Please use the chat and Q and A functions for discussion. We encourage people to share thoughts and take space, but also make space for others. Use "I" statements to speak to your specific experiences rather than generalize. Be thoughtful in your storytelling and avoid specific instances of distress that may be re-traumatizing. Laura?

Laura Cornwall: I do have a PowerPoint I'm going to bring up, but I want to share my background. My pronouns are she/her. I am a white, Queer, Mad, cis woman. I am a white, low-femme Queer woman with her hair pulled back, wearing a red and white shirt, with a sheet in the background.

I am speaking about neurodivergent people of all sorts, but my experience is in bipolar. I do not have experiences of psychosis or developmental challenges. I am presenting only part of the big picture.

I'm originally from Berkley, CA. My professional background is in theater, dramaturgy, stage management. I managed the Mercury Glass Theater, I was all over the place. I became a mental health activist there. My first diagnosis was at age 13 but my neurodivergence has been lifelong. Claiming mental illness has allowed me to get right to the point and since I am a white, privileged woman I can leverage that.

I needed a deeply disabling institution like Yale. The dean always gives a speech saying, you probably don't feel that you belong here. You do. And I did feel that, but language around imposter syndrome is often used to convince people that their feelings of not belonging relies on them feeling it, not acknowledging the unwelcoming systems in institutions.

I found I wasn't a failure just because I didn't do things the same as other people. Seeing the impact I could have changed me. I learned about the power of imagination and respect. I hold sacred the DEFY space we created as Mad folks, crips, and queers. It brought me here to where I am today.

Give me a second to get the PowerPoint up. I need tech help. It's not loading.

Speaker: Did you hit the share screen button?

Laura Cornwall: If I do, it says "host disabled screen share button."

Speaker: One second. Sreeja, you have to promote her to a co-host.

Sreeja Kodali: Got it. Sorry, everyone. Try it now.

Laura Cornwall: Do you see it? Yes. Fabulous. One more second. Mad folx and activist spaces. Opportunities for radical inclusion.

I use a lot of quotes. I want to amplify the beautiful work that came before me. All text on slides will be read. It's not additional information. This is a mix of theory, practical suggestions, and quotes. As a background in the performing arts, I think it's the personal and political, practical and theoretical. We're going to talk about these Things:

Terminology. Practical suggestions. Barrierss to actions. Radical access and inclusion. Sources. You will have action items to take with you. I have an extensive list of sources that I cite at the end. Former scholars and folx on social media. We will have a question answer after the 60 minute presentation.

We're going to talk about ableism and sanism. I talk about psychiatric survivors. There is mention of police violence and I do talk about my trauma.

Access check-in. I gesticulate a lot. I will have to move around some. I'm trying to accommodate a back injury. I will drink water, and I may have a cough coming in. If we were sharing physical space I'd say this same thing; Do whatever you need to do to be comfortable. That's one plus of online work.

[Reading quote: Resisting binaries and boundaries and central to inclusion as well as the idea of Madness. It's my motivation. [Echo.] It's my motivation in weaving theory into a talk on practicalities. All forces act together, you can't understand one element without the others.

We have another quote from Leah Lakshmi Piepzna-Samarasinha [reading.] Her book is beautiful.

[Reading quote on slide]

My goal is to realize spaces like that which are grounded in imagination, community, love, etc. If you take anything from this, I hope that you get that solidarity is an act of love.

These terms could be a talk themself. If you're interested in learning anything further about what I talk about today, hit me up. My contact info will be at the end of the talk. Today we will talk about [reading points on slide]

Rather than pinning down disability, I prefer this quote from Alison Kafer's book, which I will cite extensively today. [Reading quote on first point]

Then, [reading second bullet point quote]

Then, I use the slash of dis/abiltiy. This comes from Dan Goodley. [Reading third bullet point quote]

Disability is fluid and contextual. This runs contrary to the medical model. [Reading quote on slide]

The medical model focuses on individuals. It focuses on normalcy and operates in a curative framework at the expense of societal critique. An opposite viewpoint is a societal model. An example for that is building without ramps in saying that the society puts the barriers there.

Alison Kafer opted for the political/relational model. [Reading first bullet point quote]

Furthermore, from Simi Linton [reading second bullet point quote]

It's important to note that not everyone who exists under these bigger umbrellas of disability identify as disabled or need to. In a political and relational model, we share a struggle because of how we are positioned in society, not how we personality identify. If you live that experience, even if you don't identify that way, we are comrades.

Autistic activist, Nick Walker defines neurodiversity as [reading first bullet point]

They argue there are alternative ways of thinking and apprehending the world. This is backed up by evidence in humans and other species. [Reading second bullet point]

From there, we get neurodivergent and neurotypical. Neurotypical folks have minds that work the way society deems typical and then neurodivergent folks have brains that work and different and beautiful ways. This gives us comrades because our experiences and needs may differ. We share a struggle against neuro normativity.

What is Madness?

[Reading first bullet point]

There's no way to refer to me and my folks that isn't politicized in some way because our existence is politicized. Current terminology includes intellectual disability, mental health service user or consumer, neurodivergent, crazy, Mad, etc.

[Reading second bullet point]

Mad has a broad historical sweep. The focus on brains and drugs and recent. Writings on Madness have existed for as long as humans documented their lives. It's throughout human history.

Those of us who identify as crazy or Mad have Made a deliberate chance. [Reading third bullet point]

I will also add that the use of Mad is tied but not limited to the Mad movement, which was a response to the carceral industrial complex. I would encourage you to check out last week's presentation on the mental health industrial complex. The two presenters did excellent work and dove into these nuances.

At a basic level, ableism is discrimination against disabled folks. It's much thornier than that. I like Talila Lewis' quote. [Reading first bullet point]

As Dan Goodley puts it [reading second bullet point]

We're not meant to ableism is an important arm of white supremacist capital. It is meant to prevent any imagining of new ways of being.

Sanism is ableism focused do neurodivergent. [Reading first bullet point]

It is essentially the punishment and repression of neurodivergent. Imani Barbarin says [reading second bullet point]

Sanism in practice looks at discrimination in housing and employment. It looks at a focus on violence when people who have neurodivergent are 12 times more likely to be the victim of violence. These statistics get more dire when you look at race, class, etc.

These come into play around forced or coerced psychiatric intervention. This leads us to psychiatric survivors. [Reading first bullet point]

[Reading second bullet point]

I will not go into psychiatric trauma because it can be deeply triggering and we don't have the time for that today.

I identify as one of those people who resist going into the psychiatric system. I take medication and talk to my director, but fight tooth and nail to keep myself and loved ones out of the psychiatric system.

Let's get into Crip theory. [Reading first bullet point]

From Carrie Sandahl [reading second bullet point]

Heather Sykes tells us [reading third bullet point]

Dan Goodley also expands on that. He says that crip theory fits well with neurodivergent politics.

What do I mean by Activist Spaces? It's any space virtual or Physiol that includes anyone involved in activism, justice, etc. If it's a space you care about having neurodivergent people, then it's what I'm talking about today.

Apart can include teleconferencing, phone, etc. Together can include the casual to the formal meals, protests, parties, etc. It's all those things we can do much less of these days.

There are some things that are important to remember. From the incredible deaf-blind tech inventor Haben Girma [reading quote at bottom of slide]

It doesn't matter if the technology is there if we don't use these technologies. Captioning, having pronouns on Zoom, etc. are only excellent if the culture uses them.

Being at home doesn't mean that boundaries are not important. Being at home doesn't mean I don't need time between events, or that I don't have anything else I'm doing, etc.

What do we mean by access? Mine definition is based on Katie Rose Guest Pryal from *Mind Interrupted.* [Reading quote on slide]

When I talk about access, I mean the idea that a space should already be welcoming to people with varied needs. They shouldn't have to ask for it. Pryal also notes that the key isn't to solve all problems but deepen the channels of access.

The idea of something being fully accessible does not exist. If it's fully accessible for one person, it's probably not for another. It's not an absolute. It's about generosity.

I will go into the ethos of this later, but first I will go into a far from comprehensive ways you can help those neurodivergent in your sphere.

You can ask for preferred contact methods. This is an opportunity to show you understand people have different modes of operating. And you're more likely to reach people if you know what is most comfortable for them.

Give as much information in advance as possible, including content warnings whether you think it's triggering or not. Access of the space, including temperature, chairs, weather. If there are agenda documents, attach them. You can't predict everyone's needs and all of that, but reach out. Assume people need the buffer.

People communicate in a lot of ways; mix your methods. Include emails, texts, etc. Also change language modes. Simple language can be a help for all people, as can graphics or video. In activist spaces there is a lot of emphasis on theory and texts. Consider whether you're prioritization of theory is a block for folx.

I'm thinking of formal spaces here. Discuss systems and expectations. Social cues are subjective. Activist spaces often move quickly, leaving neurodivergent people behind. If you haven't thought about who determines the pace in your group, now is a good time. You can have a talking totem, time after for questions and gathering of thoughts, keep a living document that people can add to, have shared hand signs or cards you hold up.

Feedback is rarely considered outside of work, school, and formal institutions. But we give informal feedback all the time. Neurodivergent people oft in give feedback in ways that are not valued. Margaret Price says, [reading quote at bottom of screen.]

The goal is a community where people are open to on starting conversations. Access check-ins are helpful. Takes the onus off dis/abled folx to make that space. I did that in about 2 seconds. We all have bodies, minds, and needs.

Physical space. This is a behaviorally flexible/friendly space where people can eat, fidget, or stim around. I have to do some sort of drawing as I listen. All the drawings in my presentation is from my notes in grad school. Places to sit and restrooms are important. I take medication I have some intermittent nausea, so I just have to take care of myself.

If you can model these norms, do. I did this. Over time, people got used to it. I was also in a position where this was safe to do. Have places to sit and make sure some seating options are fat-friendly. If all you have is chairs with arms, your fat comrades are screwed. Fat-phobia is rampant in activist circles.

I also suggest you have pillows on the floor for people with pain. The room should be highly obvious and labeled. You may not be able to make changes if you're in a space that's not yours. Maybe you can change the bathrooms to be gender-neutral. Some may be OK with that. If not, make sure you identify the single stall restrooms. Make sure you have accessible restrooms.
Have warnings for high-sensory elements like flashing lights, video, darkness, smells, loud music, etc. It isn't about, you can't come to this. Rather, there are three specific moments you may want to step out of the room. The safe space room is here.

If I come in to your chaotic event as a neurodivergent person, tell me who I can access to accommodate my needs.
Avoid scented things. Provide friendly fonts and copies of things spoken. Consider a quiet, low-stimulus space where the neurodivergent person can escape to take care of themselves. Maybe it has plants, low lights, is quiet, has snacks and comfortable seating. This very existence of a space signifies you are thinking about neurodivergent people.

Access. Sometimes our enemies are labeled by us as "crazy." I've done it. So are you coding awkward people as dumb or awful, or saying behavior is weird, question if that is sanist thinking. Acknowledge different perspectives and backgrounds and their value.

If you see someone hosting an event without the access elements, ask them. Some people don't put this information up because they're afraid of getting it wrong. None of us are perfect. If you're afraid of imperfection, you're blocking people out.

Keep inviting us, even if we cancel. I canceled often. But my friends kept inviting me. If you're watching, I love you all it makes a huge difference.
Be OK with people not being still. Allow neurodivergent people to behave in the way that is comfortable for them, and you may find the group as a whole works better.
If something is genuinely disruptive, yeah, talk about it. But was it just bumping up against the status quo?

Honor bodily needs. Honor bodily realities.
Be mindful of substances. This is big. Alcohol and caffeine carry a lot of social weight. Often, events are organized around alcohol and coffee or tea. Try to include non-alcoholic beverages, beverages without caffeine. Don't shame people.

Don't enforce toxic positivity. Allow us to be in our natural states. Be flexible - enthusiastically flexible - about asking how things can be better.

BELIEVE US. That's a whole slide. Please. The number one struggle as Mad people, universally, is people don't believe us. We're gaslit and shamed about things we know to be true. It's exhausting to have to justify your lived experience.
For those of us with experiences that include breaks from realty, being gaslit is especially terrifying.

Know that community support outside of the industrial mental health complex is so important. I can't get into it now because of time, but just trust your neurodivergent comrade. Do all you can to protect that. Believe us even if we're not in the room. We know people say things about us behind our back. Challenge what is said. Believe us.

Here is a quote from Alison Kafer, Crip Time. Oh, my internet is unstable. Be aware of that. [Reading quote beginning at top of page. Reading second paragraph on slide.]

So why is this so hard? At a basic level, people don't think about it. Even in activist spaces. Neurodiversity rarely comes up. This is a sanist culture bogging us down. It sits at the intersection of many identities.

Intersections. [Reading quote from Isabella Kres-Nash at top of slide:]

[Reading quote from Kafer.]

Robert McRuer asks [reading second bullet point]

Mia Mingus tells us how [reading third bullet point]

A space can't be inclusive if it isn't recognizing and recognizing with these elements. A useful graphic of privilege is the wheel of intersectionality from Jessie.

At the center, we have unique circumstances of power, privilege and identity.

Sreeja Kodali: Some folks are saying they're having a hard time with the cutting in and out. Would you mind trying to see if pausing the video will improve that?

Laura Cornwall: Sure thing.

Sreeja Kodali: Thanks, and sorry for the interruption.

Laura Cornwall: No worries.

Sreeja Kodali: We'll see if it works.

Laura Cornwall: All go from here?

We have unique circumstances of power and then other aspects of identity. Around those identities are identity specific oppressive forces which are things like racism and homophobia. Around those forces are the larger society focuses like the economy, capitalism, education systems, etc.

A side note is that Jessie is currently traveling across the country to get life saving surgery. We are saving space for them and hoping they can reach care.

It's important to know who has power and is setting norms. If one person does that too much there are likely to be oppressive power structures in your group.

If we don't establish clear goals, it's easy to fall into the same oppressive systems we face from society at large. Our defense mechanisms have been honed by the capitalist white supremacist world and it's easy to snap into oppressive paradigms.

To break this requires trust. It's important to remember that disability doesn't equal family, for us white folks.

Criticisms of people's approaches to life and health, and not letting them make chances about their bods, how neurodivergent often aren't believed is the same for many other groups. Then there's weaponizing mental illness. There's a trend on social women who, when called out for saying racist or other problematic things, use their mental illness as a shield or justification for what they have done. This is incredibly dangerous and toxic, especially for other white Mad folks, it's up for us to shut that down.

In the resources you're using as a group, be sure you have voices from disabled people of color.

[Reading quote on slide]

Conflict can be healthy and valuable if approached directly and empathetically. What are some things that arise when people neurodivergent and disabled people share space?

There's not a clear line, we can all slip into Madness.

Sreeja Kodali: One other thing. Would it be possible to bring down the pace for some folks?

Laura Cornwall: Yes, absolutely.

Sreeja Kodali: Thank you, and sorry for the interruption again. [Laughing]

Go on.

Laura Cornwall: I do talk a mile a minute. It's an effort for all of us.

The Mad community does a fair bit of policing each other. This has to do with the oppression Olympics. Who has it worse or whose illness is worse? The division between sane and crazy worsens that.

There are things that may read as neurodivergent in one space and normative in another.

Presumed access to diagnostic information is another one. Not all Mad folks have access to or want a diagnosis. Diagnoses are useful in specific circumstances and can be wielded against people. We shouldn't have to share personal information to be believed. It's not necessary to provide access.

Knowledge of a person's diagnosis or general disability status doesn't mean they provided consent for you to ask whatever you want at any time. It's important to honor consent with information like this. If I let you into this circle, I expect out. Respect that.

Neurotypicals need to practice not asking why someone needs it. Neurodivergents, I want you to practice not offering information. "I'm not going to be able to be there today. Thank you for understanding."

Mary on Instagram, at Invalid\_\_art said that [reading final bullet point]

Lots of neurodivergent people have no interest in a cure. A cure is in the medical model. Approach to wellness is personal. Allow us to share how we navigate the medical industrial complex.

Often, people think they can tell or predict how we are or will be doing. That is false. Many neurodivergent folks are excellent at masking. It's often a defense survival mechanism that clicks in without us intentionally choosing to do that. We can share something without sharing everything.

Just because you heard something about our health doesn't mean you have all information. Disabilities also change day to day, and year to year.

Madness as laziness is a huge issue in activist spaces and has pushed a lot of people out of these spaces. [Reading quote under bolded bullet point]

This culture of exhaustion is incredibly prevalent in activist work. It's certainly why I dropped out of a lot of those spaces. Think about whether you code people as lazy because they take the time they mean.

Madness isn't solely mental. Madness comes with a lot of physical, and this is especially true for autistic folks. There's a lot of good work on the holistic experiences autistic folks go through. Medications also come with a lot of side effects. That is definitely true for me.

Boiling identity down to illness really sucks. Not everything can be attributed to illness. We're still regular folks. On the flip side, boiling nothing teardown to illness also sucks.

There's a quote that I hold dear about this. [Reading quote on slide]

So, keeping those dynamics in mind, despite faulty premising these, these keep communities in conflict. Red herrings keep oppressive power structures. We can look at high/low functioning campaigns about normalizing the dichotomies of illness.

You've probably heard of someone referred to as a high or low functioning whatever. This is rooted in a white supremacist capitalism framework of function value. If you are considered low functioning, nothing is offered to you and there's no room for growth. If you're high functioning, everything is expected and there's no room to struggle.

This is to pit folks against each other. The problem is in our head. The struggle with sanism means . . . disability and existing. Comparing ourselves helps no one except the status quo.

The super crip narrative is based on disability porn. Mental illness is super variable. Something that is easy before may be hard. I may develop new skills and lose old ones. It doesn't matter.

When I any normalizing . . . we have all seen in director's offices, dorms, social services, etc. "Are you sad, tired, hearings a frowny storm cloud." It's good to educate people. Most of these campaigns focus on depression and anxiety. This erases the experiences of people with other kinds of Madness. The programs often reinforce neurodiagnostic criteria that leaves people doubting their lived experiences.

These are markers of health rather than well being. They sell the idea that mentally ill people can be "just like everyone else." This is harmful of so many. These operate in medical model. They are often infantilizing and are often from an abled neurotypical gaze. They offer solutions that are inaccessible or ill advised. Counseling is often not available for people. Medication is often given without much thought, can have a physical impact, etc. Often who sponsors these campaigns are big pharma. They want you on their meds.

When I talk about medic/natural, I'm talking about the differences in care. [Audio cutting out] [reading second point on slide]

Every human is different. Still true. Harm and trauma from the medical industrial complex is real - believe it. It's valid. It's possible we have Made choices about our care. Don't ask me about yoga, turmeric, etc. Dismissal of alternative and natural forms of care, however, is racist and classist.

So with these struggles in mind, I'll read another quote from Leah Lakshmi Piepzna-Samarasinha. [Reading quote on slide.]
How do we learn to love each other? With radical access and inclusion. Eddie Ndopu says, [reading quote.]

Alison Kafer says, [reading quote.]

From Tanya Titchkosky [reading quote.]

Rather than incremental change to the status quo, radical inclusion suggests recentering and rebuilding. Making spaces more comfortable for neurodivergent folx makes it better for all. Ask, how would this operate, what would success look like? Imagine it. Do it.

We get a lot of resistance. [Reading Alison Kafer quote.]
Lack of money and resources. That's real. Scrappy activist groups often don't have a lot of resources. But this is also about culture and community buy-in. A Quiet Space can be Made with limited resources you may have around your house. Yoga mats, pillows, blankets. Phone Chargers are important for people with crisis apps on their phones. Have water. Have non-perishable snacks.

"We don't have neurodivergent people here." I call bullshit. Neurodivergent people are good at masking. I would hide by dissociating during events. I would stay still through events even when it meant I couldn't focus and I'd be exhausted. But just seeming OK is a defense mechanism that kicks in automatically sometimes.

Slow down. Even I move quickly. It's sometimes hard to remember to slow down. Capitalism has conditioned us to move quickly. Question - who benefits from this? Check if your group is valuing urgency over agency. Ask about why you are invested in this work? Why do we need this? Anti-oppressive work requires Mad, disabled, neurodivergent voices. This is new so it seems hard. We need buy-in for people beyond us. Radical inclusion means different things in different spaces. It is a mindset and practice.

Action items.

Listen to and learn from other neurodivergent folks. Normalize access check-ins. If you are looking for specific folks to learn from, hit me up. I might know them. Normalize asking how people prefer to be contacted. Don't ask for private info if you're neurotypical, and if you're neurodivergent practice not offering it. Have hard and soft deadlines. Neurotypicals, interrupt sanist rhetoric. Neurodivergents, interrupt your internalized sanism.

I ask myself, who is benefiting from my sanist response to myself? What am I actually asking for, what would I need? Would I say this to my neurodivergent comrades?

[Reading quote on slide.]

These are the source texts I was quoting from. I'm just clicking through them so it's in the recording. If you need this list in another form, hit me up. Personal shout-outs to the people who helped me move through these four years. [Listing names.]

That is the presentation. I can close my window. Sreeja, what's be3st to move forward to the question and answer?

Sreeja Kodali: You can leave your video on. We have a few questions from folks in the .Q/A. I'll read them.

How do you help change mindsets of those whose careers are wrapped in the medical model, like psychiatrists.

Laura Cornwall: That's a great question. It's coming down to resisting the medical/natural. Plenty of people are invested in those systems. Invite them to welcome other things as well. Rather than convincing them their system is harmful, I think a useful first step is to convince them of other resources as well. Even though the harm conversations are important.

Sreeja Kodali: Great. Another question: There's been a big push by Pharma to co-opt/falsify patient advocacy groups in all fids. Do you see neurodivergent folks pushing back on this?

Laura Cornwall: I don't have experience as much in medical advocacy groups. There is room to make change. Because of the way Pharma and hospital lobbyists - this is why radical, Queer Crip safe spaces are incredibly important

That said, it's a huge issue. In the same way we see the Queer movement being coopted by companies selling rainbow shit, I think we need to remember that if they're trying to take it away from us, we're doing something useful that threatens established systems.

Sreeja Kodali: Great. How do we ask activists to create accessible spaces without taking up space during times of crisis? Thinking of BLM organizing directly post George Floyd's murder or protests that happened directly following other acts of state violence.

Laura Cornwall: Excellent question. There are a few elements. The first is, taking for example [audio cuts out/returns] Black activists who are taking action. How can we show up in ways that are safe and useful. Look to those leaders. They're there, even if they're being hidden. Especially around BLM, Inani Barbarin is an amazing resource.

But if you're saying, we have to go out in the streets - what are other ways to support that work? For my safety, I need XYZ. Can I offer other things? Can I make posters, signage, digital art? That's great for those of us who can't safely go into the streets. For those of us with multiple disabilities in COVID times, going out to protest in the streets can be dangerous and scary.

You could say, I think I could be valuable operating in this way. Again. If people feel pushback to the activist work they're doing, they get defensive. If you approach it as expanding opportunities, people tend to be more open to imagining other realities.

Sreeja Kodali: Another question. How do you navigate the guilt that can come with stepping back if we hold other privileged identities and it seems like it is our responsibility to be putting in the work?

Laura Cornwall: I grapple with this as a white woman who has an invisible disability and privilege. I recommend finding other folks who share your privileges and marginalized aspects. I found talking to other Mad white women useful because I could process through the guilt and complicated feelings without putting that on someone doing the work themselves.

I think the way to fight urgency is to propose that yes, the work is urgent, but this work is not being to end. It's not like, surprise! It's all solved. It requires the urgency. We need people on the vanguard read ready to show up. We need to make sure people have warm, safe spaces to come back to. It's about saying, there are other ways too. How can we operate in a way that is not detrimental to us. Otherwise it's not sustainable.

Sreeja Kodali: Great, this question is shifting gears to medical spaces. Can you give examples of how neurotypical folks can help neurodivergent folks when they enter hostile medical spaces? Examples given are when they are given meds or the doctors don't trust their neurodivergent patients.

Laura Cornwall: I know this conference is connected . . . I don't have a lot of experience in that.

One thing that is very tricky is that in COVID times, people can't bring in other support people with them. Often, that's having patient advocates who are right there. That's really helpful.

An important thing, like with asking how someone prefers to be contacted, if the neurodivergent person is able to communicate verbally communicate that way. You can also ask them how they prefer to communicate, you can bring in cards to say writing things down is easier.

Particularly for autistic and folks with developmental disabilities, they communicate in a different way. People in a medical complex don't understand how they communicate and don't believe them. If someone seems to be in distress, if they are writhing, crying, etc. it's important to consider whether the circumstance is distressing to them. Often to intervene, the medical approach is to drug and restrain them. Instead, consider if there are non interventionist ways to check in and see. They may be freaking out because there's a million people around them, there's sterile light, it's really intense, etc.

We can also continuant to have these conversations. A lot of people working in these spaces don't know about different neurodivergent models, conflicting indignities, etc. You can just get people involved in that. If you are working in medical circumstances . . . people are not being given pain meds. Both people of color and Mad folks, because they are not believed, tend not to get the main medications they need. If there are questions about specific circumstances, I can try to answer them. Those are my broad thoughts.

Sreeja Kodali: Thank you. We have plenty more questions rolling in. I want to do a quick housekeeping plug. In the chat, there is a feedback form. Be sure to check that out. We would love to have your feedback. There's a sign up for future sessions. I wanted to share that before moving on to the next question.

Someone is saying you mentioned something along the lines that disabled folks should not have to ask for accommodations but we should act with empathy at the center. How do we balance that with people's needs being individual and specific?

Laura Cornwall: Excellent question. Again, it's about modeling behavior. I think there are some things that are universally useful. I went over a lot of those things. Again, you can't predict all needs. As this person wrote, everyone has different individual needs . . . beautiful about being in disabled spaces. You see the variety of ways people exist.

If you do a lot of work to suggest your space is welcoming, you create an environment where that disabled person is more comfortable asking. They know they won't be interrogated . . . can't create the perfect time. The more we can create a fairly welcoming space, it comes less of a thing to ask for addition changes.

If you are someone who needs a specific access component, and you're not comfortable going to the head of the group, whoever your fellow is in this, ask if they know the best person to talk to or if they could ask to someone.

If you are a neurotypical person in this space, if you have a neurodivergent friend, ask if there's anything you can ask to make this more accessible for you. That way there's less of the power structure where a disabled person lacking power has to ask a powerful person for what they need.

Sreeja Kodali: Great. Another question is how to go about asking an organization how they address access needs. If you have examples that would be great.

Laura Cornwall: One second. I feel like my answer to all of these is, "it depends." It depends. [Laughing]

For me, this is pretty new. I've not had to do this much. I also left grad school and had a complete break down to deal with the trauma of grad school. I have been unemployed and then a pandemic hit. With Yale, I spoke to my direct advisors.

Then, I spoke to both the dean who handles EDI issues and I also went to the disability office. [Audio cutting out]

. . . hierarchical spaces, there is probably an HR person. They can be a good person to start with. If you ask about their access intentions and they are confused, or don't know how to answer you, you have just gotten a big answer. If they have things to offer, they can then direct you to other people.

Another way to do it is to just ask your colleagues, friends, people, etc. who are there what their experience has been.

If you are lucky enough to have disabled people in your immediate circle, definitely ask them. I learned a lot about what would be challenging at Yale from ill people and people doing activist work before me. I'm sorry I don't have tons of examples. I'm happy to thank . . . [Audio cutting out]

Sreeja Kodali: Great, your examples are wonderful, Laura. We are really happy you are here tonight with us, and blessing us with all your knowledge. [Laughing]

Let's see what other questions we've got. Someone has asked if you could share further. This is more on the theory based one. Could you share more about the origins of disability in racial capitalism and how this impacts the way disabled people come to be permanently marked in the boundary between sane and Mad, and disabled and abled, and how that is crystallized?

Laura Cornwall: That's a super awesome question that I do not feel qualified to answer. All of my theory is books I read when I had time. I've not read a lot about that. That said, I know there are some useful and informative texts. If that person wants to shoot me an email, I'm happy to build a list of some people I think can answer that question.

Sreeja Kodali: We have another question. They really appreciate your point that we shouldn't presume that someone has access to a diagnosis or wants one. This resonated with them personally, as did much of your presentation. People at work expect you to be able to label your struggles to offer you leniency. Do you have suggestions for work?

Laura Cornwall: I'm glad you appreciated it. As a white woman with a lot of access to care, it took a while to come around to the idea that this isn't necessarily useful or necessary. One thing to do is to decide for yourself what terminology you want to use, whether it's disabled, crazy, mentally ill, or none of those things. Decide how you choose to identify. If you can say you identify as this and my needs are this, people may try to push for diagnosis. The more clear you are, the less likely they are . . . [Audio cutting out]

A lot of it is about confidence. My approach to this language is using what will be most useful in that moment. Sometimes I use Mad or crazy when I want to drive home a point or make someone feel uncomfortable about their privilege. Sometimes I use more vague terms and dance around it.

If people really try to ask, say that you don't think it's relevant to the conversation or information that you're comfortable sharing. I think it's great when you can get into conversations about why that medical model may not be super awesome. A lot of it comes to trying to stand your ground. If you have allies in that space and accomplices, they can intervene. Often it's helpful to have a neurotypical person who jumps in and validates what you're saying, and takes the attention off you. I recommend building a circle so you don't have to take all of that yourself.

Sreeja Kodali: Great. One last question, maybe that we'll end on, is more of a housekeeping type question. There have been a lot of interests in your slide and presentation. Will you be able to make the slides available?

Laura Cornwall: Absolutely. I will email them to you after this. You can make them available to folks.

Sreeja Kodali: Wonderful. Thank you so much, Laura.

Laura Cornwall: Absolutely.

Sreeja Kodali: This came up in the chat. We will make the videos and transcripts for all the session available to registrants. We will send out instructions on where to access those. Once again, thank you for your incredible presentation. Thank you for attending. We hope to hear your thoughts on tonight's session in the feedback forum. We hope you join us for future sessions.

Laura Cornwall: Thanks guys.

Sreeja Kodali: Thank you.

[Zoom meeting ended]\_