Title

Panza Awareness: Constellations of Health and Healing Toward a Decolonial, Feminist Turn in Race-Conscious Medicine

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Panza Awareness: Constellations of Health and Healing
Toward a Decolonial, Feminist Turn in Race-Conscious Medicine

by

Sonia Cristina Hart Suárez

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requirements for the degree of

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in the

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of the

University of California, Berkeley

Committee in charge:

Professor Ramón Grosfoguel, Chair
Professor Charles L. Briggs
Professor Winston Tseng

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Abstract

Panza Awareness: Constellations of Health and Healing
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Doctor of Philosophy in Ethnic Studies

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This dissertation claims a decolonial turn in healing sciences is possible by nurturing the epistemic and ontological practice that I call "*panza awareness*" (gut-knowing in English and *el saber de la panza* in Spanish), which is the embodied exercise of listening to our gut feelings and learning to interpret the information that comes from our body as valid knowledge. It proposes a mapping (or constellation) of possibilities for healing the body that centers Black and Indigenous people of color (BIPOC)—with a focus on a Black, Indigenous, and Chicanx/Latinx perspective. It outlines the limits of biomedical ways of understanding the body through race-based, individualized medicine; and it introduces an alternative, race-conscious approach to producing knowledge about health and the body alongside students and community members of color. Using interpretive methodologies in a transformative action research framework, this dissertation generates ethnographic data through a community-engaged, BIPOC-oriented workshop called the *Panza Knowing Workshop*. I designed and tested the *Panza Knowing Workshop* through the pilot program discussed in this dissertation.

For this dissertation's first intervention, I 1) study and critique the cultural concept of distress known as *ataque de nervios* (loosely "nerve attack") and 2) develop *panza awareness*. Using a decolonial, feminist-informed critique of *nervios*, I propose a shift from the individualist mandate, "*Te tienes que cuidar tus nervios*" [You must take care of your mental health], to a collective, empowered invitation to foster *panza awareness*. Through *panza awareness*, we can begin to fill in the gaps in our knowledge of healing and the body. As a second intervention, I demonstrate that the *Panza Knowing Workshop* generates knowledge of connections between body, mind, health, and knowledge of embodied and ancestral healing modalities. The workshop enacts action research by reciprocally providing psychoeducation and community resources for health and healing to workshop interlocutors. It imagines how biomedical and embodied and ancestral knowledge of the Global South may continue to emerge in respectful, humanizing co-existence in line with the Zapatista imperative to imagine a world where many worlds are possible.

I dedicate my dissertation to a free Palestine and to liberation for all Indigenous and diaspora peoples of the world.

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Preface

There I was in Havana, Cuba, sitting in a room full of spiritually developed and enlightened Black diaspora women, receiving their guidance through an *espiritista* (Afro-Cuban spiritualist) ceremony known as the *misa de coronación*, or coronation mass. I was beginning the Afro-Cuban Lucumi ritual practice known as "making santo" (*kariocha*) to become a consecrated priest of the orisha named, Eleggua. At my *misa de coronación*, days before my formal initiation —and under the authority of my godmother and the *espiritista* medium hired to run the coronation—I was told of my main spirit guide. This "guardian angel," who has been with me since I was born and who has guided me through life's ups and downs, is John Hart—the signer of the U.S. Declaration of Independence and my eighth great paternal grandfather, an enslaver and a colonist. I was disappointed and upset.

I will never forget the voice of Tania Martínes *Omó Changó*, affirming, "It is the spirit holding the declaration. He stood up." (*Es él de la Constitución. Él se paró.*) "Make it make sense," I questioned in shock. When I told my godmother (*madrina*), Leonarda Sardiñas Enríquez *Okán Tomí*, about my doubts, she said, "He is your guide. He has seen the light." (*Él es tu guía; tiene mucha luz.*) I wrote these words down in my notebook after my ceremony to try to integrate what I was learning about my life, with more questions posed than answered. My faith was tested in the moment my elders revealed this identity to me. John Hart, the signer, *el firmador*, brought me to Orisha religion? He led me to be a decolonial scholar? How could a colonizing enslaver be my closest spiritual ally in life—me, a decolonial, feminist, disabled, queer Chicana? I identify with my Mexican-American mother, who raised me. I learned Spanish first; I grew up on welfare; I am an activist; I believe in *brujeria*; I practice a Black religion. None of these parts of me seem to carry the touch of an enslaver, colonizer. But it all proved to be an invaluable revelation. I was being given the opportunity to practice what I preach. I had to reckon with my White privilege as the daughter of a White man in a whole new way, a deeper way, because this paternal blood connection proved stronger than I ever imagined. I had to surrender to the new forms of evidence offered to me in my spiritual practice that grew my faith. I had to turn a new leaf at the level of my intergenerational karma. I had to surrender to the teachings of my religion and my new way of life.

By taking my spiritual vows seriously, and by owning the complexity of what I was learning about myself, I had to learn to see the world in a radically new way. It became increasingly hard to continue to discipline myself to do things in my life and work the "normal way." I could not go back to my work striving for the 'evidence base' of things anymore—decolonial thought and Black and women of color feminisms already have the evidence. I had to commit to doing work that would be radically different from the status quo and beyond the Eurocentrically accepted way.

This initiation story represents the turning point in my autoethnographic research, it represents the epistemic and ontological axis from which I shape my dissertation research in Ethnic Studies. Even as an academic scholar, I am a medium for the messages that I carry from the mixture of my bloodlines, the stories of my life carry them, and it is my onus to articulate them. When I was sitting on the divination mat during kariocha, I was told, "The world needs to see something made from your hands," (*El mundo tiene que ver algo hecho por tus manos*). I stand at a particularly complex and contradictory intersection of race, academic praxis, and spiritual practice, and I owe it to my godmother to do as I am told and let the words typed through my fingers in the form of research exist in the world. Sure, I know the decolonial

imperative from my research and student activism, but I also know it from the spaces of my bones, from my heart, my gut. For me, the push to see and act in the world from a decolonial and feminist lens is an unrelenting urge and a constant struggle. My lived experience and ways of understanding the world irrevocably changed through my religious rites. I had to learn to think and be in the world in new ways after making *santo*.

A few days after the signer was revealed as my guardian angel, as I sat in front of the cowrie shells in the culmination of my initiation rites, Ivan Esquijaroza Calderón *Obbá Ilú*, the master of ceremonies of my *kariocha*, told me, "Despite being so intelligent, you have achieved little because your nerves have betrayed you." (*A pesar de ser tan inteligente, eres muy poca cosa porque los nervios te han traicionado.)* This felt like a slap in the face. I was already studying "ataques de nervios" from an ethnographic standpoint in the university, but I did not expect to hear the term *nervios*, along with this biting message during my ceremony. It was too close for comfort. I had recently struggled with suicidal ideation and had taken a medical leave of absence from my program. I felt like I had been benched by the coach. People say that your dissertation work should be something that you are passionate about, but this was another level. In that moment, I truly became the subject of my own research. My *nervios* flared. I cried a lot in days and years following. But I also prayed a lot and returned to Havana as often as possible to learn from my elders. I tried to keep up with my new spiritual practice, which was a profoundly lived, quotidian practice. My decision-making began to change, the ways in which I moved through the world began to change, and with these divine messages, my journey to understanding *nervios* became a deeply embodied one.

"Orula traveled the world, *ahijada*. The orisha were well connected with all parts of the world. They serve all of humanity." These were the words of my godfather, Evaristo Rodríguez *Otrupon Yekun*, in Chicago, when I asked why non-Black Chicanxs and other non-Black people were allowed to practice Lucumi Orisha religions. As my practice developed, my sense of belonging in Orisha religion also evolved. I began to truly walk the path of the Orisha. Through these types of questions, posed over time as I deepened my relationship to my spiritual elders, I began to put the seemingly disparate pieces together, because my spiritual work and my academic practices informed and shaped each other. I committed to using an autoethnographic methodology, because my intellectual work on *nervios* and race-based behavioral health studies demanded a framework that would accommodate my story. My experiences learning about *nervios* through Lucumi Orisha religion fundamentally influence the ways in which I approach my research because it is how I move in the world. I did not want to turn my elders into participants and subjects in my research; but I wanted the conversations they had with me (as I navigated both their spiritual advice and my academic work) to be connected to the research.

After my *kariocha*, I collected myself during my year in white (*iyaworaje*). I went back to Havana and asked my *madrina* about her experience with *nervios* in her capacity as an orisha priest. She saw *nervios* all the time in her godchildren and family. The Orisha have much to say about the topic. Several Orisha have stories (*patakin*) associated with *nervios*, for example, Obatala is known as the maker of heads, and he takes responsibility for people who suffer from mental illness. It is said that he himself has a propensity to drink, and sometimes, Obatala drinks to excess when he is making the new heads bound for earthly life. In Lucumi thought, the etiology of mental illness can often be traced back to this *pataki.* For these people, Obatala steps forward as their main guide in life, and they are taxed with the journey to tap into Obatala's qualities of equanimity, or cool headedness, to balance or resolve their mental illness. The oral archive of knowledge known as the Orisha, Odu, contains countless axioms about *nervios* as well

as prescriptions for how people might approach their healing. In our conversation, my madrina repeated a phrase she uses often, "This means to get to work, not to worry," (*Esto es para ocuparse, no para preocuparse).* My godmother explained the simple guidance, which is that the things said or marked down in the context of ceremony and initiation were meant to shed light on problem areas to resolve or abate them. For her, it does not matter if it is *nervios* or any other state of imbalance (*osogbo*) afflicting the person, what matters is that the Orisha always give you a way through it. "The Orisha have lived everything, but they did *ebbo*," (*Los santos vivieron todo todo todo lo que ves aqui, pero hicieron ebbo*). The notion of *ebbo* is translated both as 'work' or 'sacrifice,' and in this context reflects my godmother's perspective that it matters less what the affliction is, and more that there are spiritual workings and lived actions that can move the person out of their state of imbalance. This is the crux of the research at hand, the *Panza* Awareness workshop does not claim to help to define what *nervios* is or even what it means for people, but rather it acts as a scholarly *ebbo*, a working of sorts, that takes forward moving action rather than looking down to try to define *nervios.*

In our conversations about *nervios*, and then over and over in various contexts after the fact, my madrina emphasized that there are spiritual and biological intersections in people who experience *nervios.* Her approach is always to acknowledge the coexistence between spiritual and biomedical healing. She is a fan of pills! When I pressed if she would specify what is her approach to helping a godchild complaining of *nervios*, she said, "I tell them they must go marching to the psychologist, there's one on every corner, and if they can get medication, even better. And here in my [religious] house, with the [Orisha and the dead], we take care of the rest." (*Les digo que deben ir marchando al psicólogo. Hay uno en cada cuadra, y si pueden conseguir la pastilla, mejor. Y aquí en mi casa, con ellos, nos encargamos de lo demás.*) She believes in the value of tackling our problems using both the biomedicine and the ritual practices available to us. In Cuba, where she practiced as a dental hygienist before dedicating herself full time to spiritual practice, she has found compatibility between biomedicine and the practice of Lucumi tradition. I was reminded of Lia Ling's Hmong parents in *The Spirit Catches you and you Fall Down,* who echoed something similar, desiring, "A little medicine and a little *neeb*," referring to their traditional spiritual belief system (qtd in Fadiman, 1997, p. 110). During my conversation with my godmother on the topic of *nervios*, she also referred me to speak to one of her godchildren, who is a physician and Orisha priest in Havana. Lucumi practices are highly informed with biomedical knowledge in these ways. These conversations led me to question, what if the inverse was true as well? What were the biomedical possibilities of a future that takes non-Western traditional thought seriously? These experiences and the resulting questions led me to take seriously dissertation research that would interrogate the boundaries of knowledge production within the study of behavioral health across intersections of race and gender.

Introduction

Producing Knowledge With and For BIPOC People: Interpretive Methods for Gender and Race-Conscious Medicine Research

It was as a former doctoral student of counseling psychology that I learned of the gastroenterological connections to psychology and mental health. After rethinking the study of *ataque de nervios* (loosely "nerve attack") via decolonial and feminist frameworks as a student of Ethnic Studies, I rejected the extractive, top-down approach to studying *nervios* in an academic setting.[1] And I began to explore creative ways to shape the burden of knowledge production that was ahead of me in ways that lateralized the process and brought in my community as co-creators of healing knowledge.

This dissertation claims a decolonial turn in healing sciences is possible by nurturing the epistemic and ontological practice that I call "*panza awareness*" (gut-knowing in English and *el saber de la panza* in Spanish), which is the embodied exercise of listening to our gut feelings and learning to interpret the information that comes from our body as valid knowledge. In Spanish, the term *panza* means the belly as well as the gut (the gastrointestinal tract). It is also a cultural idiom that has been reclaimed within the Chicana feminist perspective via ancestral and embodied knowledge to mean gut, as said with a sense of humor and a sense of pride in a body-positive way (e.g., Grise and Mayorga, [2004] 2014). In my conceptualization of *panza awareness,* the *panza* represents the gut, the belly, and also a Chicanx/Latinx sensibility. It recognizes the interconnectedness of the gut to multiple intersecting, interdependent social conditions–as expressed through our experiences of the body, including mind and soul. *Panza awareness* represents an act of knowing in a decolonial way, a psychological and somatic *rasquachismo* (underdog perspective) (Ybarra-Frausto, 1989) that seeks to elucidate the intersections of various embodied oppressions, as well as the applications of ancestral Indigenous and diaspora knowledge systems toward healing knowledge.

This community-engaged study of knowledge production and learning about the body proposes a mapping (or constellation)[2] of possibilities for healing the body that centers Black and Indigenous people of color (BIPOC)—with a focus on a Black, Indigenous, and Chicanx/Latinx perspective.[3] It outlines the limits of biomedical ways of understanding the body through race-based, individualized medicine; and it introduces an alternative, race-conscious approach to producing knowledge about health and the body alongside students and community members of color. Using interpretive methodologies in a transformative action research framework, this dissertation generates ethnographic data through a community-engaged, BIPOC-oriented workshop called the *Panza Knowing Workshop*. I designed and tested the *Panza Knowing Workshop* through the pilot program discussed in this dissertation.

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[1] I elaborate further on *ataque de nervios* and its varied definitions and meanings in Chapter 1.

[2] I thank Native American Studies scholar Sierra Edd for her teachings on constellations from an Indigenous perspective. The conceptual framing of knowledge as transdisciplinary or constellational that I utilize in this dissertation was developed, in part, during a zine-making workshop led by Edd. It also developed from our conversations as we discussed the decolonial potential for our workshop modalities in knowledge production. I discuss Indigenous notions of "constellation" throughout the dissertation.

[3] I use the terms Latinx/Chicanx to reflect the unquantifiable range of expressions of gender and sexuality among our communities, as well as a historical consciousness of intersectional oppressions (Pelaez Lopez, 2018). I also use these terms interchangeably with Latina/e/o and Chicana/e/o to reflect the diversity of usage in everyday life.

For this dissertation's first intervention, I 1) study and critique the cultural concept of distress known as *ataque de nervios* and 2) develop "*panza awareness*." The latter is a new concept and practice that more equitably addresses the uneven morbidity of illnesses that emerge in culturally specific ways; it encompasses but does not rely on expressions of *nervios*. *Ataque de nervios* is typically used as a translation of mental illness, like panic disorder or post-traumatic stress disorder, but *nervios* alone can also refer to mental health, the mind, and even the spirit more broadly. Without a decolonial feminist framing, *nervios* (as it is used by and applied to people experiencing suffering) is not a generative concept. In medical anthropology literature, *nervios* represents a cultural idiom of distress that adopts the biomedicalized frameworks of medicine to articulate their embodied experiences of racial and gender inequity (e.g. Scheper-Hughes, 1992; Santiago-Irizarry, 2001, p. 34). Departing from a decolonial, feminist-informed critique of *nervios*, I propose a shift from the individualist mandate, "*Te tienes que cuidar tus nervios*" [You must take care of your mental health] (an autoethnographic observation that I have heard and repeated many times over), to a collective, empowered invitation to foster *panza awareness*. In other words, in the moments when *nervios* (and *ataque de nervios*) are used as pathologizing terms, I suggest *panza awareness* instead–as a response (but not a replacement) that still respects the concept of *nervios* in Chicano/Latino communities. The term enacts movement against static racialized overgeneralizations and toward self-determination and knowledge production. Through *panza awareness*, we can begin to fill in the gaps in our knowledge of healing and the body.

Thus, via an analysis of the *nervios*-to-gut connection, I find that *nervios* emerges as a term that references but is different (in critical ways) from a Westernized conception of the mind. A decolonial, critical analysis of *nervios* in the existing literature not only conceptualizes the mind-body as interconnected but also includes the concept of spirit (via the embodied and ancestral knowing of people of the global majority). It is for this reason that *nervios* and *ataque de nervios* often appear in the literature, and in everyday experience among Chicano/Latino people, as related to *brujeria* or other non-Western spiritual technologies. Stepping away from the mind as a rational/reasoning organ, *nervios* represents a place of connectedness between body, mind, and spirit. In this unwitting (mis)translation of Indigenous and diaspora notions of the body/mind/spirit into medicalized terms, *nervios* undermines the Cartesian supremacy ascribed to the reasoning mind. It points to an interconnectedness within the nervous system of body, mind, and spirit–as well as to the relational links between people, their communities, and their social and material structures. These biosocial ecologies remain elusive or invisibilized in our most common conceptualizations of biomedicine and the body.

Panza awareness is the meeting point, as well as the space in between, *nervios* and the gut. The conceptual intervention proposed in this dissertation examines a *nervios*-gut connection through *panza awareness*, whereby *panza awareness* is how we articulate the influence of inequality on our bodies. In this telling, I rely on Stuart Hall's conceptualization of articulation as the meeting point, space in between two bones, joint, and connector of the space in between (1980, 1986). Hall explores the etymology of articulation in a sense of both difference and connection. Articulation, as in a joint, represents both a location of difference from one part to another, as well as a point of connection or shared space. We can use the *nervios*-gut connection, along the logics of cultural knowledge frameworks and without participating in a pathological framework, to get at *panza awareness*. But we cannot access embodied and ancestral knowledge of the mind, body, spirit via the *nervios*-gut connection alone, as it remains reliant on translations toward biomedical terms (Santiago-Irizarry, 2001, p. 35). This is the value of *panza awareness*.

As an experience and expression in Latina/o communities, *nervios* is still something that is real. So, instead of telling people not to use the term, I suggest *panza awareness* as a response and remedy (not a replacement) for our understanding of *nervios.* By proposing *panza awareness* as an alternative approach that considers the chief complaints of embodied suffering *and* refuses to pathologize categories of illness absent a world-historical framing, I argue that fostering awareness of our own embodied knowledge (as well as an awareness of our ancestors' conceptualizations of healing and the body) represents a new horizon for knowledge production about the body. *Panza awareness* is how we elaborate on the connections between *nervios* and the gut in a decolonial way, including the multiple ecosocial health inequities that emerge from the conditions of oppression embodied by people of color.

As a second intervention, I demonstrate that the *Panza Knowing Workshop* generates knowledge of connections between body, mind, health, and knowledge of embodied and ancestral healing modalities. It enacts action research by reciprocally providing psychoeducation and community resources for health and healing to workshop interlocutors. This ethnographic data aligns with my critique of race-based medicine–with a focus on *ataque de nervios* as an exemplar of racializing biomedical narratives that privilege dualistic, Eurocentric logics and epistemologies (Chapter 1). The dissertation positions participants in relational, dialogical ways. It engages workshop participants as agents of knowledge production within a methodological structure of reciprocity. It imagines how biomedical and embodied and ancestral knowledge of the Global South may continue to emerge in respectful, humanizing co-existence in line with the Zapatista imperative to imagine a world where many worlds are possible. I purposefully bring Ethnic Studies and biomedicine into conversation (both thematically and methodologically) alongside real time engagement with the embodied and ancestral knowledge of BIPOC people.

**

The dissertation consists of five body chapters, as well as an Introduction and a Conclusion. This Introduction explores several interdisciplinary research practices that highlight the transformative work of interpretive methods. It argues that interpretive frameworks (e.g., action research, ethnography, group work, and cultural productions) provide creative opportunities to center people of color (especially women) within the humanities and social sciences and contribute productively to gaps in medical knowledge of race-based medicine. The *Panza Knowing Workshop* harnesses interpretive methods to conduct decolonial, feminist research that produces knowledge in collaboration with workshop participants and community members.

Chapter 1 analyzes a case study from a DSM casebook to provide two divergent opportunities for conceptualizing of race, gender, and mental illness. It first illuminates how biomedical psychopathology racializes and genders women of color who experience mental illness. It then analyzes *nervios* and *brujería* through the theoretical frames of intersectionality and embodied knowledge to resituate *nervios* as an opportunity to consider alternative epistemologies of mind, body, and spirit. This chapter examines how *nervios* appears in the biomedical literature, makes connections between *nervios* and *panza awareness*, and serves as the critical point of departure for the *Panza Knowing Workshop*–which emerges as a model for community participatory action research.

Chapter 2 introduces the project's theoretical framework, with foundations in 1) pedagogy and production, 2) transformative action research, and 3) critical race, decolonial, and

feminist analysis. After presenting the methods of data collection and data analysis, the chapter explores the dissertation's methodological framework, as articulated by "pedagogies of collaborative knowing," alongside a decolonial attitude through the conceptual framework of biocommunicability. This section also underscores the power of feminist and decolonial health action research to cultivate knowledge production grounded in the community, intervening in transdisciplinary conversations about social medicine. Finally, the chapter concludes with a discussion of the dissertation's contributions and findings. It shows that the *Panza Knowing Workshop's* community-engaged transformational research methodologies respond to critiques of race-based medicine by looking instead at knowledge from community members who propose their own solutions to health inequities.

Chapter 3 provides an overview of the *workshop*. It includes a description of the *Panza Knowing Workshop*'s theoretical and pedagogical orientations, documentation of the protocol used to structure and personalize the workshop events (e.g., lecture, storytelling, grounding, *dialogo*, feedback, and archiving), and an overview of the pilot series dates, locations, and contexts. It explores the problems of knowledge production and health inequities that produced the *Panza Knowing Workshop* and elaborates on the concept of the "*panza* archive" (Appendix C).

Chapter 4 highlights two observations and two theoretical conceptions from the *Panza Knowing Workshops*, incorporating both secondary literature and some data from the workshops. It outlines two autoethnographically interpreted observations taken from the workshop: 1) "the lightbulb moment" and 2) participants' hunger for healing, ancestral knowledge, community, and social justice. It also elaborates on two theoretical conceptualizations 3) a world of YOUS and 4) pedagogies of knowing. This chapter shows how knowledge production can be reciprocal and why research that is community engaged benefits from decolonial, feminist frameworks. Furthermore, it demonstrates that the study of a race-conscious conceptualization of health and the body can move beyond extractive and/or pathologizing frameworks. Indeed, race-conscious knowledge production can adopt a decolonial feminist approach by bringing lay people into the process of understanding health and illness.

Chapter 5 traces *Panza Knowing Workshop* participants' evolution from awareness of the gut as a place exclusively of gastrointestinal activities (Stage 1) to recognizing it as a key link in the mind-body connection (Stage 2). The subsequent phase (Stage 3) involves going beyond a literal understanding of the gut-brain connection to a conceptual and bio-social application of gut-brain knowledge. Hunger emerges as a repeated signifier for this stage of knowledge production. Through ethnography, the chapter demonstrates that after being introduced to a decolonial feminist perspective and the *panza* as a place of knowledge, many participants were able to articulate various categories of hunger–for healing, ancestral knowledge, community, and social justice.

This Conclusion outlines future directions of the workshop and recommendations for decolonial feminist research in the healing sciences based on the *Panza Knowing Workshop*. It emphasizes the possibilities of knowledge expansion by working transdisciplinary across ethnic studies and the health sciences.

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This Introduction explores how a range of feminist, decolonial, scientific, and biomedical research practices dovetail productively when operationalized within frameworks that take the

interpretive turn in knowledge production that refutes race-based medicine or "the system by which research characterising race as an essential, biological variable translates into clinical practice, leading to inequitable care" (Cerdeña, et al., 2020, p. 1125). Interpretive frameworks for research on race and gender inequities in biomedicine build bridges between positivist traditions of the health sciences and critical knowledge productions emerging within social sciences and humanities. The interpretive turn in knowledge production responds to real life research and policy gaps around biosocial and sociocultural phenomena (like health inequities), rejecting the presuppositions of empirical science—while *also* showing compatibility with evidence-based approaches (Yanow and Schwartz-Shea, 2014). Interpretive methods support race-conscious medicine (alternative approach to race-based medicine) that "emphasises racism, rather than race, as a key determinant of illness and health, encouraging providers to focus only on the most relevant data to mitigate health inequities" (Cerdeña, et al., 2020, p. 1125). This dissertation's methodology also integrates modes of reflexivity that enable researchers to seek out their own sociopolitical, historical, and embodied biases, stakes, and influences in the knowledge they produce (p. 114). Through decolonial and feminist research, the *Panza Knowing Workshop* relies on interpretive methods to produce knowledge in community with workshop participants who themselves hold unique knowledge about their bodies and health.

This chapter is divided into four sections. First, it advances interpretive frameworks based on feminism and decolonial research methods as beneficial for the study of race-conscious medicine and as useful for health scientists alongside empirical research. Second, it explores interpretive paradigms as a complement to the secularized knowledge of biomedicine and highlights scholarly research on these paradigms' interventions that are equally as rigorous as biomedical research. Third, the chapter analyzes humanities and social science methods used by women of color and decolonial researchers to understand the lived experiences of people of color; these methodologies eschew the stereotypes legitimized by Eurocentric norms and instead value the diversity of human experiences. The final section presents three methods that mobilize decolonial and feminist methodologies through interpretive processes to make constructivist knowledge legible to scientific researchers.

Race-based Medicine and Interpretive Research

This Introduction argues that interpretive frameworks that utilize decolonial and feminist modes of research design contribute productively to gaps in medical knowledge of race-conscious medicine; they are useful ways to integrate feminist and decolonial thought into biosocial paradigms of biomedical knowledge production. Existing biosocial paradigms recognize how biological and environmental influences interact. But health inequities of race, ethnicity, gender, or sexual orientation also require the interpretation of power, society, and the body–something that race-based medicine does not do (Montoya, 2011). Indeed, "[r]ace assignment is not an independent proxy for genetic difference" (Wright, et al., 2022, p. 3). In fact, the American Medical Association passed a 2020 resolution to "counteract the notion of racial essentialism" in "clinical practice, medical education and research" (T. Smith, 2020). At the individual and population levels, politically aware health sciences researchers seek to address both complex biosocial diseases as well as ecological, sociopolitical, and cultural conceptions of difference that create inequities in health (Krieger, 2011; Epstein, 2008).

A diverse scholarly knowledge base advocates for increased attention to biosocial and eco-social theories of health and illness. Researchers across the health sciences, social sciences, and medical humanities have demonstrated how biological and genetic pathways to health

coexist *alongside* social, structural, and ecological pathways (e.g., Baer et al., 2003; Nichter, 2008; Marks, 2009, p. 277). This interdisciplinary canon links power, social constructions of difference, biomedicine, and the body. While these links inform the most pressing issues of medicine today, they are poorly understood by the scientific community. Increasingly globalized contexts and movement of peoples over time and space means that colonial, racial, and gendered sciences contextualize the health experiences of nearly all the world's populations; and it is not feasible to systematically divorce issues of "culture" from questions of "science" (Marks, 2009, p. 263).

For such agencies and campaigns for health, it is hard to find evidence-based research that seeks to deconstruct the social determinants of health and offer socioculturally sensitive interventions to health inequities (WHO, 2015). As a result, health scientists have called for evidence beyond randomized controlled trials—the generally accepted gold-standard of biomedical research. Instead, they argue that global and public health studies require alternative forms of evidence (Crawford et al., 2015). Even researchers with the US Department of Health and Human Services, as well as those of the WHO, recognize that traditional forms of scientific evidence are limited by their positivist and quantitative boundaries, which lead to discrepancies and dead ends in research development and applied interventions (Crawford et al., 2015; Penman-Aguilar et al., 2016; WHO, 2015). They argue that public health and biomedical disciplines should no longer give hierarchical preference to empirical research because non-empirical forms of evidence may more closely match the research questions that arise in the study of social pathways to health (Bonnefoy et al., 2007).

Biosocial variables of health that involve racialized and gendered constructs are hard to measure through the conventional scientific method. Indeed, existing data on race-conscious medicine is daunting and often harrowingly incomplete. These issues of knowledge production reflect the vexed relationship between biomedicine and communities of color. Thus, it is important to specify how exactly health inequities have causes rooted in the biology of individual humans *and also* causes rooted in sociopolitical contexts and knowledge production processes themselves (Bonnefoy et al., 2007). Interpretive paradigms address gaps that limit the study of these perennial issues of health, race, and gender. We see this exemplified in the *Panza Knowing Workshop* through its rendering of knowledge of the body filtered through the embodied experiences and ancestral knowledge of healing modalities that may otherwise escape the biomedical or clinical eye.

Interpretive Paradigms

Knowledge itself is generated, and research is not naturally occurring. Rather, it is historically, epistemically, and ontologically situated by time, space, individual, and collective experience (Yanow and Schwartz-Shea, 2014). Interpretive paradigms recognize such intersections and co-productions of knowledge. In doing so, they find that research on race-based medicine has been dominated by positivist approaches to knowledge production. Whether quantitative or qualitative in methodology, positivist and related paradigms validate empirical observations and assume universal, knowable laws of nature, which are constructed around rubrics of Christian theology and Eurocentric applications of reason (Marks, 2009; L.T. Smith, 2013; Denzin and Lincoln, 2005). Interpretive scientists refute these presumptions yet share the 'scientific' attitude of doubt and procedural systematicity that represent central attributes of scientific method.

Interpretive paradigms developed from the imperative to move beyond the secular turn of colonial science. It does so by de-godding knowledge and Eurocentric reason, optics, and cognition as the ideal modes of "discovering" universal truth (Marks, 2009; Wynter, 2003). In biomedicine today, secularized knowledge draws a dichotomy between nature (objectively knowable) and culture (subjective and un-bound by the laws of nature)—resulting in a teleological paradox whereby paradigms of science exempt themselves from their own standards of objectivity (Marks, 2009; Zuberi and Bonilla-Silva, 2008). The interpretive turn that contests these dichotomies and teleology evolved from genealogies of phenomenology and hermeneutics (Yanow and Schwartz-Shea, 2014). These philosophical foundations deem separations between natural, social, and cultural worlds to be socio-cultural constructions and focus instead on meaning-making processes and the interpretation of meaning as analytical science (Yanow and Schwartz-Shea, 2014). I find these philosophes compatible with decolonial, feminist approaches to knowledge production.

Beginning in the early-twentieth century, phenomenologists emphasized that the researcher's perspective shaped the generation of knowledge. Indeed, the tradition of hermeneutic analysis developed from awareness that cultural artifacts, or material manifestations of consciousness, convey the meanings and understandings that people draw from their embodied, lived experiences (Yanow and Schwartz-Shea, 2014, p. 9, 19). Phenomenology and hermeneutic theories understand knowledge as dynamically interdependent with the ontologies, epistemologies, and methodologies that produce them. Drawing from these philosophies, interpretivists showed concern for ontological embodiments, or how we experience our lived contexts even before we interpret them as knowledge. Epistemology determines the structures by which we conceptualize knowledge itself and how we know what we know. On the other hand, methodology represents the process by which a researcher's ontological and epistemological standpoints, including their points of privilege, oppression, and bias, become enacted as knowledge production.

Sociologists Eduardo Bonilla-Silva and Tukufu Zuberi prioritize an interpretive turn in which the researcher's prior views and social situatedness shape their ability to interpret data because data does not innately tell a story. Instead, they "use data to craft a story that comports with [their] understanding of the world" (2008). Bonilla-Silva and Zuberi emphasize that epistemologies—our logics of inquiry and knowledge constructs—are not divorced from the realities of human lives, ideologies, or methods. Interpretive researchers depart from the trappings of positivist epistemologies that adhere to the tenet that "seeing is believing," yet still produce objectivity by recognizing multiple understandings of reality and multiple sites of meaning-making. While interpretivists in science and technology studies know that no universal or ultimate truth may be applied to the realities of other bodies, times, or spaces, they stake claims to "stronger" forms of objectivity that emerge when accounting for more than one version of reality (Harding, 1995). I rely on this interpretive turn when analyzing the data from the *Panza Knowing Workshops* in order to demonstrate how the knowledge carried and embodied by community members (who themselves stand at the intersections of multiple oppressions) can contribute to a healthier future.

Interpretive frameworks attest to new forms of rigor as they operationalize post-positivist ontologies and epistemologies, including methodological, quantitative, analytical, and systematic processes (Yanow and Schwartz-Shea, 2014). For example, a randomized study of heroin addiction, which may causally link heroin use and suicide, is one example of "scientific" rigor. By contrast, interpretive processes may demonstrate rigor by using the same public statistics on

heroin addiction yet analyzing them through an ethnographic design that uses participant observation, personal relationships, and immersion in the population over a long period of time. Anthropologist Angela Garcia, for example, generates analysis of power as an important consideration that is missing from standard approaches to addiction (2010). Garcia systematically re-frames a statistical trend over a longitudinal time lapse and through geographic, relational, and intergenerational lenses to demonstrate how (in the absence of power) suicide transforms the role of heroin in marginalized populations and reflects a means to negotiate relations of care among heroin users. At the same time, since it values quantitative evidence of addiction, Garcia's interpretive work humanizes the otherwise victim-blaming narratives of addiction among Native American and Mexican immigrant populations.

Garcia's interpretive turn is important because addiction research maintains a strong behavioral focus that can ignore structural conditions of power. Assumptions misconnecting behavior and biology also persist in other disease categories like chronic illness. For example, medical anthropologist Michael Montoya's ethnography reframes predominant biomedical narratives and evidence showing that Mexican Americans have a greater susceptibility to type 2 diabetes (2011, p. 5, 134). Through his multi-disciplinary and interpretive research, Montoya finds that diabetes among Latinxs does not follow the logics of behavioral, racial, or genetic determinism as current biomedical knowledge indicates. Instead, it represents a complex disease with both environmental and biological triggers.

Montoya traces how, in the absence of interpretive frameworks within biomedicine, diabetes research, and data on race-based medicine understand diabetes among Latinxs as an "ethno-racial disease," effectively recycling bygone logics of racial biology that depict non-White bodies as genetically inferior (2011, p. 9, 195). For Montoya, "bioethnic conscription" is a more useful concept to understand how and why diabetes incidence is higher among people of color. Drawing from biosocial theories, the conscription of bioethnicity is the process whereby the social origins of human difference are folded into a biogenetic or clinical claim (2011). In this way, Montoya seeks out the social and material structures that contextualize biological expressions of pathology. Specifically, he identifies how existing empirical health data on diabetes is shaped by the racialized presuppositions of scientific experts. Montoya creates new meanings about the confluence of biology, race, and population health by interpreting racial inequities in diabetes as evidence of the compulsory enlistment of ethnicity to serve as a biomedical marker of pathology.

Beyond medical anthropology and related disciplines, organizers and activists of social justice need empirical data to support their work, and quantitative data is not necessarily antithetical to decolonial and feminist praxis. In an address for the Data Center based in Oakland, CA, Māori decolonization theorist Linda Tuhiwai Smith and social psychologist Michelle Fine emphasized the dearth of and need for numbers and data within communities organizing for social, civic, environmental, and reproductive justice. This is necessary in planning, funding, and advocating within the political realities of our times (2013). Smith elsewhere asserts that research is a "dirty word" for Indigenous people, but she is careful to elucidate the possibilities for epistemic decolonization and structural equity available through the revisioning of the contours of academic research (L.T. Smith, 2013). Smith and Fine remind us that interpretive researchers offer tools to identify the intersections between biomedicine and power that activists, clinicians, and policy makers require to make systemic transformations. My goal with the *Panza Knowing Workshops* is to harness not only my interpretations of evidence that link the mind, body, health,

and illness, but also the understandings of these interconnections that are held by community members and students across a variety of settings.

Interpretive, Feminist, and Decolonial Research

Women of color feminist epistemologies and epistemologies of the Global South contain invaluable knowledge of the pathways to health that lie at the intersections of race, gender, and the body (Krieger, 2011). Interpretive designs that integrate feminist and decolonial theory alongside traditional biomedical knowledge offer ways to center women of color in research on race-conscious medicine in humanizing ways. Psychologist Thirusha Naidu asserts that decoloniality is an important "theoretical perspective from which to interrogate sociohistorical, geopolitical, and economic perspectives on gender, race, and heteropaternalistic influences in medicine emanating from a basis in colonially developed systems of knowledge production" (2021, p. S9). For women of color and decolonial researchers, humanities and social science methods have produced alternative modes of understanding the relationship between social and cultural structures, nature, and the human body. Interpretive frameworks value these methods and alternative modes of meaning-making and produce ways to understand health that also reflect lived experiences and embodied knowledge.

Black feminist theorist Patricia Hill Collins specifies a methodological call for imagination and creativity from within social science, which aligns with the interpretive turn in research (2009; Yanow and Schwartz-Shea, 2014, *xiv*). Black feminist sociological thought uses Black women's testimonies and the knowledge gained from their lived experiences as well as cultural texts produced by women and people of color themselves. By creating alternative truths, knowledge production situated in Black women's embodied agency and self-authored meaning-making contests the controlling, Eurocentric narratives at the root of positivist research paradigms in biomedicine (Collins, 2009). These alternative situated truths innovate a style of knowledge production that commits to an applied praxis of Black feminist theory. This is artfully described by African American studies scholar Ra Malika Imhotep and scholar of performance studies Miyuki Baker for the Church of Black Feminist Thought. They write, "In challenging us to center the everyday application of our work, our words, our actions, Patricia Hill Collins calls for a mode of theorizing that serves the self that is collective... [W]e recommit to the work of translation. Of speaking to the people and to the power free from the hierarchies that would render us silent" (2019, p. 12). In Collins's theoretical innovations, the voices and experiences of lay people are necessary to the process of knowledge production.

Feminists in science studies, like Donna Haraway and Sandra Harding, have used Collins's critical approach to standpoint theory to show how socially situated knowledge rooted in women's lives, despite (or perhaps because of) its heterogeneity, can debunk the androcentric logics of "objective" Western science (Haraway, 2015; Harding, 1995). As modeled in the texts produced by Collins, Haraway, and Harding, interpretive methodologies may utilize cultural texts (as well as social structures) as they employ disciplinary methods from the humanities and the social and natural sciences. Feminist thinkers paved the way for scholars from multiple disciplinary orientations to take up the study of health and the body while centering women of color bodies and their multiple knowledges (TallBear, 2013; Wailoo et al., 2012; Clark and Olesen, 1998; Comas-Díaz, 2006; Fett, 2002; Gonzales, 2012; Roberts, 2012; Skloot, 2011). Increasingly, their interpretive work has created opportunities to account for the intersections between the past and present and the structural and social conditions of race and gender hierarchies. The work of these and other scholars informed the design of the *Panza Knowing*

Workshops and constitute part of the storytelling presentation I give at the beginning of the workshops to help participants understand decolonization and the mind-body connection.

Research that seeks to humanize and center the lived experiences of people of color is oriented toward revealing the gaps in the archive and misrepresentations of history found in our most accepted canons (Trouillot, [1995] 2015). History is dynamic and relevant to the present, not isolated or essentialized in the past; and in turn, sociocultural and political relations of power inexorably link the past to the present moment (Molina, 2006). Using an interpretive framework to demonstrate the power of the past, historian Natalia Molina identifies public health as a foundational site of racialization. She analyzes archival materials and texts (including policy), reports, statistical data, and legislation—as well as media, photographs, speeches, interviews, and biographies to demonstrate public health's significant role in producing Eurocentric logics of difference (2006). Molina's methods of interpretation show how doctors and health experts, alongside governing authorities, produced medicalized notions of race and gender that negatively construed the bodies of African American, Mexican, Japanese, and Chinese peoples in the public imagination.

Framing her research through the lenses of medicalization, race and gender, Molina prioritizes the health experiences and perspectives of disenfranchised subjects themselves. Her interpretive framing begins not with her choice of methods, but through her choices of population, time, and space, i.e., Mexican and Asian immigrants in late-nineteenth and early-twentieth century Los Angeles (2006). Her methods for centering their standpoints combine the collection and analysis of quantitative data from official public health and census archives alongside a diversity of cultural texts and popular media. While much of Molina's archival data was not produced with the intention to humanize Asian and Mexican Americans, her (re)interpretations of these data do. In effect, privileging the standpoints of women and people of color produced modes of interpretation that enabled Molina to specify linkages between healthcare and governance that promoted colonial and Eurocentric racial projects taken up through the field of public health. Her work also relies on feminist epistemologies to analyze gender alongside race intersectionally, which in turn generates more substantive evidence of her assertions. Molina's interpretive framework produces both empirical evidence and qualitative significance of race and gender-specific practices of public health and medicine.

The significance of "expert" constructions of health and disease along lines of race and gender is that, historically, claims to scientific objectivity of biomedicine legitimized preexisting stereotypes. They also institutionalized these stereotypes in ways that still shape people's experiences of embodied health as well as dominant systems of healthcare. In his discussion of the hegemonic medical model in Mexico and elsewhere in the Western hemisphere, for example, medical anthropologist Eduardo Menéndez recognizes that existing hierarchical ideologies of medicine will continue to shape the study and practice of medicine (2020b). However, Menéndez also dares to imagine medical futures that include active and egalitarian participation in doctor-patient and institution-patient relations. He notes that biomedicine continues to be characterized by the predominant social forces of individualism, asociality, and–among others–mercantilism; but a medical future with more symmetry in the doctor-patient dyad is possible, if that relationship is patient driven (p. 22). He imagines a future that centers social relations, socialist worldviews, and/or Indigenous health interventions (e.g., "el buen vivir"). And Menéndez suggests that a different medical future can be achieved by a patient population that takes action (because they are experiencing high illness morbidity and mortality rates), as well as by doctors and other medical actors who must also participate in lateralizing the patient-doctor dyad (p. 4).

I propose that this dissertation's interpretive approach (which integrates decolonial and feminist framings of culturally based health concepts) answers Menéndez's call for active participation from the people impacted by health inequities (2020b). Through the lens and frameworks of Ethnic Studies, the relationship of knowledge production about the body appears in this dissertation as the participant-researcher relationship which can serve as the basis for horizontalizing the patient-doctor relationship through a patient-driven modality. This and other transdisciplinary approaches to biomedical topics disrupt the epistemological foundations that produce historical erasures, medicalize sociocultural paradigms, and inscribe relations of power onto the human body (Santiago-Irizarry, 2001). New health knowledge horizons emerge within interpretive framings that are seated in decolonial and feminist epistemologies, as is clearly illustrated by the findings of the *Panza Knowing Workshops*. The remainder of this Introduction examines a selection of alternative methods that harness the contributions of feminist and decolonial thinkers to interpretive processes.

Alternative Examples of Methodologies for the Study of Biomedical Paradigms

An interpretive turn may use empiricism in new ways to make even constructivist and other non-biomedical knowledge legible to the scientific evidence base (Yanow and Schwartz-Shea, 2014, p. 9). Typically, constructivist, feminist, and decolonial paradigms within the humanities and social sciences, which outwardly divest from positivist priorities and Eurocentric assumptions, often have few practical applications in health policy or practice. Yet, together with an interpretive framework, the points of tension between biomedical, social science, and humanities research can be productive. Interpretive research may draw from these fields in multiple ways, for example at the levels of a researcher's ontological and epistemological standpoints, or through methodologies and ways of generating or analyzing data. Interpretive epistemologies are operationalized in an array of research designs and, though certainly not a comprehensive list, *action research, ethnography, group work,* and *cultural productions* exemplify the dynamism of the interpretive turn. These processes are apt for the study of complex processes by which social constructions become embodied and understood as biomedical knowledge. And they demonstrate specific methodological techniques and procedures by which biomedical, decolonial, and feminist epistemologies can be harnessed within interpretive research. When designing the *Panza Knowing Workshop*, I relied on interpretive research methodologies to generate processes by which lay people, students, and academics may give shape to the knowledges that they embody, all of which have historically been invalidated, pathologized, or relegated as folkloric or subaltern (e.g., Berry, 2019).

Action Research Interrupts Historical Cycles

When the Third World Liberation Front (TWLF) student movement negotiated for knowledge and pedagogies that would represent the diversity of human history and experience in the late 1960s, they set the precedent for knowledge production that directly engaged people-of-color communities and coalitions (Blauner, 1969). From the legacy of the work of scholar-activists who transgressed disciplinary boundaries to meet the needs of their communities emerged a robust battery of tools for centering real people. Complementing the pedagogical imperatives of the TWLF, action research represents a body of interpretive frameworks—sometimes known as *participatory action* or *community participatory research*—that also have roots in neo-Marxist and liberation theologies of the Global South. Action research is characterized by shared ownership of research projects; community-based analysis of social problems; and direct forms of community action (Kemmis and McTaggart, 2005). Medical

sociologist Winston Tseng observes that as participatory researchers, "We need to think upstream and downstream to address these issues. We need to start downstream, or locally. Social movements and social change really start in our own backyard… prioritizing those most at risk or those most adversely affected" (2022). At the Health Research for Action Center at the University of California, Berkeley, Tseng applies these principles to show how participatory action and community participatory research routinely make critical interventions in medical knowledge of communities of color, positively impacting health outcomes and practices in collaboration with both people and community-based organizations (e.g., Ivey et al., 2012).

Michelle Fine analyzes the work of action research that blurs the lines between researcher and researched, exploring the complex humanity that straddles each end of the research dyad in meaningful, sustained ways (1994). To this extent, action research interrupts the binary constructed between expert and public, researcher and subject, or doctor and patient. It departs from an approach to science that benefits the interests of scientific authorities and stakeholders. Action research involves overlapping and sometimes non-chronological cycles of self-reflexive planning, acting and observing; reflecting, replanning, acting, observing again; and then reflecting again, and so on—all in collaborative participation with the subjects and objects of the research (Kemmis and McTaggart, 2005). Action research aligns with a transformative paradigm of mixed methodology set out by educational researcher Donna Mertens (e.g., 2019), because both support a cyclical model in which community members participate in the research process throughout all various stages of the research (Kemmis and McTaggart, 2005). Perhaps most importantly, transformative research paradigms like action research involve a methodological belief system that explicitly interrogates issues of power, both within research methods themselves and within the interventions developed or encountered by the researcher (Kemmis and McTaggart, 2005).

Ever conscious of power dynamics between researcher and researched, community action research frequently reflects the needs of social movements to explore alternative ways of doing things in settings where the impact of their activism is unclear (Kemmis and McTaggart, 2005). Action research methods that engage the communities they study have been embraced by social, clinical, feminist, POC, Indigenous, and activist scientists alike because they create opportunities for research that value the political realities of their contexts, self-reflexively. Action research has been singled out as compatible with standards rooted in Indigenous and diaspora principles that are used by Indigenous researchers—such as participation, relationality, commitment, and accountability (Smith, 2013; Simpson, 2017). It also displays ethical methods of research that respect Indigenous cosmologies and rights to self-determination (Denzin and Lincoln, 2005). Thus, action research can be transformative and emancipatory by virtue of how it posits key interpretive assumptions: that people know and can reflect on their own lives; have questions and priorities of their own; and have skills or sensitivities that can enhance (or undermine) community-based projects (Smith, 2013). Action research has created important inroads for methodologically elucidating the priorities and voices of peoples typically marginalized by the social and biomedical sciences. As a form of action research, the *Panza Knowing Workshop* seeks to create spaces in which academically- and socially marginalized people may take a dignified, non-extractive seat at the proverbial table of knowledge production.

Ethnography and Collaboration for Interpretive Research of Health

Ethnographic methods that seek collaboration with other knowledge producers and generate modes of self-reflexivity represent examples of methods conducive to action research (Denzin and Lincoln, 2005). As demonstrated earlier in work by anthropologists like Garcia, Montoya, and Molina, ethnographers taking an interpretive turn in topics of biomedical health knowledge prioritize historical context, cross-cultural interactions, and awareness of power and markers of difference (Hesse-Biber, 2014; Yanow and Schwartz-Shea, 2014,). These interpretive priorities are reflected in the following standards of ethnographic research, which expect a researcher to 1) display membership in the sphere of study, 2) engage in reflexivity as a form of analyzing the self, 3) be visibly active and present in the text, and 4) engage in dialogue with informants beyond themselves (Farrell et al., 2015). Ethnographic work positions the researcher within realms shared by their research participants and contests research praxes that essentialize, homogenize, and flatten the diversity of experiences and conditions survived by marginalized populations.

Within the medical humanities and medical education research, ethnography has been considered an emergent method that engages both the mind and body of the knowledge producer (Hesse-Biber and Leavy, 2006). These methods respond to the increasingly visible need within medical humanities and medical education research to draw attention to problems of "cultural competence," race, and cross-disciplinary debates—interrogating *both* simplistic reductions of human life to biology *and* simplistic reductions of human suffering and health injustice to cultural relativism (Hesse-Biber and Leavy, 2006). Drawing from the interpretivist paradigm in which reality is subjective and constantly changes, ethnography does not seek out a single underlying reality as supposed by universalist philosophies (Hesse-Biber, 2014). Instead, social scientists, clinician-educators, and medical researchers who utilize ethnographic methods seek to conceptualize the multiple "culture(s)" by which they understand their work and themselves in relation to it (Farrell et al., 2015).

Taking advantage of ethnographic methods for biomedical research, collaborative analytic autoethnography is a method from the emerging field of medical humanities that deconstructs the process of knowledge production of health science and healthcare. Instead of focusing on objects or subjects of observation, collaborative ethnography turns the gaze back onto the producers of knowledge by using self-reflexivity, structured analysis, and peer-to-peer collaboration. Recent authors on this method outline four fundamental aspects to the collaborative analytic autoethnographic framework, specifically research that is: (a) systematic, framed by a research question and using explicit, transparent methods; (b) problem-based, drawn from the researcher's practices; (c) cyclical, if the changes derived from the findings obtained in one cycle will be tested in subsequent action research cycles. Scholars of collaborative ethnography also specify (d) that the learning process and outcomes (action), which link the phases, are transformative to the practices and behaviors of the researcher (Acosta et al., 2015). Unfortunately, the form of collaborative analytic autoethnography prescribed within the medical humanities and health sciences continues to conceptualize even *collaborative* autoethnography as a practice used only by peers of health providers and clinicians. It does not necessarily conceptualize collaborations between researchers *and people* as valid, and thereby reproduces hierarchies that situate experts in an epistemically privileged position. As we will see with the *Panza Knowing Workshop*, lateral knowledge production sustained by collaborative autoethnography can involve a range of actors with knowledge of embodied manifestations of health and illness.

Interpretive Group Processes

Group work represents an interpretive process that can be harnessed alongside action research and ethnographic methods to advance the study of race, gender, and health. Group processes are inherently collaborative; and in formalized methods of group work, researchers or group leaders design groups to bring people together and generate knowledge from interpersonal processes (McCarthy and Hart, 2011). Increasingly visible in biomedical contexts, group work creates spaces to address the needs of more than one person at a time and functions as a comparatively cost-effective intervention for community and institutional settings. Group processes offer both methodological structure and engagement between the researcher and the community being researched, thereby addressing interpretive concerns for the structural, material, and relational contexts of the social and biological pathways to health and benefiting research on race-conscious medicine.

Drum and colleagues identify criteria for developing such collaborative group interventions in effective ways, noting five key elements: 1) identifying the change-strategy (What is the goal/purpose of the group?), 2) establishing the composition of the group (Who 'belongs' here?), 3) identifying therapeutic factors (What is going to help this meet its goals?), 4) facilitating the interpersonal group process (Who can lead this group?), and 5) delineating key elements of the intervention (What steps must this group follow, and which steps are flexible?) (Drum et al., 2011). In group work following these steps, the researcher practices both critical self-reflexivity and action-oriented interventions created in dialogue with the community or group-members.

Research using group and peer-supported interventions is legible within biomedical institutions, yet it invokes the types of questions that are critical to interpretive research drawing from feminist and decolonial paradigms. For example: Who initiates the project? What are the goals of the project? Who sets the goals? Who sets the research questions? And who designs the work? (Denzin and Lincoln, 2005, p. 131). Group processes reflect the interpretivist commitment to phenomenology, which seeks to identify *agency and intersubjectivity* inherent in processes of constructing our social and interpersonal realities (Yanow and Schwartz-Shea, 2014, p. 15). The intersubjective aspect of a phenomenological approach to knowledge production elucidates individual embeddedness in collective social realities and historical-cultural-social structures. Group work systematizes collective and intersubjective processes in ways that support interpretive bridgework. Part of the power of the *Panza Knowing Workshop* is in the collaborative group interventions that bring people together across intersections of oppression and marginalized identities to tackle issues of health and the body that are of interest to individuals and health knowledge institutions alike.

Interpretation, Health, and Cultural Texts

There is plenty of research that uses each of the three alternatives posed above to study biomedical issues like racial health inequities, which is why this Introduction analyzes their interpretive underpinnings. However, unlike the methods developed in the social sciences, humanities methods of producing and interpreting cultural texts are much less common in biomedical contexts. The hermeneutics of interpretation, however, support the view that cultural texts and other expressions of the human condition harness the meanings and significance we give to our individual and intersubjective contexts (Yanow and Schwartz-Shea, 2014, p. 16-17).

Health researchers have increasingly drawn from the humanities to address the problems of knowledge production in their fields (Charise, 2017; Jones et al., 2017). Knowledge about

health created through humanities methods elucidates the medicalized notions of the body that typically pathologize the social conditions and inequities faced by people of color, yet it also shows a vested interest in understanding and utilizing the healing power of culture (Kristeva et al., 2018; Clarke et al., 2010). Innovating the fields of biomedical research and education, the health humanities researchers argue for a radically interdisciplinary approach that 1) values epistemological differences, 2) views issues of biomedical knowledge in both private (health care) and public (education) sites, and 3) establishes a dialogical relationship between universal and local forms of knowledge and practice (Charise, 2017, p. 436, 440). These acts of meaning-making and relationality divest from biological determinism and reinterpret the significance of categorical conceptualizations of the body. They create inroads by which othered people may enter the dialogue to reimagine health and the body in equitable, embodied, and intergenerationally-informed ways.

Though not consistently represented in the nascent field of the medical humanities, decolonial and feminist art forms take on many of the most polemic topics of health research (Kristeva et al., 2018; Atallah et al., 2021). For example, *the Panza Monologues* (Grise and Mayorga, [2004] 2014) is a Chicana feminist play that explores the complex intersections between race, gender, sexuality, and the body, as it responds to colorblind logics of White, feminist productions, like the *Vagina Monologues* (Ensler, 1998). The content of the play gives homage to feminist figures of the Latinx/Chicanx cultural landscape like Gloria Anzaldúa and Frida Kahlo and shows how Chicanx identity is shaped by the experiences of discrimination throughout the life cycle via Anglo-Christian epistemologies and systems. The script reads, "In the war of our bodies, it became clear to me that before you can get to the battle of the *chocha* (slang for vagina) we have another score to settle, another place on our beautiful bodies to baptize, actualize, a place that had been demonized, sterilized, starved, stuffed, covered over" (p. 41). Critically, the *Panza Monologues* focuses not on the female reproductive organ nor on racialized markers of skin color, but rather on stories, *testimonios*, re-enactments, poetry, song, dance, visuality, and memories that coalesce around the *panza*. They write that the goals of this play are to generate "discussions of body image, obesity, diabetes, identity, place, and history," and to tie together "race, culture, socioeconomic history, material and political realities and adaptations, and their bodies (p. 16). By weaving together the stories and experiences that they collected from Chicanas in Texas, playwrights Virginia Grise and Irma Mayorga create a potent Chicana, feminist intervention through their conceptualization of the *panza*. The *Panza Monologues* serve as an inspiration for my own project, and the *Panza Knowing Workshops* likewise seeks to represent the insider stories and personal experiences of marginalized people of the global majority–recognizing this knowledge as valuable, valid, and as healing stories in and of themselves.

Grise and Mayorga take an interpretive turn in their approach to Chicanx health by integrating performance with direct acts of pedagogy and community outreach. Their published play includes the script, the history and development of the play, and a topographical mapping of San Antonio, Texas to show the role of poverty, labor, education, and race/gender-divisions, which contextualize their conceptualization of the *panza*. Perhaps most relevant to the development of the *Panza Knowing Workshop*, their text also includes guidelines for how readers can produce a staging of the *Panza Monologues*–or adopt methods like "*panza* parties," where themes and methods used in the play can be explored by the community without the presence of the play's authors. This pedagogical orientation in the publication horizontalizes the relationship between the authors and its audiences and offers ethical means for reproducing and

disseminating the *Panza Monologues*' knowledge and healing objectives. While I did not stage the play myself, I did heed their directives in imagining a community space for discussing the *panza*. Grise and Mayorga also weave together many biosocial and sociocultural intersections onto the stage, including narratives linking body image and dating; food deserts and diabetes; poverty and trauma; and language, citizenship, and belonging. They reimagine the gut or *panza* as a site of wisdom and knowledge, one where Chicanx feminists may reinterpret the pathologies assigned to Chicanx/Latinx fat (or skinny) bodies, as well as their knowledge of healing remedies passed on from generations before. This Chicana, feminist reconstruction of the *panza* is the lynchpin of the research enacted through this dissertation project.

The artistic methods of the humanities provide interpretive frameworks that contextualize clinical topics within social and cultural constructs of race and gender, and of health and disease itself. *Riveted* (2014), a photography exhibit by LaToya Frazier, showcases gripping images of environmental racism and health inequities resulting from economic and residential segregation in Braddock, Pennsylvania (just east of Pittsburgh) during the first decade of the twenty-first century. Frazier's work foretells how the Black, Brown, and poor communities of disenfranchised US geographies would soon garner national attention (e.g., due to the crisis of lead-contaminated water in Michigan or the toxic oil pipelines constructed on sacred and residential Native American land in South Dakota) (Washington, 2019; Whyte, 2016). Frazier portrays these ecosocial crises through her photography, as she displays the structural violence and embodied manifestations that result from social constructions of difference through domestic, geographical, and institutional landscapes. The photographs in *Riveted* display haunting landscapes of health and environmental inequities. They offer visual and affective information in places where public health statistics offer only numbers and illness categories. Sociologist Avery Gordon looks to cultural texts written by Black and Brown women of color to describe phenomena undetectable by traditional disciplinary methods (2008). In her study of haunting and ghosts, she shows how novelist Toni Morrison and others' cultural productions– including film and photography–engage social analysis "to imagine beyond the limits of what is already understandable" and to transform the limitations of scholarly disciplines (2008, p. 106, 195). Frazier's depictions of disease, her home, her mother, herself, their doctors, and their neighborhoods capture the "seething presence" of social and biological injustice that remains largely unnamed (Gordon, 2008, p. 8). Interpretive work in this vein carries the possibility to see, as described by Gordon, "what is usually invisible or neglected or thought by most to be dead and gone." These methods are important because they produce what Gordon calls, "haunting recognition" of the "seething presence" that, while unseen, is itself a form of knowing (2008, p. 63). Thus, cultural productions and textual/visual methods of interpretation prioritize the lived experiences and embodied knowledge of women of color themselves, and they also recognize knowledge production in overlapping and intersecting ways (Combahee Collective, 1977). Humanities methods, including art and other cultural texts, harness feminist and decolonial perspectives that reinterpret the possibilities of clinical research. These methodological approaches and cultural productions shape my research in transformative ways.

Conclusion

Interpretive frameworks redefine the theoretical and epistemic terms of race and gender that become enacted through biomedical research. This Introduction has highlighted examples of interdisciplinary research practices that display the transformative work of interpretive methods, including action research, ethnography, group work, and cultural productions. The turn toward

race-conscious understandings of health and illness aligns with interpretive frameworks that seek to deconstruct pathologizing and racializing tropes in biomedical knowledge with the aim of ameliorating the lived and embodied impacts of inequity as they shape the lives of people of the global majority. It has argued that interpretive frameworks offer creative ways to center people of color, especially women, commensurate with the methodologies and epistemological interventions developed in social science and humanities fields (e.g., Ethnic Studies and Gender and Women's studies). Interpretive frameworks *also* provide opportunities to show validity and reliability that are compatible with health science fields that prioritize evidence-based research and practice. These methodologies uniquely address key issues of race and gender in health inequities research because they utilize empirical and other evidence-based research tactics, yet they are also rooted in decolonial and feminist frameworks that challenge the epistemological and ontological assumptions of theory and practice. They reshape the very foundations from which we produce theory, implement methods, and interpret the resultant data as knowledge.

The *Panza Knowing Workshop*, alongside my conceptualization of *panza awareness,* harnesses the contributions of Black, Indigenous and other thinkers of the global majority. I contend that *panza awareness* represents an opportunity to reimagine *nervios* in equitable ways. The concept and subsequent act of *panza awareness* can be operationalized in ethnographic and group work formats, such as the *Panza Knowing Workshop*. This dissertation's community participatory action research is just one example of the ample opportunities within existing health science frameworks to call upon the knowledge of decolonial and feminist scholars, as well as creatives in Ethnic Studies and other humanities fields.

In the following chapter, I analyze the DSM casebook case study of Celia Vega to contrast responses to women of color and their worldviews by non-Western health practitioners and experts of applied biomedicine. I use this forthcoming chapter as an introduction to the *Panza Knowing Workshop* pilot program because it contextualizes how people of color have utilized biomedical terminology, like that of *nervios,* to express the effects of neo-colonial realities in their lives. The chapter also underscores the limits of cultural concepts like *nervios* and suggests that *panza awareness* is just one of many decolonial, feminist alternatives to bring people of the global majority into dialogue with the production of health knowledge.

Chapter 1

Conceptualizing Race-Based and Race-Conscious Medicine: A Case Study of *Nervios* toward *Panza Awareness*

The origin story of the interventions at the center of this dissertation begins at a tier-one research institution, where—as part of a psychopathology course in a doctoral program for counseling psychology—I was assigned to read and analyze a case from the Diagnostic Statistical Manual of Mental Disorders (DSM), regarded colloquially as the psychiatric "bible." This colloquialism is significant because it reflects the compelling power of this text in conceiving mental illness, including its ubiquitous presence in modern healthcare. In the desk reference casebook to one edition of this text, the DSM-IV, the first chapter introduces the psychopathology of a young woman named Celia (a pseudonym): "Celia Vega is a 21-year-old woman, born in Puerto Rico, who is brought, by the police, to the emergency room of a city hospital in handcuffs and leg chains" (Spitzer et al., 2002, p. 1). This bleak language offers a glimpse into the stigma and criminalization that emerge from the meeting points between psychiatry and women of color. However, the text does not intend to stigmatize or criminalize anyone, at least not outright. Specifically, the casebook is designed to provide a reference for US diagnostic concepts in psychology at the beginning of the twenty-first century (p. xii). They intend to support doctors to help their patients through proper psychiatric diagnosis.

After Celia's initial introduction, the authors narrate her psychopathology as "nervous" (p. 5). Clinicians in this case study waver over the proper diagnosis for Celia, unsure of what to make of Celia's *nervios* and puzzled by her amnestic, violent, and self-injurious episodes. They ask her, "What do you call these attacks or spells that keep happening to you?" (p. 1). In response, Celia attributes her psychiatric emergency to *brujería* (uncritically translated from Spanish in the text as "witchcraft") imparted from her former mother-in-law.[1] Though the discussion never addresses this detail, it is salient enough to be included in the write-up and to merit the title of this case, called simply "Brujeria." Standard procedures of differential diagnosis make it clear why attending psychiatrists diagnose Celia, albeit hesitantly, with Post-Traumatic Stress Disorder. Given this diagnosis, it is perplexing why Celia's "attacks" and *brujería* are so prominent in this case.

I highlight this case here in Chapter 1 because the dialogue surrounding *nervios* represents an important point of departure for the collaborative knowledge production proposed in this dissertation. *Nervios* is a popular discussion topic amongst both academics and lay people. Indeed, it remains relevant to clinical practices–where people express the *nervios* concept–and in everyday life, where I repeatedly witness its appearance through my authoethnographic observations as an insider researcher (an academic and Olorisha priest).[2] The widespread use of the concept is also apparent in popular culture through the now-classic, Spanish film *Mujeres al borde de un ataque de nervios* (translated as *Women on the Verge of a Nervous Breakdown*)

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[1] The term *brujería* has a range of connotations and meanings, ranging traditional or Indigenous herbal medicine to the realms of the metaphysical and psychosocial.

[2] In my research and writing, I give shape to the constellation of knowledge that exists within autoethnographic conceptualizations of my experiences learning about health and healing for and from people of the global majority, Leanne B. Simpson's perspective (2017), as an Indigenous academic, offers more ethical ways for me to express my interpretation of the pitfalls of existing frameworks as well as a reimagine knowledge futures that humanize, respect, empower, and seek healing for people of color. See also L.T. Smith, 2013.

(Almodóvar, 1988). Ultimately, my deconstruction in this chapter of how race and gender inform *nervios* contributes to transdisciplinary literature on the limitations of race-based medicine.

As I demonstrate, a *race-conscious* approach to the study of *nervios* considers the social and structural conditions of racism and sexism that contextualize the chief complaints recognized as *nervios*. Formulating a race-conscious approach to *nervios* is "critical elaboration," to use the language of neo-Marxist political theorist Antonio Gramsci, and it requires "the consciousness of what one really is." He adds that "'knowing thyself' is a product of the historical processes to date, which has deposited in you an infinity of traces, without leaving an inventory…. Therefore, it is imperative at the outset to compile such an inventory" (Gramsci, [1947] 1971). In other words, Gramsci describes how the key to knowing ourselves is consciousness of the historical processes that (sometimes invisibly) shape our experiences. My turn from *nervios* (as a race-based medical concept) to *panza awareness* (as a race-conscious approach to knowledge production) creates consciousness of the unseen historical processes of colonialism and racialization expressed in the body, mind, and spirit.[3]

Panza awareness involves shifting at the levels of the epistemological and the ontological and relying on a world-historical contextualization of *nervios* and health inequities to shape how we come to understand the maladies we experience of mind and body (epistemic shift). It then requires us to use actions of somatic grounding and relational acts of *testimonio* and witnessing to process our sense of knowing through embodied experiences (ontological shifts). *Nervios* (when it is used to mean "mental health" or "mental illness") pathologizes Chicano/Latino people, while *panza awareness* brings knowledge production to Chicanxs/Latinxs and other BIPOC people. *Panza awareness* takes inventory of the "infinity of traces" of social and political inequity that are embodied in BIPOC communities. (I further explore *panza awareness* in Chapter 3.)

In this chapter, I draw from my Bachelor of Science and early graduate training in counseling psychology, my current graduate studies in Chicano/Latino and Ethnic Studies, and my positionality as a Chicanx and practitioner of non-Western spirituality who has experienced both biomedical and non-Western healing practices for the diagnosis and treatment of mental illness. In the narrative that follows, I explore how (Afro)Latina/Chicana women (like Celia in the DSM casebook) are represented in the psychiatric literature and, by consequence, how they are treated in clinical and social settings every day.[4] While not necessarily everyone knows a woman who has complained of nervous *brujería* attacks—and many do—certainly everyone has been exposed to the stigmatizing and humiliating stereotype of the overly dramatic, semi-crazed, non-rational, and superstitious Black or Brown woman (Collins, [1990] 2009). Some of us may have even been exposed as one! Those moments are dehumanizing and unjust, and I suggest that a different reality is possible for people who occupy these intersections of race, gender, and mental illness.

Inspired by the story of Celia, I turn our attention to *Ataque de Nervios* (or *nervios*). *Nervios* is not an official psychiatric disease, but it is rather a psychiatric category used primarily to diagnose (Afro)Caribbean/Latinx/Chicanx individuals who present with symptoms that are similar in etiology to those of Panic Disorder and Post-Traumatic Stress Disorder (PTSD). In the most recent edition of the DSM, *nervios* is classified as a culture-bound syndrome or a set of

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[3] *Panza awareness* is a Spanglish term that I coined, which translates into English as "gut knowing" and into Spanish as "*el saber de la panza*."

[4] In this chapter, I position (Afro) in parentheses to signify the ubiquitous presence of African influence and ancestry among Latinx and Chicanx populations and their experiences of Latinidad.

symptoms more common in some cultures than others that are shaped by cultural context and expressed through local "idioms of distress" (e.g., nerves or attacks) (American Psychiatric Association, 2013, p. 758; United States Center for Mental Health, 2001, p. 11). This definition may seem innocuous, yet it contains racialized concepts that cause harm. The *nervios* label carries an important but often-misunderstood function in the far-reaching literature on culture and psychopathology. It acts as a point of translation between BIPOC and biomedical actors, and it also carries racial and gender bias.

This chapter begins with the case study of Celia Vega, through which I show that experts of applied biomedicine circulate ideas about women of color and their worldviews via the site of diagnosis. Then, I consider possible decolonial and race-conscious responses to existing literature on *nervios*. Finally, I rebut the conventional depiction of women of color through *nervios* by introducing another woman, coincidentally also named Celia, who is portrayed by *curandera* Patrisia Gonzales as an agent of both knowledge production and healing for mind, body, and spirit. In this process, I expand beyond an understanding of *nervios* and *brujería* as pathologies to a conceptualizing of embodied and ancestral knowledge as decolonial, diasporic, and Indigenous (modeled by women of color feminists like Gonzales). This point of entry into my conceptualization of *panza awareness* serves as a model for the decolonial feminist turn proposed in the *Panza Knowing Workshop*. With the workshop, I follow Gonzales's approach for transforming the conceptual framework by which we incorporate Indigenous and Global South knowledge about healing and the body.[5]

Biomedical Understandings of Ataque de Nervios, Brujería, and Celia Vega

I construe *nervios* as an Janus-faced site of knowledge production that offers two divergent opportunities to conceptualize race, gender, and mental illness. The first of these illuminates how biomedical psychopathology racializes and genders women of color who experience mental illness. In other words, it shows how the "propagation of race-based medicine promotes racial stereotyping, diminishes the need for research identifying more precise biomarkers underpinning disparities, and condones false notions about the biological inferiority of Black and Brown people" (Cardeña, et al., 2020, p. 1125). A woman of color, feminist reading of biomedical literature on *nervios* exposes hierarchical relationships between 1) biomedical doctors and their (Afro)Latino/Chicano patients, as well as between 2) biomedical and Global South epistemologies of health and the body. I find that as *nervios* is filtered through these power hierarchies, the category of *nervios* itself silences the knowledge that women of color carry about their own bodies.

Useful to my analysis of *nervios* is the theoretical framework of biocommunicability, which makes it possible for the *Panza Knowing Workshop* to be knowledge production–in addition to ethnography. Coined by anthropologist Charles Briggs and communication studies scholar Daniel Hallin (2007), biocommunicability is the "discursive acts and practices that focus on health and medical issues" (p. 45).[6] The term refers to cultural models of processes by which health and medical information is "produced, circulated, and received," in addition to those

[5] I use Global South according to the framing offered by Comaroff and Comaroff, who write that it is "a world that, ultimately, transcends the very dualism of north and south." They add that it is "a spatio-temporal order made of a multitude of variously articulated flows and dimensions, at once political, juridical, cultural, material, virtual" (2012, p. 47). Likewise, I acknowledge the origins that tie the Global South to Gramsci's analysis of power in "The Southern Question" (Dados and Connell, 2012, p. 12-13).

[6] Briggs and Hallin contribute to other biopolitical analysis, including biosociality. See, for example, Lee 2014.

responsible for this process and the value attributed to the information. The term critically engages how these ideological models purport to stand for cartographies of health knowledge and underscores the relationships of power to knowledge production. Biocommunicability adopts a biopolitical analysis alongside biosociality and discusses power and symbolic forms by which communicability helps us to discern the "categories, subjectivities, and discursive relations that seem to be presupposed by communicative processes" (p. 46). This framing is useful for elaborating how *nervios* continues to reproduce racist and sexist tropes about Latina/os. Conceptualizing *nervios* as part of a communicative process and discourse within complex relations of power helps to elucidate the functions (or effects) of research on this expression of disease in relation to BIPOC people. Briggs and Hallin's intervention also highlights how communicability spreads (like microbes and illness) beyond biology or the body to social and political audiences. It works to dictate the flow of information and discourse, including who is authorized to evaluate, speak about, and transmit knowledge about health and the body. By continuing the narrative on *nervios* through the derivation of *panza awareness*, this dissertation research challenges the trends in knowledge production about cultural expressions of illness. *Panza Knowing Workshop* participants and I practiced *panza awareness* to create dialogue about the body outside of health-related fields, but it is through the conceptual framing of biocommunicability that we became empowered with a "sense of freedom" to acquire knowledge in community and with a decolonial feminist sensibility (Briggs and Hallin, 2007, p. 46). With this critical freedom, I also aim to think beyond the traditional approach to *nervios*, which focuses on discussions of cross-cultural translation (or cultural competence). I do this by evaluating psychiatric research's influence in transmitting harmful racialized and gendered ideas about women of color.

An alternative approach to conceptualizing of *nervios* is through the theoretical frames of decoloniality and feminism that articulate the multiple, intersectional oppressions and the situated value of embodied knowledge. In this process, I reimagine *nervios* as an opportunity to consider alternative epistemologies of health and the body. Chicana feminist Gloria Anzaldúa describes *other* possible understandings of *nervios* by showing that border women (like those pathologized through *nervios* in the biomedical system) are always grounded in Indigenous and diasporic connections, which inspire *movimientos de rebeldia* (rebellion or rebellious movements) ([1987] 2012, p. 37). In analyzing *nervios*, I take seriously these forms of *rebeldia*– or rather embodied knowledge and resistance at the intersections of overlapping and interconnected oppressions. By contrasting the biomedical and the embodied/intersectional framing of *nervios*, the messy diagnostic of *nervios* can be rendered as a physical, psychological, and metaphorical "borderlands" that is shaped by both biomedicine and people of color. *Nervios* represents a meeting point and point of tension between biomedical knowledge and Black, Indigenous, and diaspora knowledge.

Cross-cultural psychiatry and medical anthropology have widely explored the causes and psychopathology of culture-bound syndromes, of which there are many associated with populations from non-White cultures. Some examples are "fallin' out" in African American cultures (Hunter, et al., 2014, p. 231), "brain fag" in West African cultures (Ayonrinde and Bhugra, 2008, p. 237), and "dhat" in South Asian cultures (Center for Substance Abuse Treatment, 2014). *Ataque de nervios* has appeared consistently in the literature on culture in psychology and epidemiology since 1955 (Rubio, Urdaneta, and Doyle, 1955) and is one of the more salient culture-bound syndromes associated with US Latinxs of all races. Originally called "the Puerto Rican Syndrome," it is distinguished from a panic attack by its bouts of anger and

rage–expressed through somatic, psychotic, and/or violent behavior (Fernández-Marina, 1961, p. 79). Much of the literature emerging from the study of this syndrome emphasizes the linguistic and cultural meanings of *ataques, nervios,* and the magical beliefs and practices of people who display these and other related symptoms.

Yet, there persists throughout the literature a constellation of yet-unanswered and otherwise-mysterious issues connected to *nervios*. In other words, it is still unknown if *nervios* is a disease category (theoretical) as well as exactly how *nervios* presents clinically for people in practice (practical). The implications being that clinicians are unsure of how to treat *nervios,* barring a more well-fitting diagnostic translation. Most frequently, *nervios* literature poses a question about where biomedicalists should draw boundaries between clinical diagnosis and "cultural" expression. Literature on *nervios*, in particular, is robust;[7] and I suggest that so much has been written on it because it begs a question at the heart of biomedical theories of the body and healing: "Does *nervios* represent a biological or a cultural malady?" (e.g., Roche Miranda et al., 2023).[8] This becomes researchers' linchpin question, which betrays the dualistic, individual reductionist, Cartesian, and Eurocentric theoretical foundations of most literature on *nervios* and other non-Western expressions of illness.

While *ataque de nervios* translates to English as either "nerve attack" or "attack of nerves," among its many nuanced and highly variable meanings, Spanish speakers often think of an *ataque de nervios* as a nervous breakdown or panic attack.[9] The term and category of *nervios*

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[7] In one epidemiological portrait of *ataque de nervios,* the authors found national-level data reflecting that the syndrome is expressed among 15 percent of the Latino population (Guarnaccia et al., 2010).

[8] For example, critical engagement with questions of race and science have produced an understanding of race as biosocial, a variable that is mutually constitutive of biology and sociality (e.g., Montoya, 2007, p. 96; Gravlee, 2009, p. 47). This framework shifts the decades long debates of nature vs. nurture by embracing a non-dichotomous approach. For example, in epidemiologist Nancy Krieger's eco-social theory, racial/ethnic, gender, and class inequality organize multiple pathways of embodiment, health, and disease. The framework enables us to abandon dichotomous models of disease/health and instead link disease to its source by tracing connections along multiple paths and levels. The guiding question then becomes: Where on multiple pathways can we intervene to alter the path of exposure to social and material deprivations, hazards, and trauma along categorizations of race, gender, and class? (2011, p. 214). Critical engagement with questions of race and science have produced an understanding of race as biosocial, a variable that is mutually constitutive of biology and sociality (e.g., Montoya, 2007, p. 96; Gravlee, 2009, p. 47). This framework shifts the decades long debates of nature vs. nurture by embracing a non-dichotomous approach. For example, in epidemiologist Nancy Krieger's eco-social theory, racial/ethnic, gender, and class inequality organize multiple pathways of embodiment, health, and disease. The framework enables us to abandon dichotomous models of disease/health and instead link disease to its source by tracing connections along multiple paths and levels. The guiding question then becomes: Where on multiple pathways can we intervene to alter the path of exposure to social and material deprivations, hazards, and trauma along categorizations of race, gender, and class? (2011, p. 214).

[9] My mother—a bilingual, first-generation, US-born, Mexican American Chicana, counselor, and special education educator—insists that I translate *ataque de nervios* as a panic attack when I explain this research. Though some researchers would disagree (e.g., Keough, Timpano, & Schmidt, 2009, p. 16-21), recommendations for the DSM-V by Lewis-Fernandez and colleagues back up my mother's claim (2010, p. 212-229). I would also add that, in addition to bilingual and Spanish speakers, English-speaking clinicians of medicine and psychology (doctors, nurses, pharmacists, therapists) and experts in cross-cultural psychology and critical epidemiology all hold nuanced understandings of the similarities between *Nervios* and panic attacks. From my experience, these conceptualizations are often kept behind the scenes of published literature, which favors more literal translations of the term to distinguish it from an official panic attack. Bowker and Star share a telling example that speaks to this discordance between what people know versus what makes it into the classification and literature itself, noting "psychiatrists increasingly use the language of the DSM to communicate with each other and their accounting departments, although they frequently do not believe in the categories they are using" (1999, p. 60).

emerged as a way for Puerto Rican servicemen to convey to US military psychiatrists and clinicians their struggles with post traumatic-stress disorder (PTSD) during or following their time in the service, it *nervios* has connections to experiences and expressions of trauma (Rubio, Urdaneta, and Doyle, 1955; Fernández-Marina, 1961; Mehlman, 1961). *Nervios* (when used by Chicano/Latino people to mean, broadly, "mental illness" or "mental health") does not, in fact, exist outside of the biomedical paradigm–even though patients and professionals certainly understand the term differently, as exemplified above by the encounter between Celia and her clinicians.[10] Critical medical anthropologist Mark Nichter has explored some of the underlying linguistic and idiomatic subtleties of culture-bound syndromes (including *nervios*) since the 1980s (e.g., 1981). His influential research on idioms of distress has helped subsequent researchers to assess "patients' social relational, as well as 'cultural,' context and adaptive/maladaptive strategies for coping within these nested contexts" (2010, p. 408). Furthermore, Nichter notes that idioms of distress can help identify a group's response to social injustice and discrimination (p. 404). These explorations of cross-cultural assessment and diagnosis reveal how the process of categorizing health is fundamentally an *exchange* between doctors, researchers, patients, and publics (Trostle, 2005, p. 85).

Analyzing the exchanges of power in relationships between patients and biomedicine, anthropologists have deepened our understanding of the phenomenon of *nervios* and the significations evident in expressions of this concept. For example, *nervios* (*nervos* in Brazilian Portuguese) emerged in poor northeastern Bahia, Brazil, when its residents needed to express to their doctors that the hunger caused by structural inequality had psychosocial effects. This hunger was in addition to–or in lieu of the physiological/material effects of hunger–as medical anthropologist Nancy Scheper-Hughes shows (1992, p. 169). In her ethnographic approach, Scheper-Hughes reveals the fundamental significations of an increased use of *nervos* as a replacement for complaints of hunger. In her breakdown of the social relations underlying folk expressions of *nervos*, Scheper-Hughes specifies:

> The transition from a popular discourse on hunger to one on sickness is subtle but essential in the perception of the body and its needs. A hungry body needs food. A sick and "nervous" body needs medication. A hungry body exists as a potent critique of the society in which it exists. A sick body implicates no one. Such is the special privilege of sickness as a *neutral* social role, its exemptive status. In sickness there is (ideally) no blame, no guilt, no responsibility. Sickness falls into the moral category of bad things that "just happen" to people. Not only the sick person but society and its "sickening" social relations… are gotten off the hook (1992, p. 174).

Scheper-Hughes phenomenological analysis of *nervos* reveals that the medicalization of poor Brazilians' public health problems obscures the social conditions that lead to high disease morbidity and high mortality rates among these disenfranchised populations. The result of this and other scholarly interrogation of cultural concepts and idioms of distress (e.g., *nervios*) has

[10] In Mexican Traditional Medicine appraches, *nervios* would be conceptualized via the concepts of *aires*. In Lucumi Afro-Cuban diaspora approaches, *nervios* would be conceptualized via concepts like *iwa pele* (even character) or the cool head.

resulted in a more robust and nuanced approach to the psychology of people of color in the US and internationally–one that integrates analysis of social constructions (Nichter, 2010, p. 412).[11]

However, even this helpful work falls short of providing holistic depictions of and support for the people who experience non-Western symptoms and disorders like *nervios*. Often, these studies conflate or otherwise uncritically subsume racial and gender categories within the realm of culture as they wrestle with the incongruence between people's experiences of illness on the one hand and Westernized concepts of psychiatry and medicine on the other (e.g., Kohrt et al., 2014, p. 365). Medical anthropologist Vilma Santiago-Irizarry describes these medicalizing tendencies in her ethnography of New York City psychiatric settings, with a focus on Puerto Ricans. She writes, "[A]n ataque de nervios, even when recognized as such, was discursively characterized [by clinicians] as 'hysteria' and treated through the application of a Freudian interpretive framework–that is, as a psychosexual expression of female distress" (2001, p. 35) Instead of foregrounding an examination of "folk" categories of disease, Santiago-Irizarry visibilizes "the political dimensions of institutional practice and the construction of ethnicity among ethnic elites who wield cultural and professional authority within a contemporary sociocultural domain permeated with power (ibid). In other words, she analyzes relations of power embedded in constructs of ethnicity and processes of medicalization among Puerto Ricans in psychiatric settings. While Santiago-Irizarry's study represents a critical examination of *nervios* and related cultural constructs of disease in clinical practice, her focus on ethnicity and culture traps the work in the disciplinary limits of anthropological analysis. My turn toward a decolonial analysis of Chicano/Latino mental health shifts away from existing modes of knowledge production used to conceptualize the contours of *nervios* and its implications in Chicano/Latino communities.

The story of Celia on page one of the DSM casebook was, regrettably, racist and sexist and displayed an unwillingness to attend holistically to Celia. I use a woman of color feminist intervention to address these omissions. With this approach, I can read back into her a sense of her humanity and autonomy. I initially ask four questions in my reading of this example of biomedical literature on *nervios* in psychiatry. In my decolonial feminist reading of this example of biomedical literature on *nervios* in psychiatry, I look for textual evidence of racialized, gendered, and sexualized representations. I conceive of this chapter as a primary document that reflects the biomedical archive of the body of literature that seeks to understand *nervios*. I ask: 1) How are race, gender, and sexuality represented in the stories and uses of *nervios*?[12] I also seek out evidence that a critique of *nervios* is relevant to academic discourse on race-based medicine. Significantly, *nervios* continues to emerge in the literature via its usage in clinical and popular settings (e.g. Roche-Miranda, et al., 2023; Ginzburg et al., 2020; Ustun, 2022; Moitra et al., 2018). To map its appearances in the literature, I ask: 2) Where is there evidence of the clinical use and academic reproduction of this disease category? Through the lens of biocommunicability (Briggs and Hallin, 2007), which I will further explore in Chapter 2, I ask: 3) Where does power and discourse shape the experiences of the various actors who utilize this term? *Nervios*' appearance in the literature replicates knowledge hierarchies that give doctors and their biomedical perspectives more power than patients who embody the experiences and knowledges

[11] For a broader, more thorough analysis of how conversations surrounding cultural concepts play out in global health, see Nichter (2008).

[12] J. Singh's *No Archive Will Restore Me* (2018) helped me to conceptualize the archive that can represent *nervios* and its implications on the BIPOC body. Even more concretely, Natalia Molina's *Fit to Be Citizens?* (2006) models how to utilize archival research to shape new understandings of Chicano/Latino and Asian health.

of the Global South. Finally, to locate structural and institutional structures of power that create these inequities, I ask: 4) Where can we identify hierarchies between expert and patient, science and superstition? It is these hierarchies that produce the necessity for cultural concepts of distress like *nervios*. This is evident in the examples of the Puerto Rican/Taíno men conscripted into US military service, the starving people of Bahia who appealed to *nervos* to communicate the lived effects of hunger, and Celia–whose proximity to traumatic sociocultural conditions (as well as to the medical and prison industrial complex) exemplifies the appearance of *nervios* in clinical practice and in academic literature. The conditions that produce the phenomenon of *nervios* are the same ones that position *nervios* as knowledge about the mind-body that is invalid or lacking without a biomedical or academic translation.[13]

Race, Gender, and Sexuality in the Narratives and Uses of Nervios

A typical analysis of Celia's case would focus on the obstacles to diagnosis or, at best, socioeconomic vulnerabilities represented in the cultural concept (e.g., culture, language, education, and class); but I choose instead to highlight how the social and structural categorizations of race and gender shape psychiatric depictions of *nervios*. Celia is given a Spanish-name and identified as Puerto Rican-born, though the case lacks any detail about her immigration history and language ability. Issues of translation appear in the story when clinicians ask her to clarify what she means by "attacks" and "spells." They also struggle to translate the meaning of her "nervous" feelings. Her gender and sexuality are prominent in the case. She is described as seductive and having displayed "wild" behavior. Her depression was exacerbated by a recent abortion. She is unemployed, financially dependent, and cohabitates with a boyfriend (rather than a husband). She had been married and had two children as a teenager. Her ex-husband was a drug dealer, and the case explains that Celia does not enjoy sex and can only engage in intercourse if she is under the influence of drugs. She lost custody of her two children to the former mother-in-law, who Celia claims did *brujería* to her. The clinicians are unclear why she cannot care for her children but specify that she gets "nervous" around them. Lastly, her psychopathology is fundamentally linked to her history of childhood rape(s) and incest.

Evidence of Clinical Use and Academic Reproduction of this Nervios Category

The DSM casebook chapter is titled "Brujeria" [sic], which (as the authors explain) was chosen to make the case "easier to refer to." This style of cheeky naming of psychological case studies is described as "[f]ollowing Freud's example," (Spitzer et al., 2002, p. xi). The casebook's audience is clinicians, teachers, and students in psychology-related fields; medical professionals; and attorneys. The preface states that the purpose of this DSM casebook is to "[apply] the principles of differential diagnosis to a wide range of patients," also indicating that it is made for use in clinical and forensic practice (ibid). The casebook is also intended as a study guide for specialty examinations, like psychiatry boards, as well as assessment of clinical staff expertise and reliability. It serves as a mediating text between the formal DSM-IV and the clinical applications because it "brings the DSM diagnostic criteria to life" and is "based on actual patients." Finally, the casebook functions as a historical reference of US diagnostic cases and concepts, past and present (p. xii).

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[13] I'm thankful to Caitlin O'Neill, Director of the LGBTQ Center at Brown University, for helping me to put into words this interlocking oppression.

Identifying Hierarchies Between Expert/Patient and Science/Superstition

The casebook is published through the certifying authority on mental health, the American Psychiatric Association. The pages leading up to the first chapter of the casebook, where we meet Celia, list its authorship by "well-known experts" in administrative, teaching, and research positions at major east coast US research and learning institutions (Spitzer et al., 2002, p. vii-xiii). The case indicates that Celia's request for a private interview is denied, and she is interviewed about her childhood rape in a room of eight clinicians. She is even asked if she "understands how fortunate she is to be in a famous teaching hospital," (p. 2). The clinicians are generally portrayed in a positive light. For example, a psychiatric resident and social worker follow up with Celia at her home; this contrasts with the patient, who does not keep her follow-up appointments. Celia's interpretation of *brujería* as the underlying cause of her *nervios* are completely ignored in the clinical interview. We may infer that the clinicians did not pursue the topic of *brujería* because it does not translate into the biomedical concepts and diagnostic framework of official psychiatric disorders, like PTSD. Ironically then, her beliefs in witchcraft are highlighted in the case's title. The hierarchical dynamics reflected here betray a supposition that the client or patient does not know what is best and that a good patient is an informed, yet unquestioning, one (Menéndez, 2020b, p. 15).

In the case of Celia, her doctors' diagnosis of PTSD (versus her own self-diagnosis of *nervios*) rests on a history of childhood sexual assault, gathered from several stages of interviews by a social worker, psychiatrists, and a group of psychiatry residents. Notably, Celia is not and cannot be diagnosed with *nervios* because it is not an official disorder, but rather an idiomatic expression frequently used by Spanish-speaking people. Her case is exemplary as a clinical resource because it highlights the many complications that arise in patient/doctor encounters in real-life contexts of diagnosis. For example, the opening sentence of Celia's case study indicates the potential challenges to producing a psychiatric diagnosis, such as her language, age, gender, race/ethnicity, immigration, and medical and criminal history. The authors write: "Celia Vega is a 21-year-old woman, born in Puerto Rico, who is brought, by the police, to the emergency room of a city hospital in handcuffs and leg chains" (Spitzer et al., 2002, p. 1). The patient's name, Celia, has Spanish origins. She is identified as a young adult, woman, US citizen, born outside of the US; and she is in some type of medical or psychiatric emergency. Furthermore, she has been implicated in criminal behavior (as indicated by the police), is in arm and leg restraints; and it may be inferred that she is poor, due to her admission into a city hospital. These demographic details are substantiated sporadically throughout the narrative. After the clinicians ask Celia if her "attacks/spells" are related to her history of sexual trauma, they note that she is "embarrassed" and classifies her attacks as induced by "brujería." This challenge to the clinicians' proposed diagnosis highlights the barrier posed by Spanish-language idioms like *nervios*, *ataques*, and *brujería*. Indeed, as the authorities on the matter of clinical diagnosis, the authors concede that Celia's condition is not fully captured by the label of PTSD, but that they assign this diagnosis because it captures the most aggravating of her clinical history as a poor survivor of sexual abuse.

Despite the existence of these doctor-patient hierarchies, people (including Celia) do manage to exert some power in these physician-patient interactions. For example, Santiago-Irizarry writes that people in biomedical settings

> engaged in cunning strategies of accommodation to the objectifying terms of medical culture and treatment, even when these strategies required them to play to the hilt their

> subordinated and dependent role. They demonstrated their ability to exploit institutional conditions… precisely because these conditions allowed them to engage in overt displays of ethnicity, to enact Latino-ness and foreignness in order to capitalize on the existing orders of entitlement that value such demonstrations (2001, p. 151).

In a way, it is as if Celia's appeal to *nervios* and *brujería* to describe her violent episodes was a bid for what little power she could eke out of the biomedical/criminal justice encounter–or a way for her to "capitalize on" the foreignness of these concepts to navigate her powerless situation. Additionally, Santiago-Irizarry discusses how even this insertion of ethnic and cultural performances, like those of *nervios* or *brujería*, do not render truly curative or beneficial effects for the patient, because the terms of ethnicity are themselves co-opted by prevailing institutional and medical discourses (ibid). Thus, even when cultural expressions are allowed clinical practice, they do not destabilize the power dynamics that inherently favor Eurocentric conceptualizations of health, healing, the body, and their agents (e.g., doctors). The discursive power dynamics underlying *nervios* are such that racial and gendered hierarchies interject their subordination of non-White people along the various routes of circulation, authorization, and clinical practice of the *nervios* concept.

This turn toward an interpretive framework that deconstructs discursive power relations of *nervios* reflects a critique of the hegemonic logics of biomedicine, expressed as "modern" medicine. I use political sociologist Ramón Grosfoguel's framing of transmodernity, border thinking, and global coloniality in my understanding of modernity throughout this chapter and dissertation (2006). Through racial capitalist projects of globalization, global coloniality represents how the epistemic and structural afterlives of colonialism retain the relations of power that were imposed across the globe through imperial and settler colonial projects, which harnessed the social construction of race through multiple biopolitical frameworks to justify the theft of land and human labor. The frameworks of border thinking (the subaltern's epistemic response to the Eurocentric project of modernity) and transmodernity (modernity conceptualized from beyond Eurocentric epistemic and ontological formations) help us to reimagine modernity as construed beyond the oppressions of coloniality. These oppressions are visible when we underscore the racial dynamics of power reflected in a discursive analysis of *nervios*. Grosfoguel and the modernity/coloniality school of thought consider these relations of power to reflect a coloniality of power, as articulated by sociologist Anibal Quijano (2000). Our current conceptualization of the modern, social, structural, and cultural relations of power is enmeshed in the power matrix of the modern/colonial world. Border thinking redefines and subsumes our notions of citizenship, democracy, human rights, humanity, and economic relations by drawing from subaltern epistemologies to (re)conceptualize the world and our sense of self within it. It transcends the defining impositions of a European modernity and redefines a (trans)modernity through local Indigenous practices and cosmologies, for example.

The transmodern, decolonial critique of "modern" biomedical approaches to race-based knowledge of BIPOC people (like Celia Vega) deconstructs the hegemonic, biomedical sense of modernity. The modernities hailed in biomedical research exemplify how, as decolonial philosopher Nelson Maldonado-Torres articulates, "the production of knowledge form[s] a nexus of power oriented by imperatives of domination and control that mirror the logic of a division between masters and slaves" (2008, p. 3). The doctor-patient hierarchies performed in the story of Celia Vega reflect a discourse surrounding *nervios* that reproduces the master/slave logics of the Eurocentric, hegemonic, medical model that contextualizes it. Deconstructing these

enmeshments within the power matrix of the modern/colonial world requires a "decolonial turn [that] includes the definitive entry of enslaved and colonized subjects into the realm of thought at previously unknown institutional levels" (p. 8). According to Maldonado-Torres, sociologist and civil rights activist W.E.B. DuBois advances that (in practice) this sort of decolonial turn must "take [on] many perspectives, particularly the perspectives and points of view of those whose very existence is questioned and produced as dispensable and insignificant" (ibid). Following these models, this chapter turns to the voices of Black and Indigenous women of color to assemble a transmodern perspective on the relations of power evident in *nervios* research.

Using Feminist Intersectionality and Embodied Knowledge to Humanize the Experiences of Women of Color

While not excluded, (Afro)Latinx/Chicanx figures are few and far between in most psychiatric scholarship, making Celia's appearance (as the casebook's first example of adult mental disorders) seem tokenistic. Indeed, critical race theorist Kimberlé Crenshaw writes that "tokenistic, objectifying, voyeuristic inclusion of women of color is at least as dis-empowering as complete exclusion" (1995, p. 10). Celia also stands out for the way she is objectified within the racialized and sexualized particularities of her case, including her belief in *brujería*. Furthermore, many points in Celia's story do indeed verge on voyeuristic, especially as her sexuality and history of sexual violence become the central causal elements of her psychological disorder. Historian Harriet Washington describes the US antebellum origins of medical voyeurism as "surgical theater," in which a "disrespect" shown toward enslaved people in clinical settings included conjecture about their sexual experiences (2006, p. 106). Washington notes how, even today, medical schools continue to speculate on the intersections of cultural behaviors and health in low-income patients, especially Black people, in a voyeuristic way (2006, p. 108). The implications of this clinical objectification can be understood through the Combahee River Collective Statement (1977) and others' theories, which have established that the intersections of multiple oppressions along lines of race, gender, sexuality, and class are rendered invisible through uncritical and generalizing categorizations (e.g., "culture").

A historically situated view of the culture of medicine may more accurately elucidate the dynamics of the diagnostic process, instead of replicating their histories of racism/sexism (as do ahistorical, culturally sensitive approaches). The biomedical, *nervios*-related literature (that merely describes social categories, names, and identities) is inadequate because it does not untangle those underlying intersections and structures of power. For this reason, the *Panza Knowing Workshop* uses decolonial and feminist research methods to address *nervios* as a reflection of inequity as expressed through the body. It also introduces the generative potential of deconstructing and reimagining health beyond the medicalizing terms of *nervios*. Generative expressions of health and embodied knowledge are achieved in the workshop through world-historical and somatic grounding exchanges between the researcher (me) and the community in the practice of *panza awareness* as well as through *diálogo* (dialogue) and *testimonio* (testimony). While I mention the phenomenon of *nervios*, the workshop invites participants to access other constellations of knowledge that validate community wisdom in the effort to access healing knowledge.

In response to similar trends in her field of critical legal studies, Crenshaw examines gender violence through a lens that acknowledges simultaneous interactions between racism and patriarchy (p. 3), which we see reflected in clinicians' treatment of Celia. This response is particularly relevant in the context of *nervios* because of its comorbidity with PTSD and

somaticizing disorders, which are often related to domestic violence and/or sexual trauma. The psychopathologists discussing the case of "Brujeria," for example, overcome the quandary of differential diagnosis posed by the *nervios* presentation by ignoring Celia's own explanations and instead labeling as significant her history of child sexual abuse. However, even as its authors highlight non-normative expressions of disease and stereotypical assumptions of culture, they fail to identify and examine underlying structures of race, gender, and sexual oppression.[14]

Underlying structures remain invisible if we (as the clinicians did) focus singularly on Celia's sexual trauma and do not account for other intersections that may contribute to, produce, or give meaning to her *nervios*. Postcolonial feminist theorist Sandra Harding observes that the stakes are particularly high for women subjects when researchers use scientific traditions to invisibilize the intersections of oppression in research and knowledge production. We see this reproduced in the psychological sciences that have produced culture-bound syndromes and *nervios*. Harding explains, "culture-wide assumptions *that have not been criticized within the scientific research process* are transported into the results of research" (original emphasis; 1993, p. 57). She also notes that scientific method provides no rules, procedures, or techniques for identifying and eliminating social interests and values and that in general the "scientific worldview" reflects that of dominant groups in Western societies (p. 57).[15]

But the scientific method is not the only approach we have at our disposal, and we can account for racism and patriarchy in ways that humanize the experiences of women of color and digress from the traditional culture/patient-focused approach to *nervios*. Harding heralds standpoint epistemologies rooted in embodied knowledge in her response to the existing, inadequate standards for objectivity that permeate the sciences. She describes how feminist knowledge from the bottom of social hierarchies arranged according to race, ethnicity, class, gender, sexuality, and other such politics "can provide starting points for thought—for *everyone's* research and scholarship—from which human' relations with each other and the natural world can become visible" (original emphasis; Harding, 1993, p. 24). Collins and other forbearers of Global South and US women of color feminist thought agree that women's experiences are the authoritative foundation of feminist knowledge, even in the context of science and objectivity. It is from their work and experiences that Black women create theory from the points where they embody their social conditions. Theorizing from the voices of Black women themselves, Collins moves us to see the potential for knowledge uttered by BIPOC people in biomedical contexts (Collins, [1990] 2009). Had the psychopathologists endeavored to understand Celia's violent and self-injurious episodes through the individual's own cultural lens,

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[14] There is one near exception to this scholarly absence: the study by Guarnaccia and colleagues, which highlights the correlation between *nervios* and a construct the authors identify as social vulnerability. While it defines the term using the below definition, it does not critically engage these variables outside of the definition: "…contextual factors (e.g., gender relations; racial discrimination; and political and economic circumstances, including poverty) that differentially and adversely impact various populations" (2010, p. 298).

[15] Elizabeth Cole introduces an intersectional approach to psychology that offers ways to integrate Black feminist thought into mainstream psychology. However, she overemphasizes social categories when she applies women of color thought to her analysis. I also disagree with her conclusion, where she states: "To translate the theoretical insights of intersectionality into psychological research does not require the adoption of a new set of methods; rather, it requires a reconceptualization of the meaning and consequences of social categories" (2009, p. 178-9). Cole does not distinguish social categories from structural hierarchies, in this case, nor are they contextualized in terms of power and history, e.g., between patient and doctor. Furthermore, critical writing on race and science shows a pressing need to reconceptualize methods and shows a long history of racist and sexist problems at the level of data collection and methods (e.g., Harding, 1993; Tallbear, 2013; Washington, 2006; and Bolnick, 2008).

they would have discovered that by mentioning both *nervios* and *brujería*, Celia understood the traditions and practices used in US Latinx diaspora contexts. They would have also realized that these ritual technologies and healing modalities may offer a more nuanced diagnosis of her psychological complaints–and the opportunity for healing. Celia's treatment at the hands of Eurocentric clinicians illuminates the value of culturally aware research that relies on feminist and decolonial research methods (e.g., the *Panza Knowing Workshop*).

Because feminist knowledge is multiple, collective, heterogeneous, and even contradictory, highlighting women's experiences requires that knowledge production starts from multiple women's lives (Collins, [1990] 2009; Harding, 1993, p. 66-68). This is one place from which to rethink the narratives surrounding *nervios* and Celia Vega. To this end, I turn to Anzaldúa's conceptualization of Chicanx knowing, of *conocimiento*. She writes:

> Before rewriting the disintegrating, often destructive "stories" of self constructed by psychology, sociology, anthropology, biology, and religion, you must first recognize their faulty pronouncements, scrutinize the fruit they've borne, and then ritually disengage from them.… Knowing the beliefs and directives your spiritual self generates, empowers you to shift perceptions, te capacita a soñar otros modos of conducting your life, revise the scripts of your various identities, and use these new narratives to intervene in the cultures' existing dehumanizing stories (2002, p. 559).

Here, Anzaldúa explains that it is necessary to dismantle the invisible value judgements that academic disciplines impose onto Chicanx women. Without doing this, these judgments will continue to racialize and oppress Chicanx women in theory and practice at multiple points of encounter in formal, academic thought. I see the DSM's psychiatric category of *nervios* as one of these "stories" constructed by sanctioned representatives from the very disciplines that Anzaldúa cites above. This passage reflects the fundamental approach that will expand the story of *nervios* from one that unwittingly dehumanizes (Afro)Latinos/Chicanos into one that allows us to dream up other modes for conducting research and producing knowledge. Anzaldúa's vision of knowledge enables me, from my position as both a Chicanx and researcher, to apply a new narrative to existing *nervios* research. Anzaldúa writes, "When you're in the place between worldviews (nepantla) you're able to slip between realities to a neutral perception" (2002, p. 559). Unlike conventional biomedical "knowledge," *conocimiento* represents a new kind of neutral objectivity.

In *Methodology of the Oppressed*, Chela Sandoval talks about this practice of *conocimiento* as oppositional consciousness and differential movement (differential as it functions as a process and a shifting location). She also refers to differential movement as "decolonizing *movida*" or an epistemic and ontological shift away from the dominant racializing logics that oppress people of the Global South (2000, p. 140). Sandoval identifies one type of oppositional consciousness as differential consciousness (or *la conciencia de la mestiza*, according to Anzaldúa). Differential consciousness is a mode of consciousness linked to a self-conscious social movement or praxis that helps "citizen-subjects" (people of the Global South) learn to negotiate and transform their social conditions. Sandoval guides us to continually analyze power and move through power structures, including those institutionalized through biomedical, academic knowledge production. The *Panza Knowing Workshop* is a social technology for the praxis of *panza awareness*, one that supports participants to make "decolonizing *movida*" away from the pathologizing, racializing entrapments of *nervios* and

towards self-conscious, healing realizations.

To think beyond the racializing, gendering tendencies of academic uses of *nervios*, I rely on work that transgresses disciplinary boundaries from a standpoint of people of color in the Global South and US third world. I focus on knowledge produced by women of color healers and authors who are disciplinary *nepantleras* (threshold people). For example, *curandera* and registered psychiatric nurse Elena Avila is a *nepantlera* who directly engages conventional medicine. She finds many complementarities between *curanderismo* and modern healthcare but argues that partnership across these disciplines is only possible if "the modern doctor is able to have a genuine attitude of respect toward folk healing and genuine interest in its healing modalities" (1999, p. 308). Given reciprocity and validation of this kind, non-Western knowledge can broaden our views of medicine. *Curanderismo,* just one of the many traditions that have been accused of and referred to as *brujería*, represents a non-Western discipline that understands disease as caused by biological factors in addition to emotional and soul factors (p. 182). The implications of these "alternative" perspectives from other knowledge systems are vast. In Chapters 4 and 5, I introduce some of these findings that emerged from the *Panza Knowing Workshop*, which is built on interpretive frameworks that center BIPOC people. Herbalist and traditional birth attendant Patrisia Gonzales provides an example of an Indigenous approach to understanding *brujería* and a community member with visions. She narrates the origin story of an Apache-Chicana elder and grandmother of the Mexican Sun Dance in Teotihuacan, Mexico. Whereas Celia Vega is a pseudonym for an anonymous Latinx psychiatric patient, Celia Perez-Boothe is a real Latinx/Chicanx elder introduced by Gonzales. I offer this story as a new starting point to think about woman-of-color psychology, as this real-life Celia exhibits a very different view of (Afro)Latino/Chicano knowledge than what I have found through biomedical interpretations of *Ataque de nervios* and clinicians' responses to *brujería* (which they define as witchcraft). In the below excerpt, Gonzales describes one of Celia Perez-Boothe's teachings about a psychologically and emotionally taxing time in her life:

> Grandmother Celia finds Spider near her hair, her long white hair, not yet braided for the day. She saves Spider and goes to shake it outside, where Wind takes it. Sun Dance Grandmother goes back to her braiding, and in her mirror she sees lots of little spiders in her white strands. Spider mother had had some babies on white hair woman, lots of little baby spiders clinging to her white strands. Grandmother Celia goes to Mexico to sacrifice. In the Mexican Sun Dance circle not far from the Teotihuacan Spider Woman, where spiders hang from her hair, Grandmother Celia sees a circle of light, a web of light—Spiderwoman's woven tress of prayers. At the tree of life, she saw strands of light attached to everyone in the Sun Dance circle and attaching to everyone. "They were knitting a web…. These *hilos* (threads) just kept attaching to everyone. That is how I became godmother to the spiders." The web of life, the circle of life, spun out this story (2012, p. 188).

Here, we see how Grandmother Celia interacts with the web of life as if it were a form of communication between her and other celestial beings (e.g., Sun, spiders, other people), described by Gonzales with a sense of magic and magical realism. She listens to Spider's message–about the interconnectedness of all living things and the circumstances in which we find ourselves–and then she takes action. She goes to sacrifice and pray, to practice the ritual technologies available to her for self-preservation. In her travels, she witnesses the movement of

light and life up from within the buried roots of the tree of life. Taking the shape of her prayers, the light travels out to the Sun Dancers, who are her grandchildren and who dance to receive their grandmother's prayers, her light. Were Grandmother Celia to describe her visions and her identity as "godmother of spiders" to the same clinicians who evaluated Celia Vega, they would surely pathologize her within DSM frameworks as dissociative, schizophrenic, or hallucinatory demented. But in Gonzales' Chicana feminist rendering, Celia's experiences and visions are not pathologized and are taken seriously, both by her family and the *curandera* narrating the story. While Grandmother Celia and Celia Vega do not exhibit the same "symptoms," they do exemplify behavior that clinicians would typically identify as disordered.[16]

The elder Celia conceives her world in terms of a pre-Columbian, Mesoamerican system of knowing the cosmos, which allows her visions to carry meaning and, as her prayers are answered, enables her spiritual practice to produce healing for herself and her loved ones, as they connect through her engagement with the realm of spirit. Her families are varied and distinct, but they gather in spiritual practice and become interconnected through Grandmother Celia's powerful relationships to the cosmos–her *brujería*, if you will. In this process, through which her prayers and interactions with the divine produce light/life, she learns to understand life in terms of a web–and according to the ritual knowledge and technologies she inherits from her Indigenous ancestors. Gonzales writes, "[in] time of quaking changes and cycles ending, [Grandma Celia] tells me: 'You stand alone at the center of the web. Spin out. All women are Spider-woman'" (p. 188). Grandmother Celia's teachings, like Gonzales's Indigenous medicinal practices, show people and their experiences in terms of the principles of a cosmos that is relational (as opposed to individualized), cyclical (as opposed to linear), and living (as opposed to static) (e.g., p. 190). This luminous and prescient Celia teaches that every woman may participate in divine healing by recognizing her position at the center of a web and then recognizing her ability to spin away from this web when it becomes unstable or disordered. The *Panza Knowing Workshop* accepts that all people have this same potential for healing. And it creates a space for community members to recognize the value of their *panzas* and to together produce knowledge derived from this space. I propose 1) articulations of knowledge, like *panza* awareness, that are embodied and rooted in ancestral cosmologies as well as 2) a shift from articulations of the pathological (e.g., *nervios*) to Indigenous and diaspora conceptualizations of healing.[17]

A Chicana feminist reconceptualization of the case of Celia Vega and her presentation of *nervios* could benefit from knowledge of the Mexica divinity known as *Coatlicue* because her teachings frame the experiences that we understand as mental illness in a non-pathological way. In *Borderlands,* Anzaldúa conceptualizes moments of instability or blocks in life as the Coatlicue State. *Coatlicue* is the depths, patterns, and internal whirlwinds of the psyche ([1987] 2012, p. 68). She (*Coatlicue*) both gives and takes life; but these processes exist in relationship to pain

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[16] To take another example, in interviews with rural girls in Northern India, psychologist Ayurdhi Dhar found that they did *not* utilize the language of pathology to describe their experiences with depression, mania, hallucinations, and psychosis. Rather, she writes that "their experience was shaped by indigenous discourses around deities, spirits, unhappy ancestors, and unruly desires" (2020, p. 394). Dhar concludes with an argument *against* the haphazard application of psychological interventions developed by the Global North, as "the structure of this subject begs us to not uncritically import forms of knowledge that are inapplicable and potentially dangerous" (p. 406).

[17] What I propose is *not* what Eduardo Menéndez discusses as an anthropological trend to research traditional healing in ways that validate it as cultural but otherwise seek to uphold biomedical interests, politics, and ideological objectives (2022). Rather, this is an articulation of Indigenous and diaspora knowledge that is valid, albeit different from rational, Cartesian biomedical knowledge.

and suffering–which we either face and give voice to or hide from, deny, and allow to stagnate. When we experience movement from spaces of light within the cycle of life–through *Coatlicue*– to blockages, darkness, and *mictlán* (the underworld) (p. 70), we also access the properties of *Coatlicue* that permit us (as Grandmother Celia teaches) to spin away from the constricting, painful web of life–to create new threads and new webs. Anzaldúa describes these forms of creative, life-making acts and adds, "It is this learning to live with la *Coatlicue* that transforms living in the Borderlands from a nightmare to a numinous experience" (p. 95). *Coatlicue* is useful for understanding *nervios* in a decolonial, feminist way because we may use it to conceptualize Celia Vega's *ataques de nervios* via a Mexica Indigenous framework. Through *Coatlicue*, we can understand her *nervios* as a legitimate response to the pain and suffering experienced by a Puerto Rican woman moving through the spiritually impoverished Global North, which subjugates her and her knowledge of non-Western ways of thinking about the mind and body.

Reconsidered through the teachings of these outsider experts, we can gain a new sense of how to understand the nightmarish, traumatic episodes of *ataques de nervios* plaguing our younger, psychologically pathologized Celia. I do not mean to imply that *nervios* represents a positive experience (indeed, anyone who has experienced *nervios* would agree that it is scary and undesirable). But like *Coatlicue*, perhaps something empowering and healing can come from learning to live with and understand the connections between *nervios* and *brujería* by invoking non-western knowledge of *brujería.* In the case of Celia Vega, her prognosis is grim; she does not continue psychotherapy and her mental health remains mostly untreated. What might have transpired had Celia's worries of *brujería* been considered seriously? *Nervios* represents an invisible friction between the visions, experiences, and knowledge of (Afro)Latinxs/Chicanxs. Anzaldúa writes of Catholic and Protestant religions that they "encourage fear and distrust of life and of the body" and "encourage a split between the body and the spirit and totally ignore the soul" (p. 59). I would argue that the beliefs and sciences of psychiatric biomedicine do the same. This friction produces a complex crossroads and a confrontation with a *Coatlicue* state that forces us to discern a new path for *nervios* and other culture-bound syndromes.

Conclusion

In this tale of two Celias, the first pseudonymous Celia of psychiatry is plagued by her episodes of trauma, unreasonableness, and *brujería*. Through my re-reading of *nervios*, I have argued for the introduction of a second, real-life Celia, who is taken seriously by her community, including her academic interlocutors (i.e., Gonzales). She is allowed to reframe the imbalance and disconnectedness typical of *nervios* into a conceptual framework of the Indigenous of the Global South that offers remedies for healing in lieu of categories of pathologization. The juxtaposition of the Celia, victim of *brujería* and *nervios*, alongside a new Celia places the figure of the Indigenous or (Afro)Latina/Chicana in a position of power and expertise where she has access to new ways of interpreting and addressing her pains and instabilities. This comparison also provides new options and futures for understanding the experiences of *ataques de nervios*. In these new futures, I envision *panza awareness* as a decolonial, feminist shift toward empowering, agentic articulations of knowledge about the intersections of mind, body, and spirit that are rooted in embodied and ancestral ways of knowing.

I begin my dissertation on embodied and ancestral knowledge production in community action research with this study of *nervios*, *brujería*, and Celia Vega's suffering at the hands of biomedicine to illustrate the contours of a decolonial turn in knowledge production. This

research begins with a critical deconstruction of existing, race-based examples of biomedical knowledge about Latina/o mental health in the case of *nervios.* It then elaborates a conceptual, historically situated response at the level of epistemology through *panza awareness* before enacting a movement toward decolonized knowledge production through the *Panza Knowing Workshop*. It is through a decolonial, Chicana feminist turn that we see how *nervios* is an important starting point to recognize women of color's embodiment of distinct worlds across the raced and sexed boundaries that divide psychopathology from *brujería* in hierarchical ways. I propose that instead of the health sciences advancing the study of "culturally competent" concepts like *nervios*, we shift to foster dialogue in community to conceptualize health and the body in ways that depart from Eurocentric frameworks. *Panza awareness* is one such conceptual framework that integrates a range of knowledge in a transdisciplinary way. By operationalizing *panza awareness* through the *Panza Knowing Workshop*, we also integrate community in reciprocal, generative ways.

The following chapter outlines the dissertation's theoretical framework and methodological framework. It also discusses my data collection methods and data analysis methods. Finally, it introduces the workshop's findings, which future chapters then elaborate on.

Chapter 2

Pedagogies of Collaborative Knowing: An Overview of the Dissertation Phases

Key words from the title of this chapter, "Pedagogies of Collaborative Knowing," outline the methodological framework of this study. *Pedagogies* maps on to its feminist and decolonial roots, *Collaborative* maps onto its action research roots, and *Knowing* maps onto its roots in interpretive knowledge generation processes. A decolonial attitude may be operationalized in research using methods that 1) horizontalize the epistemic positions of both "researcher" and "participants" by framing research relationally; 2) offer an exchange of knowledge through pedagogies that share the researcher's knowledge with their community; and 3) engage community members as collaborators in knowledge production. Collaboration in research (with an emancipatory and feminist attitude) generates knowledge that fills gaps in the existing biomedical evidence base and its applied practice. It underscores two key implications for the intersections of biomedical and decolonial research. First, the knowledge generated from collaborations with community in real time about gaps in the knowledge base reveals the *epistemic alternatives* to biomedical paradigms. Second, when biomedical research is collaborative in a decolonial way, epistemic alternatives emerge that center the lived experiences of racialized and gendered people because they draw from *embodied and intergenerational knowledge*.

My findings show that it is possible to move beyond the theoretical and methodological approaches utilized in the study of race-based medicine by creating research modalities that center a decolonial attitude, thereby supporting research on race-conscious medicine. The *Panza Knowing Workshop* rethinks knowledge production as an active, dynamic, changing, and multi-focal process of relationality and interpretation. It embraces pedagogies of collaborative knowing and refuses frameworks and methods that homogenize and/or occlude the embodied and lived knowledge held by people of color (Tuck and Yang, 2014). Pedagogies of collaborative knowing represent acts of reciprocal engagement and learning through community, a generative process of co-creation. Non-hierarchical approaches to action research pushes back against race-based medicine and can produce research that utilizes biomedical knowledge and takes seriously non-biomedical knowledge. Additionally, the decolonial turn in these approaches aims to engage with collaborators in ways that are not appropriative of their contributions nor their ancestral legacies. Collaborative knowledge production in research that is directed toward deconstructing race-based medicine and, instead, understanding the causes of and solutions for health inequities. These collaborative approaches represent an opportunity to disseminate health knowledge to the community and, more importantly, procedures to laterally engage people marked by race and gender as agents of knowledge production.

This chapter provides a comprehensive introduction to the dissertation's theoretical orientations and methodological frames. It begins by outlining the dissertation's theoretical framework before delineating the methods of data collection and data analysis. The chapter then traces the dissertation's methodological framework. It concludes by briefly summarizing the study's contributions and findings.

Theoretical Framework of Dissertation

The theory used in this dissertation draws from the disciplines of Ethnic Studies, psychological sciences, and medical anthropology. Theoretical frameworks that are produced

transdisciplinarily render what medical humanists have called a "radical dialogic encounter—a place for conversation with those outside our own areas of specialty" (Schillace, 2018). Thus, this dissertation rests on the theoretical foundations of three primary fields: *pedagogy and production* (drawing on the post-structuralist concern for power in the creation of knowledge), *transformative action research* (drawing on theories of interpretation, phenomenology, and hermeneutics), and *critical race, decolonial, and feminist analysis* (drawing from critical and modernity/coloniality theories).

Post-structural analysis in medical anthropology and Ethnic Studies of public health show us how to trace power to identify erasures in dominant biomedical narratives. We would otherwise be precluded from using traditional methods to answer the question of racial and gender equity in health. Instead, we turn to new ways of researching the health of BIPOC people by *not* asking whether *nervios* is biological or cultural; instead, I observe that race-based, individualized medicine is not a productive way to understand human bodies to begin with and that the knowledge embodied by the community is a valid and desirable place to start. I understand that racism shapes this field, even if inadvertently. Doing so requires divesting from dualistic analysis of health categories and instead generating analysis at multiple levels, including the structural, social, and ontological aspects of knowledge production and epistemologies of health and the body. This framing deconstructs the hierarchies constructed in binary terms between "the experts" and "the subjects" of their research, and it recognizes the many forms of knowledge held by both sides of the dyad.

Medical anthropologist Eduardo Menéndez argues that the hegemonic medical model, which prevails as biomedicine today, can be transformed in the future through telemedicine, robotics, and (notably) paradigms and practices of self-attention (*la autoatención*) (*not* self-care) (2020b). In much of the Western hemisphere, in Menéndez's framing, practices of self-attention are laden with the lived and embodied traces of inequitable social forces of a transactional (capitalist) medical model. But he offers that change at the level of the patient-doctor relationship may also represent new medical futures that enable an agentic patient role. Menéndez notes the equalizing potential available through self-attention paradigms, as they exist outside of the patient-doctor dyad. Self-attention processes (e.g., Chinese Traditional Medicine or Ayurvedic medicine) are more than simply esoteric, DIY remedies; indeed, they draw from the robust academic disciplines behind them. Self-attention also draws from important community loci to represent a health modality that is guided by the struggles, values, and knowledge of the collective–even when focused on the self (2020a). Menéndez proposes a medical future in which self-attention paradigms and public health work together to solve population health problems. He writes, "*Lo que proponemos es una autoatención cuyo eje sea colectivo y no individual, que impulse el empoderamiento de los sujetos y microgrupos a partir de ellos mismos, y de las tareas que tendría que hacer la salud pública*" [What we propose is a self-attention located at a collective and not individual axis that propels the empowerment of its subjects and microgroups from within themselves, and from the tasks that would need to be undertaken by public health.] (Menéndez, 2020a, p. 18). In other words, Menéndez's new paradigm of self-attention encourages mainstream health institutions to put agency around health and the body in the hands of patients.

In the present formulations of *panza awareness* and the *Panza Knowing Workshop*, principles of *autoatención* are fundamental in horizontalizing the relationship between participant and health knowledge producer. *Panza awareness* and the workshop both take advantage of how, despite the hegemony of the biomedical model, paradigms of self-attention

create interstices through which people may call upon alternative healing knowledges as well as their own personal knowledge. The collaborative approach to knowledge production proposed in the *Panza Knowing Workshop* operationalizes a methodology of collective self-attention practices as a decolonial feminist act of making health knowledge in an accessible and reciprocal way. This act of epistemic and ontological differentiation via *autoatención* enables a deconstruction of biomedical supremacist assumptions about health and the body.

Theories of biocommunicability demonstrate how knowledge circulates in relation to the structures of power that generate biomedical narratives and experiences (Briggs and Mantini-Briggs, 2004). Knowledge circulates in particular ways that are determined by stakeholders in institutions of power, which are the neoliberal social and economic systems put in place by imperial and settler colonialists of Europe beginning in the sixteenth century (Hall et al., 2013; Rosaldo, 1993; Scheper-Hughes, 2009). Without an analysis of power and the world-historical context of colonialism, biomedical knowledge producers analyze the body and public health in ways that continue to reproduce Eurocentric critiques of Eurocentrism (Grosfoguel, 2012; L.T. Smith, 2006). This paradox traps even BIPOC researchers who attempt to theorize and practice alternative knowledge production from within the biomedical sciences and practice of medicine. Briggs and Hallin propose the biocommunicability framework to visibilize the relations of power that contextualize our phenomena of health knowledge production. They document three major ideological projections that shape the pedagogical processes of transmission of biomedical health knowledge: biomedical authority, patient-consumer, and public sphere (2007, p. 49). In my turn toward a decolonial feminist envisioning of Chicana/Latina health knowledge, I propose that the *Panza Knowing Workshop* represents health knowledge production that can be elaborated beyond the prevailing ideologies listed above. *Panza awareness* proposes a discourse of health knowledge production that subverts the existing hierarchies. It offers a collaborative practice that utilizes some constructs and findings from biomedical knowledge systems but also expands beyond these toward an egalitarian and embodied knowledge.

Thus, the theoretical contribution introduced in this dissertation is an analysis of health knowledge production from a feminist, decolonial lens that rejects the conceptual limits of the individual, reductionist tendencies of biomedical and social science theory. It instead looks at biomedicine in comparison to embodied and ancestral knowledge from "organic intellectuals" (Gramsci, [1947] 1971) and non-Western theories of the body and healing from a world-historical analysis at the global level. This project assumes a decolonial theoretical orientation via decolonial theorist Nelson Maldonado-Torres's interpretation (2017) of psychiatrist Frantz Fanon's framework ([1952] 2007). It articulates a world of YOUS, "where subjects treat others as YOUS" instead of as outsiders (Maldonado-Torres, p. 440). YOUS, in his work, is a first-person pronoun that acts as a referential to recognize people within a collective, humanizing conceptual rubric–as opposed to an individualist, objectivist one. This ontological and epistemological grounding engages humanity in a fundamentally relational, non-dichotomous mode of connection. It is a theoretical shift that destabilizes the hierarchies of knowledge and being that structure biomedical thought along lines of race, gender, and sexuality; and it instead conceptualizes knowledge production itself as a dynamic process of relationality and interpretation across a rubric of connectivity, reciprocity, and exchange.

I take up a decolonial perspective in this dissertation, modeling the cornerstone of decolonial thought emerging out of Latin America and reflected in philosopher and historian Enrique Dussel's "ethics of liberation," which argues for a transmodernity that reflects both a philosophy and a praxis created by and for the oppressed people of the periphery (Espinoza

Lolas, 2022). As explained by critical theorist Ricardo Espinoza Lolas, the transmodern epistemic and ontological movements suggested in the ethics of liberation calls for thinking beyond the predominant social and symbolic structures of a world-historical context of oppressive racial capitalist appropriations by a militarized Europe, United States, and even China over the people and lands of the global majority (2022, p. 15). Dussel envisions an ethics of liberation not as a static, academic philosophy but as an ethic that is practiced. Through a transmodern lens, Dussel situates oppressed peoples from the cosmovisions of the Global South to update the modern traditions of globalization and capitalism that expound their science and reason as superior, when–in fact–they represent "irrational ethical decadence, insensitive to the suffering of [their] victims" (Dussel, 1998, p. 635). Dussel sees theorizing and philosophizing as transformative processes that require its creators to be agents of change in search of avenues toward liberation of oppressed people of the globe (Espinoza Lolas, 2022). His decolonial, transmodern framing pinpoints how projects of knowing must enact processes of liberation, in addition to creating knowledge about them. This liberatory sense of knowledge production is at the center of this dissertation.

Indigenous theorists, like Leanne Betasamosake Simpson (2017), have drawn on an Indigenous understanding of "constellations" as a theory of knowledge and resistance that shows how individual points become portals for understanding when joined in relation to other individual points to form dynamic and overlapping constellations. Similarly, for queer, Black feminist sociologist M. Jacqui Alexander (2005), engaging the ontological work of "oppositional consciousness," as modeled by Black feminist theorist Audre Lorde, involves looking at knowledge in a *situated* way. Alexander also advances that reframing how we see ourselves in relation to others requires doing the pedagogical work to "intervene in the multiple spaces where knowledge is produced," (p. 5). Consequently, this dissertation puts decolonial ways of knowing into practice by creating meaning and generating knowledge via logics of relational constellations, along with a feminist orientation to value embodiment and standpoint epistemology within knowledge production. It does not abandon the movement toward equity in biomedicine and health along lines of race and gender, but rather brings biomedical questions into dialogue with the perspectives of Indigenous people and people of the Global South.

While it might have been easier to design a qualitative project that focuses on existing iterations of race and gender in medical training texts, my dissertation is deeply shaped by the emphasis that I put on embodied and ancestral healing knowledge, which is seldom addressed in the existing literature. Thus, my research questions, conceptual framework, and research design choices are related through the common motivation to generate knowledge about race, gender, and *cosmology*. Theorists of color often integrate analyses of spirituality and cosmology into their work on health and healing. For example, Chicana feminist Gloria Anzaldua theorizes on *la facultad* as a psycho-spiritual method of borderlands Chicana knowing that undoes the pathologizing stories of the self-constructed by mainstream disciplines of psychopathology (2012). Her theories draw on Mesoamerican cosmologies to deconstruct knowledge and structures that are based on European, Cartesian epistemologies. M. Jacqui Alexander (2005) also posits an epistemic imperative to "take the Sacred seriously" and implies the urgency of focusing not only on how/why the Sacred is important to racialized subjects in the terms of their ancestral cosmologies, but also on how Eurocentric conceptualizations of the Sacred informed the West's (so-called) secular epistemological foundations. This specifically entails asking how Christian, Eurocentric thought framed the creation and circulation of the hierarchical classifications that paved the way for modern institutions like health. It also means we must

value alternate cosmological frameworks and ancestral knowledge systems held by BIPOC people.

Maldonado-Torres (2014) further supports my theoretical turn toward cosmologies and ancestral knowledges of the Global South, which biomedical logic identifies as antithetical to the biological sciences and relegates to the "cultural" field of religion. Arguing for critical engagement between scholars of religion and race, he explains:

> Religion and race have come to define how we imagine entire groups of people within societies and across nations in the modern age. If one looked at the literature on religion and race as modern concepts or areas of study, however, one would find that scholars theorizing religion and those theorizing race are not typically in serious conversation with each other (2014, p. 691).

Maldonado-Torres makes visible the religious logics of Christianity and other Abrahamic religions within the racial imaginaries that we engage in biomedical contexts. He observes that, in acts of theory and knowledge production, religion and race are construed as independent of each other; but, in fact, they collude in defining racialized communities (p. 691). In my theoretical framing, I deconstruct the religious and racial entanglements inherent in the study of Chicano/Latino health. I also imagine the possibilities of constructing BIPOC health paradigms that remain co-constituted by religion, though via the religious cosmologies of the Global South. For example, in my exploration of *Coatlique*, Grandmother Spider, and *panza awareness*, I prioritize race, gender, sexuality, *and* cosmologies of the Global South in contrast to academic conversations around race-based medicine. Here, I seek opportunities to explore how the intersecting oppressions of hegemonic Christianity, Western scientific reason, and the dominant neo-liberal world system have come together to produce secularized, racialized, and gendered notions of biomedicine that are actively circulated across health professionals and their various interlocutors. From this exploration of the intersections of Eurocentric oppression, I make shifts toward a decolonial, feminist reimagining of Chicano/Latino health within a new, transmodern framing that takes seriously the worldviews, technologies, and intellectual productions of people of the global majority.

This dissertation's *theoretical* orientation begins with the question, "How might a methodology of the oppressed (one that values the collective theorizing of people in my community) further race-conscious medical research and advance racial and gender equity in the health of diverse populations (Sandoval, 2000; J. Taylor, 2003)?" This question emerges from my analysis of "cultural concepts of distress" in the psychological sciences and medical anthropology, as well as my study of the disorder known as *ataques de nervios* (attack of the nerves) (as examined in Chapter 1). Importantly, *nervios* became a part of my training as a researcher over two distinct periods of my formal education—first as a student of counseling psychology, with a multicultural, culturally-competent, scholar-practitioner framework. I then returned to the disorder as a scholar of ethnic studies, in the context of a critical race framework within medical anthropology. Both times, *nervios* emerged as a pedagogical tool to explicate the complexities of health knowledge and practice that seeks racial and gender equity in health and healing. However, rather than analyzing *nervios* (and whether or not it is a cultural or biological phenomenon), this dissertation maps out how theories of embodiment and world historical systems help us to replace the existing analysis of race-based medicine beyond the individual reductionist, pathologizing logics of biomedicine. I accomplish this theoretical departure by

centering the knowledge and experience of the people of color (to whom cultural concepts of health are applied), contextualizing race-based biomedical knowledge in its historical context and contributing to research on race-conscious medicine.

Additionally, this dissertation's theoretical deconstruction of secular biomedical dualisms and individual reductionisms opens the possibility to conceptualize community engaged action research that is transformative. It is transformative not only in how we conceptualize the individual within their local contexts but also in how we conceive of the multi-directional links between individuals and the world historical structures that play out at a world scale. Action research equalizes power hierarchies because it acknowledges social and power relations and includes local knowledge to promote collective processes (Schwartz-Shea and Yanow, 2013). Sometimes known as community participatory research or critical participatory action research, it has been an important methodological framework by which to bring decolonial and interpretivist paradigms into applied sciences. The theoretical foundations for action or participatory research, thus, also respond (at least in part) to a decolonial turn, by creating the possibility for community-engaged research that is not extractive and authoritative over knowledge of BIPOC bodies and their health and is instead generated via the agency of BIPOC people themselves.

Finally, this dissertation intervenes in conversations about social medicine across disciplines. Nearly twenty years ago, medical anthropologist Paul Farmer and colleagues wrote, "The holy grail of modern medicine remains the search for a molecular basis of disease…. [But an] exclusive focus on molecular-level phenomena has contributed to… a tendency to ask only biological questions about what are in fact *biosocial* phenomena" (2006, p. 1686). By that time, social medicine had already been a field of study for over 100 years, challenging Eurocentric conceptions of health that ignore the impact of structural violence, social forces, and political processes. In other words, social medicine is valuable because it recognizes "that the characteristics of society affect health and illness more than biology does, and social change affects the outcomes of health and illness more than health services do" (Waitzkin, Pérez, and Anderson, 2020). But as Farmer and colleagues rightfully acknowledge, public health has yet to fully integrate the lessons of social medicine.

At the same time, social medicine in the Global North tends to emphasize s*ocial determinants* of health over *social determination* of health, as the former focuses on "classic risk factors and individual lifestyles," while the latter centers "underlying social processes and structural forces" detrimental to health (Drummer, 2018). Unsurprisingly, this concept of the social determination of health originated in the Global South (in Latin America) and has yet to find favor with the World Health Organization and other international organizations. Medical geographer Eric D. Carter observes, "To some, Latin American social medicine exemplifies what Boaventura de Sousa Santos has called 'epistemologies of the south' (meaning the Global South), to rival the rigid, unimaginative, and destructive modes of thought that characterize Western modernity" (Carter, 2023, p. 6). Carter underscores the benefits of learning from practitioners and researchers in Latin America about their approach to health knowledge production, as it acknowledges the dimensions of power inherent in these relations and offers more egalitarian alternatives.

However, social medicine (even in Latin America) does not typically center Indigenous epistemologies, to its detriment. In a just-published book chapter, medical anthropologists Vivian Laurens and César Abadía-Barrero invite researchers to consider how global health might be decolonized by incorporating Indigenous epistemology and praxis. The authors cite *Buen Vivir*

as one example of this approach. "The Indigenous epistemology and ancestral practice of *Buen Vivir*," they elaborate, "gained recognition in the late 20th century as a fundamental aspect of Indigenous movements and a platform for progressive governments that won election in South America" (Laurens and Abadía-Barrero, 2024, p. 293). Briefly, *Buen Vivir* recognizes the relationship between humans and nature and champions for the coexistence of multiple ways of living and knowing (p. 300). As an illustration of *Buen Vivir*'s integration into one health-care project, Laurens and Abadía-Barrero introduce the Colombian Red SaludPaz (HealthPeace Network) (of which they are members) and highlight its approach to community health through policy change; nature and food sovereignty; ancestral health practices; and the recovery of the local, political organizing history (p. 304). Similarly, the *Panza Knowing Workshop* contributes to research on social medicine (specifically the social determinations of health) by creating a safe space for collaborative dialogue, in community, that visibilizes relations of power as embodied and recognizes the Indigenous and diaspora knowledge of health that we carry with us today.

The interventions outlined above reflect the theory and method of oppositional consciousness modeled by Chicana, feminist thinker Chela Sandoval, whose methodological contributions (while technical in their theoretical movements) rest on a singular apparatus of "love" as necessary for forging twenty-first century modes of decolonizing–accomplished through technologies of social transformation. In this dissertation, pedagogies of collaborative knowing are informed by this Chicana, feminist model for a loving modality of knowledge production that reinvents love "as a political technology, as a body of knowledges, arts, practices, and procedures for re-forming the self and the world." (Sandoval, 2000, p. 4). This dissertation harnesses pedagogies, collaborations, and procedures for knowing that act, in Sandoval's language, as "methodology of the oppressed" and methodology of emancipation (2000).

And just as Sandoval's work stands on the shoulders of Black and Chicana feminist and decolonialist thinkers, the knowledge production achieved via this dissertation research merges theory and practice as modeled by historian and feminist theorist Ula Y. Taylor, who declares that "the life of the mind does not require an academic baptism" (2006). In the introduction to her study of Black women intellectuals in early-twentieth-century Harlem, Taylor writes that "street scholars" are "[g]rounded in specific, lived realities [and are] … in the forefront of giving voice to the complicated issues of the day." She also channels neo-Marxist theorist Antonio Gramsci when she classifies these street scholars as "organic intellectuals" (U. Taylor, 2006, p. 154; Gramsci, [1947] 1971). In the *Panza Knowing Workshop,* participants are also "street scholars" who require no academic training to produce knowledge about health and the body. Calling in my community through pedagogies that invite collaboration on the knowledge production process, I also adopt Taylor's conceptualization of black feminist theorizing, classified by African American studies scholar Ra Malika Imhotep and scholar of performance studies Miyuki Baker as "the birthplace of praxis" (2019, p. 3). For example, in her study of Pan-American freedom fighter Amy Jacques Garvey, Taylor coins the term "community feminist" to mean women whose "activism is focused on assisting both the men and women in their lives... along with initiating and participating in activities to 'uplift' their communities.... [T]heir activism discerns the configuration of oppressive power relations, shatters masculinist claims of women as intellectually inferior, and seeks to empower women by expanding their roles and options" (2003, p. 64). Jacques Garvey is one such example of a "community feminist," avows Taylor. Taylor models this praxis in her own work as well. As Imhotep and Baker poetically state, Taylor's work is a "mode of learning in and through deep and thoughtful engagement with

your folks... that happens in the body [and] in the streets... when we laugh together, when we dance, when we playfully disagree and when we affirm each other's wanderings" (2019, p. 3). Pedagogies of collaborative knowing, operationalized through *panza awareness* and the *Panza Knowing Workshop*, act as opportunities to practice knowledge production that is a "dynamic fusion of theory meeting practice" (Christian, 1996, p. 153).

Methods of Data Collection

For data collection, I relied on the methods of 1) ethnographic observations, 2) field notes, 3) close readings of cultural production, 4) participant observation, 5) semi-structured and open-ended interviews, and 6) community-based workshops.

Methods of Data Analysis

This project employs four primary methods of data analysis. 1) Transcription and coding of interviews, interactions, and observations in the field. 2) Close reading of discourse, cultural production, and archival materials authored by BIPOC, women, and femmes. 3) Textual analysis/content analysis of psychiatric and related cross-cultural literature that cites, references, or otherwise deals with the key terms: race-based medicine, race-conscious medicine, individualized medicine, race/gender health disparities/inequities, cultural concepts/idioms of distress, *ataques de nervios*, *ataques*, and *nervios*. 4) Critical autoethnography recounting how I learned new ways to analyze and critique *nervios* through my own academic and religious practice–and how my research expanded beyond race-based medicine and into transformative action research methods.

Methodological Framework of Dissertation

Health action research, as well as related methodologies in medical and health humanities, can offer new understandings *of* and *within* populations marginalized by hierarchies of race and gender (Hesse-Biber and Leavy, 2006; Jones et al., 2017; Krieger, 2011). Health humanities frameworks often acknowledge intersectionality and even may critique biomedical notions of health by expanding research to a broader disciplinary array of health professionals and of experiences of illness (Jones et al., 2017). In the medical humanities, Sandra Acosta, Heather Goltz, and Patricia Goodson (2015) follow an action research framework that is systematic, problem-based, cyclical, and transformative in order to create transparency about health practices and health research methods simultaneously. Acosta, Goltz, and Goodson demonstrate how action research and its off-shoots (e.g., "collaborative analytic auto-ethnography") draw knowledge out of lived experience and value subjective, emic, and local knowledges in biomedical research. Auto-ethnographies, in particular, prioritize a constantly self-reflexive lens that help to transgress incompatibilities between biomedical, post-structural, feminist, and decolonial forms of creative knowledge production that is rooted in the strengths and perspectives of the researcher and their communities (Acosta et al., 2015; Denzin and Lincoln, 2005). As communication studies scholar Mohan Jyoti Dutta theorizes, "[T]he body of the academic [is] the site for intervention into the authoritarian-neoliberal regimes of knowledge production" (2018, p. 94).

Indigenous studies scholar Eve Tuck and Ethnic Studies scholar K. Wayne Yang (2014) define "pedagogies of refusal" as pedagogies that challenge the ethical standards of research that are rooted in settler colonial systems. In other words, pedagogies of refusal are the decision to seek alternate epistemologies and methods of interpretation regarding the embodiments and

narratives of race and gender, embodied and ancestral knowledge. Pedagogies of refusal are not simple "no's," assert to the authors (2014, p. 812). Examples can include declining to do research that commodifies those being researched or declining to expose stories for the spectacle of the settler colonial gaze. These refusals represent a way of thinking and a way of humanizing researchers themselves, who can otherwise assume a God-like role as expert creators of knowledge (2014). This study practices a refusal of top-down, categorical ways of learning about health and the body by documenting my process of developing a community action, which contributes to health research as well.

The levels of analysis in this project draw from the theoretical contributions of "eco-social" perspectives of public health; decolonial perspectives of Ethnic Studies; and Indigenous, Black, and Chicanx feminisms and queer theories. Eco-social analyses look at intersections between health and socially constructed phenomena (e.g., racism at multiple levels, ranging from the global to the individual) (Krieger, 2011). Decolonial analyses in this project deconstruct, reframe, and generate perspectives on health and health research that prioritize a decolonial attitude of relationality, reciprocity, and collaboration. Indeed, the decolonial turn (employed at multiple intersecting stages of self-reflexive analysis in the *Panza Knowing Workshop*) is a fundamental aspect of putting theory into practice by humanizing both researcher and the researched throughout the analytical process. Finally, feminist analyses orient this project via standpoint epistemology, embodiment/embodied knowledge, and subaltern knowledge. Making the case that knowledge about health and the human body may be located beyond the epistemic privilege of biomedicine, these feminist contributions strengthen the analysis of validity and reliability drawn from the ethnographic, action, and critical research generated in this project.

Data generation

1. Embodied Knowledges
2. Ancestral/Inter-generational Knowledges of Healing and the Body
3. Community Knowledges of Health and Health Inequities
4. Methods of Transformative Action Research for BIPOC Populations

Contribution

More than twenty years ago, the US Department of Health and Human Service published a report, which found that "the system of mental health services currently in place fails to provide for the vast majority of Latinos in need of care" (2001). This report was meant to urge stakeholders—ranging from clinicians, policymakers, and academics—to address the striking racial disparities in mental health. They specifically wished for a more substantial underlying knowledge base of public health–spanning theory, research, and data. Indeed, over the past 23 years, this call to action has prompted new studies about Latino/a health. Yet, the resulting biomedical knowledge and (ostensibly) culturally sensitive interventions within race-based medicine remain highly contested. Scholars began to call for evidence beyond randomized controlled trials, the generally accepted gold-standard of biomedical research (e.g., Bonnefoy et al., 2007). Even more recently, the American Medical Association called for clinicians to "counteract the notion of racial essentialism" in "clinical practice, medical education and research" (T. Smith, 2020). Researchers have responded by demanding *race-conscious* medicine (e.g., Cerdeña, et al., 2020; O'Brien and Clare, 2023; Barrett-Campbell, et al., 2022). The *Panza Knowing Workshop* is a response to these calls.

The *Panza Knowing Workshop* contributes to community-engaged transformational

research methodologies and data generation protocols that can be mobilized in health inequities research. Of course, health paradigms that involve racialized and gendered constructs prove hard to measure through conventional research methods. For this reason, the study of race-conscious medicine requires alternative forms of evidence (Bonnefoy et al., 2007). Non-empirical forms of evidence may more closely answer the research questions that arise in the study of race-conscious medicine; and they can help us focus on inequities that can be traced via social pathways to health (US Dept. of Health & Human Services, 2010). At the same time, feminist and decolonial paradigms within the humanities and social sciences—which directly engage sociocultural concepts like race and gender—often have few practical applications in health policy or research. This dissertation finds the points of tension between biomedical and sociocultural paradigms to be productive spaces for knowledge production about health issues that are distinguished along lines of race, ethnicity, sex, gender, behavior, and "culture" or cosmology.

The *Panza Knowing Workshop* emerged from my research that juxtaposed non-Western interpretations of health with biomedical categorizations of race and gender-specific pathologies, departing from the cultural concepts of distress used in Chicanx/Latinx race-based medicine. While I did not want to collect data on these comparisons using conventional evidence-based approaches, I found few existing examples of transdisciplinary scholarship that centered the voices of community people themselves. From this need, I designed the *Panza Knowing Workshop*–to challenge existing biomedical narratives describing racialized and gendered disorders. One example, as examined in Chapter 1, is "*ataque de nervios*." Out of this research surfaced the *Panza Knowing Workshop*, which offers a historically situated re-framing of knowledge about the mind-body connection, specifically the *nervios*-gut connection (as described in the Introduction). Even more importantly, the workshop recognizes participants as experts of their own experiences, carriers of ancestral knowledge, and collaborators of knowledge production harnessed through *diálogo* and witnessing (as discussed in Chapter 3).

Findings

Multiple significant themes emerged from the ethnographic and workshop procedures carried out through the pilot series used to develop the *Panza Knowing Workshop.* Across the multiple action and analytical processes that constitute this pilot, there appeared two applied/action-oriented observations and two theoretical conceptualizations, which I explore in Chapter 4. The first observation is the emergence of a *"lightbulb moment"* that emerged among workshop attendees as a repeatable and reliable pattern during the sequence of psychoeducational and collaborative dialogue in the workshop events. The second observation is a reclamation of the concept of *"hunger"* through the dialogue and witnessing processes where attendees were given the opportunity to imagine and generate new forms of understanding about the health issues that emerged among their community members. The first theoretical conceptualization I identified in this pilot (*a world of YOUS*) involves a conceptual intervention at the level of the collaborative methodology, whereby it becomes imperative to create ways to continually reframe, prioritize, and visibilize the *horizontal organization* of the relationship between the researcher/author and the collaborators/workshop attendees. A second theoretical conceptualization that this project generated (*pedagogies of knowing*) is the theoretical intervention that conceptualizes knowledge production not only as a process of interpretation, but also as a process that is *pedagogical and liberatory*.

Through the various workshops, there emerged three stages of evolution that many

participants passed through before articulating a figurative hunger for healing, ancestral knowledge, community, and social justice. These stages are examined in depth in Chapter 5 and include: Stage 1, a perception of the gut as related to the digestive system and an awareness of its significance in terms of health; Stage 2, an acknowledgement that the mind and gut are connected; and Stage 3, the emergence of a conceptual and bio-social application of gut-brain knowledge (as expressed through hunger).

Collaboration with people from multiple communities in real time and space shows that the *Panza Knowing Workshop* produced transformative group experiences. Transformations through group processes emerged not only from the content of the workshop itself, but also from the decolonial attitude adopted to conceptualize the group work as knowledge production equal and complementary to evidence-based research paradigms. I observed transformational moments during dialogue and sharing in group discussion, as well as via verbal and written feedback from collaborators themselves. These ontological experiences and observations suggest that even research that divests from expert-patient binaries and Eurocentric epistemologies can contribute to the evidence-base of health inequities described in terms of culture, race, or gender.

Conversely, decolonial and feminist framings operationalized via collaborative group work engage the community as equals. Collaborative methodological group work must draw from and generate plural, horizontal frameworks for knowledge production. And the "situated knowledge" that emerges from this group work can advance the techno and biosciences beyond the limitations of positivist, empiricist epistemic privilege (Haraway, 2015; Harding, 1995). Objectivity is "stronger" when knowledge is recognized as situated within the embodiments and experiences of the modern/colonial matrix.

Collaborative pedagogies represent a bridge between dominant and marginalized paradigms of knowledge and being. In the context of collaborative pedagogies, theoretical frameworks as well as analytical and generative procedures must engage plural conceptions of knowledge *on their own terms*. Plural epistemologies can also be understood as "ecologies" of knowledge that coexist in simultaneous, intersecting, and interdependent ways (Sousa Santos, 2018). Transgressing the false dichotomies between the "expert" and the "subject" of research, an ecological perspective of knowledge shows how knowledge production that divests from Eurocentric canons must affectively and systematically disengage from hierarchies of knowledge within accepted disciplinary traditions. We see this in action in the *Panza Knowing Workshop*, which teaches participants why their embodied and ancestral knowledge of the body is valuable as health knowledge from a decolonial, world-historical perspective and invites participants to conceptualize and express their knowledge of the body in a generative way.

Conclusion

This chapter introduces the project's theoretical framework, which has foundations in 1) pedagogy and production, 2) transformative action research, and 3) critical race, decolonial, and feminist analysis. After presenting the methods of data collection and data analysis, the chapter explores the dissertation's methodological framework, as articulated by "pedagogies of collaborative knowing" alongside a decolonial attitude. This section also underscores the power of feminist and decolonial health action research to cultivate knowledge production grounded in the community. Finally, the chapter concludes with a discussion of the dissertation's contributions and findings, noting that the *Panza Knowing Workshop's* community-engaged transformational research methodologies can inform critiques of race-based-medical research

across fields and disciplines–and promote instead race-conscious medical research. (More in-depth analysis of the findings appear in Chapter 4 and Chapter 5.)

In the following chapter, I provide an overview of the *Panza Knowing Workshop*, including its theoretical framing, pedagogical orientation, and workshop development that I have mobilized to address problems of race-based medicine and knowledge production, particularly in communities of color.

Chapter 3

Panza Awareness*:* An Overview of the *Panza Knowing Workshop*

What are ways to be critical of existing methods for generating and interpreting health research while also being methodologically creative to generate new knowledge paradigms of health and the body? A pilot study of the *Panza Knowing Workshop* emerged from this foundational question—seeking practices by which to foster ontological (being/experiencing) and epistemological (knowing/thinking) transformations in research on race-conscious medicine. Through ethnography and a collaborative action research approach, this pilot study of the *Panza Knowing Workshop* proposes a group intervention for exploring the connections between mind and body, which the study and workshop explore in terms of embodied health and intergenerational knowledge. This pilot proposes ways to engage with community to generate knowledge about complex diseases often misrepresented in the field of race-based medical research. Examples of this include mental health and "culture-bound syndromes" like "*ataques de nervios*" (attack of the nerves) as well as race-based biomedical knowledge of individualized medicine (like diabetes, heart disease, and autoimmune disorders).

Using the theoretical framework of biocommunicability (Briggs and Hallin, 2007), this pilot program aims to horizontalize the field of knowledge production by working creatively within biomedical fields. It demonstrates that Indigenous, Black, and Chicana feminisms and decolonial thought are compatible with biomedical research. It does so by modeling how interpretive and analytical frameworks in biomedical research and knowledge production can prioritize coexisting subjectivities and multiple ways of knowing in practice (e.g., Maldonado-Torres, 2017). This theoretical framing couches my elaboration of *panza* awareness as a conceptual intervention and decolonial praxis that emerges when we challenge the hierarchies of power that focus on the "cultural" and the pathological and instead seek to articulate the healing knowledge of the body as an archive (Singh, 2018).

While the previous chapter outlines the methodological frames and theoretical orientations of the *dissertation*, this chapter provides an overview of the *workshop*. It includes a description of the *Panza Knowing Workshop*'s theoretical and pedagogical orientations, documentation of the protocol used to structure and personalize the workshop events (i.e., lecture, storytelling, grounding, *diálogo*, feedback, and archiving), and an overview of the pilot series dates, locations, and contexts. It explores the problems of knowledge production and race-based medicine that produced the *Panza Knowing Workshop* and defines the concept of the "*panza* archive."

The pages that follow defend two major conclusions relevant to knowledge production about race-conscious medicine. Firstly, by bridging biomedical, feminist, and decolonial research paradigms, the ethnography and workshop methods employed in this study humanize and center the lived experiences of BIPOC people. Secondly, this study finds that collaborative action research generates knowledge that fills gaps in the existing biomedical evidence base and its applied practice. Thus, this pilot focuses on knowledge production in health inequities research within communities of people of color and their allies, as a response to the problematics of race-based medicine.

Race-Based Medicine, Race-Conscious Medicine, and Knowledge Production

Complex sociocultural variables intersect in disease categories that invoke race and gender constructs, often understood in biomedical literature collectively as "race-based medicine" (in contrast with the more recent and preferable "race-conscious medicine"). Medical and governmental agencies that produce and disseminate knowledge about health inequities and public health consistently report health inequity statistics along markers of "cultural" difference, for example: the US Healthy People 2020 initiative (US Dept. of Health & Human Services, 2010); the World Health Organization's Sustainable Development Goals (2015). For decades, these biomedical institutions and public agencies have set priorities in policy and research to formulate an individualized medicine approach to eliminating health inequities–appealing to research on race-based medicine at both national and global levels. Some controversial, and often deadly, individualized approaches to medicine drawn along categories of race include the pharmaceutical BiDil for the treatment of heart disease in African Americans, the infamous Tuskegee syphilis experiment, and the "cultural concepts of distress" model used in psychopathology. In these and other scientific reports of race-based medicine, differences described in terms of race or "culture" represent colorblind euphemisms for variables like racism or environmental inequities. Research that integrates epidemiological, critical anthropological, and sociological methods does not describe health inequities in terms of a racial basis or causality but rather in terms of racialized and gendered health factors that contextualize embodied experiences, expressions, and population-level patterns of disease (Nichter, 2008, p. 20). Thus, a race conscious approach that acknowledges lived inequities due to social constructions and imbalances in power (and their effects on the body and mind) aligns more appropriately with a decolonial feminist turn in knowledge production.

Emerging research on epidemiological and biomedical theories interprets complex pathways to health and shows why even evidence-based research must deconstruct and identify the sociocultural determinants of health as well as the "cultures" and epistemologies underlying the *study* of health (Charise, 2017). Without such reflexive academic deconstructions, inequities in health sometimes appear to be "race-based," while in reality they reflect "ecosocial" pathways that present challenges to biomedical knowledge production within individualized frameworks (Krieger, 2011). Ecosocial paradigms of biomedicine theorize the existence of pathways that link biology and sociology (or so-called "cultural" constructs, like race, gender, and other markers of relations of power) to embodiments of illness and health that intersect via our interdependent contexts in real life community settings (Krieger, 2011). The ecosocial concerns that contextualize health inequities present a challenge to biomedical knowledge production itself (Kelly et al., 2007). A race-conscious approach that seeks awareness of the social ecologies of our racialized world addresses those challenges inherent to health inequities research. Data on health inequities is often fragmentary, making it critical to specify how the causes of health inequities are rooted in the biology of individual humans *and also* in sociopolitical contexts, including race, gender, and sexual social hierarchies that shape biomedical knowledge production processes themselves. This pilot research of the *Panza Knowing Workshop* responds to knowledge production problems such as these by taking a race conscious approach that seeks to elucidate the world-historical context of health inequities and expressions of dis-ease by mapping out social ecologies and pathways to health.

Theoretical Framing of Pedagogies of Collaborative Knowing

This pilot is an example of action research because it implements a community-based methodology for creating knowledge about race-conscious medicine in real time and space. This theoretical section overviews how Indigenous, Black, and Chicana feminisms (as well as theories of modernity and decoloniality) frame the group procedures and analyses harnessed through collaborative, community-based knowledge generation processes in the *Panza Knowing Workshop* pilot study.

Decoloniality using Indigenous, Black, and Chicana Feminisms

It is rare to find studies that integrate biomedical forms of knowledge production along with embodied and non-Western healing knowledge; and with notable exceptions (e.g., Denzin and Lincoln, 2005), the ones that do integrate these knowledge bases are frequently marginalized in non-medical or non-professional publications. Indeed, non-Western methods and biomedical research methods can sometimes become incompatible through the research process (2006). However, Black, transnational, and decolonial thought and feminisms demonstrate that health researchers' near total unwillingness to engage with knowledge of the Global South stems from recurrent patterns of ontological and epistemological hegemony of Westernized knowledge over Black and Indigenous knowledge (Mignolo, 2002, p. 948-951; Sandoval, 2000, p. 69; Wynter, 2003). Without scientific methodologies for valuing non-Western knowledge without being exploitative or appropriative (L.T. Smith, [1999] 2012), biomedical pedagogies and knowledge reproduce Eurocentric hierarchies. While seemingly unrelated to colonial science and politics, biomedical paradigms continue to position researchers, clinicians, and other experts as epistemically and ontologically superior to people who embody racial and gendered experiences and people who carry non-Western knowledge.

Confronting these abstract complexities means engaging a "decolonial turn" in research, which sociologist W.E.B Du Bois advanced as an attitude of responsibility and willingness to take on the points of view of people marginalized by racial problems ([1903] 2006). Furthermore, a "decolonial attitude" pushes back against racial, gender, and sexual hierarchies that permeate our theories of knowledge and obscure the present-day consequences of colonization (Maldonado-Torres, 2007). Along with interpretivist paradigms of qualitative social science, the decolonial turn reorients intellectual production as "thinking"—an active (rather than a static) process (Maldonado-Torres, 2007; Schwartz-Shea and Yanow, 2013).

Decolonial psychiatrist Franz Fanon describes how colonized subjects internalize the lens of the colonizer at the level of the body and psyche as well as in the realms of knowledge production ([1952] 2007). For Fanon, avoiding the insanity of Eurocentric colonial constructions requires deconstructing colonial and racialized assumptions about ourselves and others via a decolonial attitude, or way of being, as prescribed by Du Bois ([1903] 2006). Furthermore, Fanon reclaims the agency of colonized subjects by describing a decolonial turn through epistemic *and* ontological responses. For Fanon and theorists like Nelson Maldonado-Torres (2017), a decolonial attitude resists coloniality by using de-colonial knowledge *and* embodied transformations of our sense of self and attitudes toward each other in the real world. Maldonado-Torres demonstrates that epistemic and ontological interventions like these are needed in science; he does this by highlighting Fanon's insistence ([1952] 2007) that considerations that may seem political and philosophical are just as much clinical and scientific issues (2017).

Panza awareness is an example of the decolonial turn in knowledge production about the mind-body connection amongst Latina/os. It is a conceptual framework and embodied practice that departs from a critical deconstruction of the *nervios*-gut connection. *Panza awareness* shows us how expressions of *nervios* model neuro-gastroenterological knowledge of the gut-brain connection and also model knowledge, like *brujería*, of the Global South. It first involves knowledge of the historical context of colonialism that renders medicalized concepts like *nervios*, which betray racial and gender hierarchies in society. (For a discussion of the medicalization of ethnicity and "folk" expressions see Santiago-Iriazarry, 2001, p. 33-34.) *Panza awareness* invokes knowledge that the gut and brain are connected. Furthermore, it cultivates awareness that the gut creates and enacts ways of knowing that extend past the epistemic constrictions of Eurocentric conceptualizations of the mind. *Panza awareness*, subsequently, involves practicing somatic experiences, like meditation and grounding, to bring awareness of the sensations and messages of the body. From there, *panza awareness* creates dialogue that reflects the healing knowledge that can be accessed through these embodied and epistemological movements. *Panza awareness* represents an embodied and community engaged act that decolonizes our sense of the body, health, and illness.

Because of the centrality of knowledge production, the work of this study is "pedagogical" in terms like those explored by Black feminist theorist bell hooks as "engaged pedagogies" (1994, p. 13-22). *Panza awareness*, developed as an act of knowledge production, involves both teaching and learning from the researcher *and* the participant/collaborator. Engaged pedagogies utilize liberatory methods of learning to transgress top-down, "banking" models of teaching (p. 45-58). In contrast, hooks conceptualizes dialogic engagement with both students' and teachers' suffering in real-life contexts, in community, and in loving, compassionate ways (p. 75). Via an engaged rubric advanced by hooks with emphasis on liberation theologists Paolo Freire and Thich Nhat Hanh, pedagogy can be structured by non-hierarchical configurations of theory and praxis (p. 14-16). To humanize people who occupy marginalized intersections within knowledge production processes, pedagogies should prioritize heterarchically situated (non-hierarchically organized) (Grosfoguel, 2012, p. 82), embodied, and ancestral knowledges (e.g., Grise and Mayorga, [2004] 2014, p. xi-xiii; Moraga and Anzaldúa, [1981] 2002; L.T. Smith, 2014; Comas-Díaz and Vazquez, 2018). *Panza awareness* offers a way to lateralize the knowledge production process in a race-conscious way to illuminate those embodied and ancestral knowledges carried in communities of the Global South.

hooks' relational theories of pedagogy emerge from the genealogy of Black feminist and Chicana feminist theorists who establish critical interventions in the humanities and social sciences that now bear on the emergence of fields like the medical humanities or science and technology studies. *Panza awareness* theoretically relies on feminist theories of situated knowledge. For example, Black feminist theorist Patricia Hill Collins's ([1990] 2009) sociological interventions gave shape to the empirical value of situated and embodied forms of knowledge. Her theories of "Black Feminist Thought" draw from Black women's lived experiences as evidence of the value of situated knowledge that is contextualized within the person's standpoint in time and place ([1990] 2009). Black feminist thought thus draws directly from Black feminist epistemology by centering feminist consciousness with the aim of creating the possibilities for Black women to define their realities for themselves. Collins's epistemic turn imagines "self-definition" as a method by which to resist the "controlling images" that elites in power use to manipulate social constructions of Black womanhood (p. 76).

Fields of science and technology studies have increasingly opened to the work of White feminist authors like Donna Haraway (1997) and Sandra Harding (1995) who, in turn, depend on the work of Black and Chicana feminist theorists to build the important concepts of empirical feminisms and "strong objectivity" (Haraway, 1997, p. 37). Showing the impossibility of "neutral" science while at the same time demonstrating that "stronger" objectivity is possible, Haraway draws from theoretical work by Black feminist theorist Audre Lorde and Chicana feminist theorist Chela Sandoval (Homans, 1994). She relies on their work linking embodied, ontological experience and epistemic structures of knowledge about the human body beyond oppressive and essentializing social constructions of Black and Chicana womanhood (Homans, 1994, p. 77). These examples show that, alongside the rich canon of Black and Chicana feminisms, biomedicine can also transform its reductionist patterns for studying people along lines of gender, sexuality, race, and ethnicity (Krieger, 2011, p. 202). *Panza awareness* reflects one such transformation of medicalized conceptualizations (like *nervios*) into framings and practices that acknowledge and depart from embodied and ancestral situatedness.

Embodied forms of knowledge, even within a biomedical model, should take seriously individual and collective standpoints and lived experiences. Indeed, frameworks of embodiment that were once segregated in the cultural productions of feminist and decolonial thinkers are supported by quantitative and theoretical models in epidemiology and public health. These include ecosocial theories of health that show how health inequities are produced via multiple levels, pathways, and power relations, all of which contextualize human life cycles (Krieger, 2011; Epstein, 2008). Just as health represents pathways and processes of co-constituted social, cultural, political, and biological ecologies, knowledge production is a fundamentally pedagogical process of co-constituted learning across multiple domains.[1] These overarching theoretical frames orient the methodologies, procedures, and analytical interpretations that come together through the ethnographic and workshop methods at the heart of this research.

Action Research using an Interpretive Paradigm

Action research methodologies using interpretive paradigms that put theory into practice in community contexts are well suited to the theoretical perspectives reviewed above. Interpretive research uses qualitative methodologies (subjective processes) as well as quantitative methods (objective measures), to conceptualize research not as an act of *collecting* data or discovering universal knowledge, but as process of *generating* knowledge via intersubjective exchanges and co-productions of meaning about lived and collective experiences (Schwartz-Shea and Yanow, 2013, p. 21). Health action research, as well as related methodologies in medical and health humanities, can offer new understandings of and within populations marginalized by hierarchies of race and gender (Krieger, 2011; Hesse-Biber and Leavy, 2006; Jones et al., 2017). Informed by feminist interrogations of validity and "strong" objectivity, the medical and health humanities have turned toward practice-based evidence and qualitative research (Harding, 1995; Crawford et al., 2015). Health humanities frameworks often acknowledge intersectionality, and they may even critique biomedical notions of health by expanding research to a broader disciplinary array of health professionals and of experiences of illness (Jones et al., 2017).

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[1] For example, in their study of San Diego news articles about health, Briggs and Hallin (2007) analyze these primary data as pedagogical texts. These texts serve a pedagogical function via biocommunicability to shape health discourse, including who was authorized to impart health knowledge as well as how the knowledge was to be received by patients and other healthcare consumers.

The *Panza Knowing Workshop* methodology (distinct from dissertation methodology) integrates emerging research methods within health education (e.g., community-engaged participatory research). At the same time, the methodology aligns with the decolonial turn because both pilot and workshop processes required that participants–as well as the researcher–be humanized by a research process that seeks to "understand" rather than objectify human life (Farrell et al., 2015; Maldonado-Torres, 2017; Làò Montes, 2017). Action research that directly engages the community has been used in social science research since the early twentieth century. Yet, critical researchers often trace action research to Paulo Freire and other mid-century critical thinkers on social change in education, which focused on *conscientização* (conscientization) and its purposefully political orientation toward knowledge (Hesse-Biber, 2014, p. 147). Action research equalizes power hierarchies because it acknowledges social and power relations and includes local knowledge to promote collective processes (Hesse-Biber, 2014). Sometimes known as community participatory research or critical participatory action research, it has been an important methodological framework through which to effect change in community.

Methods and Procedures of the Pilot Study

This community-engaged action research takes shape as a pilot study organized according to the distinct phases of development of the *Panza Knowing Workshop*, which serves as a model for collaborative knowledge production. The frameworks above are operationalized within 1) workshop, 2) ethnographic procedures, and 3) analytical procedures, which are conceptualized as intersecting phases that unfolded in overlapping and cyclical processes.

The *Panza Knowing Workshop*

The *Panza Knowing Workshop* was inspired by existing methods in group work and Chicanx BIPOC community-engaged pedagogies and puts theory into action with an aim to foster reciprocal knowledge sharing between communities and stakeholders in public health. The workshop represents an operationalization of *panza awareness* for academic and community settings. Workshops developed procedures to:

a) provide psychoeducation about the gut-brain connection,
b) deconstruct the epistemologies inherent in cultural concepts of distress, and
c) enact feminist and decolonial pedagogies.

Oriented by the idea that "*la cultura cura*" or "our cultures cure us" (Pérez, 2007, p. 106), the creative methodologies used in the *Panza Knowing Workshop* are modeled after the interventions of Chicana feminists Virginia Grise and Irma Mayorga in the *Panza Monologues* ([2004] 2014). Grise and Mayorga's play demonstrates how issues of identity, health, and the body are intersectional. The playwrights create a differential movement away from White feminist and culturally competent frameworks for thinking about the body and instead conceptualize how the "*panza* is political." They conceptualize the *Panza* in a vast array of significations about how race, gender, sexuality, and class are manifest through the body. They note (as indicated by the invocation of monologues in the play's title) that for Chicanas, the *panza* has a lot to say about our lived experiences. Their artistic—*yet reflexive, community engaged, and pedagogical*—depictions of health prove that even non-biomedical perspectives can help to elucidate the mechanisms at work in the sociopolitical and cultural pathways to health (Krieger, 2011).

The psychoeducational discussion (storytelling) in the workshop explores idiomatic expressions like "butterflies in your stomach" or "going with your gut" in biological as well as

experiential, embodied, and sometimes symbolic and/or imaginative terms. I offer my historically contextualized, conceptual intervention of *panza awareness* as a way for participants to imagine how decolonial knowledge of the gut-brain connection can help us understand cultural expressions of dis-ease (such as *nervios*) in ways that are empowering and put us (me and them) in dialogue as collaborators in knowledge production. The workshop introduces the concept of the *"panza knowing archive*," a collectively produced genealogy of healing modalities that intersect with the gut-brain system in some way. These conceptual exercises put science into the hands of the community and ask them to flex their tools for accessing embodied and intergenerational knowledge. Workshop participants practice imagining how healing knowledge may come from their own embodied standpoints and experiences as well as knowledge learned from elders and ancestors.

Protocols were designed to encourage and model decolonial and ancestral methods used in Chicanx/Latinx, Indigenous, and other POC communities of the Global South. Methods include: *cuento* (storytelling), *dichos* (parables), *remedios* (spiritual or herbal healing remedies), *diálogo* (dialogue/conversation), witnessing, and archiving. These methods drew from my personal experience watching a live performance of the *Panza Monologues* for the first time in Austin, Texas in 2010. In the *Panza Monologues*, Chicana feminist playwrights Virginia Grise and Irma Mayorga demonstrate how the above methods are sites where Chicano/Latino people create knowledge organically within their communities and families ([2004] 2014). The play uses these many strategies in its pedagogy, script, and staging notes. Puerto Rican feminist writer and poet, Aurora Levins Morales, likewise showcases the theoretical and practical potential of storytelling (2019). She imagines the role of historian as *curandera.* She notes that the histories we articulate on our terms become "medicinal stories" for Indigenous, Black, and diaspora people who have been systematically maligned or invisibilized (p. 69-88). Levins-Morales's reclamation of storytelling as a *remedio* for the psychosocial oppressions of the modern/colonial system is also reflected within the psychological research that increasingly seeks to decolonize the field using storytelling modalities (e.g., Samuel and Ortiz, 2021; Urmitapa, et al., 2022).

Storytelling, as a mode of knowledge production and healing, is a cornerstone of Chicano verbal art, as described by folklorist Américo Paredes. Paredes outlines the discursive subtleties of his ethnographic investigations with Mexican American people, during which informants or participants characteristically appealed to folkloric expressions and complex cultural significations in their storytelling. In his ethnographies of folklore along the US-Mexico border, Paredes's examples of storytelling traditions highlight the important role of humor–through joking, song, and the *corrido* (border ballad) (1958, 1977). For example, in his analysis of William Madsen's ethnographic observations of Mexican American relationships to biomedical germ theories, Paredes contends that ethnographic interpretation must engage with participants' sense of humor as a rhetorical device to negotiate the complex interplay between patients, healthcare practitioners, and health knowledge (1958). For example, in conceptualizing Mexican American ideas of germs as "Mickey Mice, as if germs were bed bugs or cockroaches," Paredes shows how humor is a discursive device that reflects a nuanced knowledge of health that is informed in part by medicine but also by a Mexican American sensibility of social dynamics that are expressed through humorous storytelling (1978, p. 4-5). These storytelling modalities are also reflected in Grise and Mayorga's *Panza Monologues*, as they conceptualize a Chicana feminist revisioning of how race and gender intersect at the site of the Chicano body through the humor in the *panza*. The *Panza Knowing Workshop* harnesses the discursive power of joking and storytelling in the creative ways exemplified in Chicano folkloric traditions. These forms of

verbal art represent a critical modality by which the workshop, and the practice of *panza awareness*, formulate a collaborative, community-engaged approach to knowledge production about the body.

Ethnography

Ethnographic methods were used simultaneously to systematically trace the development of the workshop and to document the community-engaged pedagogies used therein. In particular, this study used *collaborative analytic autoethnography* so that the ethnographic experience and action research orientation could be synthesized procedurally. Collaborative and analytical procedures paired with reflexive methods of interpretation are hallmarks of emerging methods in social and health sciences (Hesse-Biber and Levy, 2011; Acosta et al., 2017). More typical ethnographic methods of participant observation, taking field notes, and archiving primary materials were also used throughout the study.

Analysis

Lastly, analytical procedures to organize and interpret data from the ethnographic and workshop methods above utilized primary and secondary forms of research and data generation. Analytic procedures paired quantitative and qualitative analyses, journal and archival database research, analysis of sociopolitical and cultural contexts of the community exchanges through the workshop, and analysis of existing research on health, race-based medicine, and race-conscious medicine. Textual and visual analyses also shaped the transformation of existing gut-brain research from biomedicine into formats filtered through a decolonial and feminist lens. Analysis of cultural texts informed how the workshop used storytelling and knowledge sharing 1) to compare how biomedical knowledge circulates in "expert" versus "lay" populations, as well as 2) to show how health conversations happen in Latinx and POC communities beyond the terms of biomedicine.

Overview of Workshop Phases

Between 2014 and 2022, the pilot program of the *Panza Knowing Workshop* reached sample populations in twelve distinct settings, three of which were academic conferences in Denver, Berkeley, and Montreal (Canada); six of which were academic classrooms in the San Francisco Bay Area and Chicago; and another three of which were community events, also in the San Francisco Bay Area.

Workshops held at academic conferences were promoted only through the conference program/schedule of events, and attendance at these events reflect a self-selected audience of academics in fields including (but not limited to) psychology, sociology, gender/women's studies, Ethnic Studies, American Studies, comparative literature, and cultural studies. Conference events were attended mostly by adult women and femmes (a femme is a person who identifies as feminine of center, regardless of their phenotypical expressions of biological sex or gender), and their approximate ages ranged between 18 and 80.

Workshops held in classrooms were arranged between me and educators in my communities, including two academic mentors, a graduate student peer, and a personal friend. Classroom workshops were promoted by fliers were posted in the physical spaces of the academic campuses by course instructors and, in two cases, by program administrators. Classroom workshop events were held in courses titled, for example, "Holistic Psychology," "Chicanx Studies," "Multicultural Community Health," and "Human Biology." While students

self-selected their courses, they were generally required by instructors to attend the workshop. So, they did not self-select to attend the workshop itself. While a few (approximately four) "continuing students" represented older ages, classroom workshop participants generally appeared to be between the ages of 18 and 30. Classroom events were made up of a relatively even distribution of men and women, though contributions from a relatively smaller proportion revealed participation of people who identify as non-binary.

Workshop events that occurred in the community were promoted through paper fliers, online and social media event-listings, and word of mouth by me and the community interlocutors who invited me to participate in their programming. These audiences reflect self-selected audiences representing a heterogenous range of ages, genders, sexual orientations, occupations, ability/disability, etc., who were participating in free events open to the public—including a museum exhibition of ancestral food ways, a pop-up event hosting an array of independent Chicanx/Latinx and Black-owned businesses selling herbal and other healing products, and an annual community conference organized around the theme of empowering women of color.

Using the framework by Māori decolonization theorist Linda Tuhiwai Smith for decolonizing methodologies ([1999] 2012) and Indigenous studies scholar Eve Tuck and Ethnic Studies scholar K. Wayne Yang's methods for "refusing research" (2014), I described and counted workshop participants using only participant observation and field notes. I did not introduce quantitative or survey measures because I did not want workshop participants to feel like research subjects or objects of study; my priority was to embrace them as co-generators of knowledge. The denial of data collection intended to quantify workshop participation fostered an atmosphere of collaboration and sharing, in which participants did not feel like they were being translated into numbers, but instead recruited as peers and science makers.

The first workshop (EWOCC) was an empowering and healing experience, but I also felt conflicted afterwards because I did not tell the participants in this first iteration that I would later write field notes. I felt uncomfortable about using my autoethnographic observations since I had not specified to the participants the relationship between the workshop and the dissertation. At the same time, I recognized that the observations and collaborations from this first iteration of the event were important research. I was encouraged that the workshop really worked to produce original knowledge about how the gut acts for people as an intersectional site of thinking and knowing. This pilot workshop confirmed that I could replicate the event, even though I had to pare down the script. Most importantly, I recognized the workshop as a rich ethnographic modality that closely follows existing participatory action and autoethnographic research methods, while also adopting a decolonial feminist turn.

Over the twelve iterations of the workshop, N=272 adult participants were counted. Additionally, I estimate that a range of 2-7 people were not formally counted at any given event, leaving an approximate range of 10-50 uncounted participants who either chose not to sign-up for the *panza* archive listserv (an email list used for disseminating archival *Panza Knowing Workshop* materials and for facilitating future contact and collaboration between participants) or joined the workshop late or left early, missing the announcements about the email list. Also of note is that several participants at each workshop event self-disclosed health issues that are understood as eating disorders, anxiety/depression, and gastrointestinal and endocrine disorders. Several participants at each workshop also self-disclosed their experiences and identities of parenthood, discussing the connections between their gut-brain connections, their identities as mothers, and their biological/embodied experiences of gestation, childbirth, and caretaking.

Finally, queer and trans participants purposefully outed themselves at several workshops and expressed that their *panza* health was directly tied to these positionalities. These disclosures were unsolicited, and importantly, unexpected. It is also important to note that workshop attendance was greater than expected at each pilot event; and while the workshop was initially imagined as a small group collaboration, the pilot program required the workshop to be modified to accommodate larger group dynamics (Appendix A).

Workshop Protocol

Panza Knowing Workshops can happen in nearly any safe setting where participants can dialogue and witness each other. Like group or twelve-step models, the workshop requires access to the existing "*panza* archive," consisting of the protocols, scripts, handouts, and other materials used in the development of the workshop and the community of *panza*-knowing collaborators. Workshop moderation and organizing protocols vary; they are open to transformation via dialogue with the workshop leader, previous *Panza* participants, and (if applicable) current workshop attendees. The *Panza Knowing Workshop* consists of 4 main overlapping parts: 1) community-building, 2) information-sharing, 3) dialogue, and 4) archiving.

As reflected in the name, the workshop was designed for a Latino/Chicano audience, though participation was not restricted to any particular social or political identity categorization. The main criterion for inclusion was health-seeking behaviors or interests, as workshops are generally advertised in healing spaces or in settings that include the topic of healing and/or knowledge production. In the case of the pilot program, workshops took place at community-based events as well as academic classrooms and conferences. Thus, the ideal workshop population is generally conceptualized as a self-selected group of health-seeking participants.

The workshop is a one-to-two-hour event that introduces a basic deconstruction of racialized, gendered notions of a divide between mind and body in the form of storytelling based on my experience as a researcher in psychology and Ethnic Studies. The storytelling includes a psychoeducational presentation challenging mainstream understandings of the mind, body, and psychology, which brings in biomedical knowledge about our "gut instinct" and how our gastrointestinal system is connected to our limbic, endocrine, neurological, cognitive, behavioral, and psychological functioning. Storytelling concludes by showing how biomedical science of neuro-gastroenterology compares with intuitive and experiential forms of thinking that I learned in my non-biomedical communities, including from elders and peers in non-academic settings.

The workshop then models examples of *panza awareness* by guiding participants through somatic exercises (like tactile or visual grounding), as well as by highlighting the value of intergenerational knowledge through exercises like *limpias* (cleansings) and meditative or mindfulness techniques. Using a decolonial framework, I ground the participants using methods I learned as a Counseling Psychology doctoral student as well as methods that I use in my personal spiritual practice. After embodied experimentation with forms of non-cognitive knowing, I reframe the workshop into the terms of a focus group. This process demonstrates how I conceptualize participants as peers and collaborators in a process of co-creating new knowledge. At this point, collaborators were encouraged to seek recognition of their contributions if desired, and I verbally explained that any participant could and should seek authorship in future publications drawing from the workshop experiences. To date, participants have not followed up requesting that their oral/written collaborations be identified in publication.

The workshop then devotes most of its time to exploratory group sharing and brainstorming, using the concepts of *testimonio (testimony/witnessing)* and *diálogo*

(dialogue/conversation). The group asks questions like: What memories do you carry in your *panza*? Or what is the character of your gut? Using a discussion exercise called "*Panza* Popcorn," participants brainstorm their embodied and intergenerational knowledge by randomly picking out discussion questions that are typed on strips of paper, balled up into small spheres, and collected in movie-theater-style popcorn containers. Often, people chime in with this question to begin the conversation. Oral participation is optional, sometimes structured by small group or paired sharing, and sometimes by voluntary dialogue and/or testimony with the large group. Through *Panza* Popcorn sharing, students are guided to describe their own knowledge of the connections across the gut, mind, and spirit by talking about their own bodies and experiences, as well as sharing recommendations and healing practices. (See Appendix B for the "*Panza* Popcorn"' questions.)

Participant observation shows that collaborators in *Panza Knowing* have diverse, yet deep, knowledge of the interconnections across their minds, bodies, and spirits. In particular, the dialogue, stories, and observations shared in the focus group portion of the workshop showed that religion, spirituality, medicine, health, and illness intersect in peoples lived realities in notable ways. Instead of just discussing intellectual topics, we were able to share original contributions about the connections between health, society, and the body that become apparent when fostering awareness of the *panza*. Participants contributed personal healing modalities and a multiplicity of non-biomedical ways of conceptualizing the body. I call these contributions "*Panza awareness* recipes," which I collected in field notes and through participant contributions (e.g. social media handles, website links, book references, or live/oral demonstrations) and subsequently transcribed and reproduced in the form of a handout for future participants (Appendix C).

Panza awareness recipes serve as pedagogical aids and are generally reviewed in the last step of the workshop, along with an experiential, expressive, or written closing activity. As early as the first pilot, it became clear that the topics explored in the workshop brought up serious and visceral memories and lived realities. Thus, aside from practicing mirroring and facilitating dialogue, the workshop requires time for a closing activity to provide an experiential resource for transitioning out of the group space. Providing tools for noticing, grounding, recentering, and calming stressful feelings emerged as a key element of the workshop facilitation protocol.

As a gesture of reciprocation, participants receive printed and/or electronic handouts of this *panza* archive (Appendix C). Handouts include blank space or lined pages so that the participants could add confidential notes or transcribe their own interpretations of the recipes. The handout used in the first workshop included recipes—ranging from Indigenous food recipes to instructions for self-massage, forms of artistic and narrative expression, and practices for healing talk medicines. I constructed the first iteration of the handout in dialogue and collaboration with academic peers and people in my communities, including people who identify as biomedical practitioners, healers in non-Western traditions, as well as lay people.

Ethnographic Phases

The central questions that guide the ethnographic focus of this study include: How did the *Panza Knowing Workshop* emerge? What are the local contexts and meaning-making processes that produced this action research? And how did the *Panza Knowing Workshop* develop over the span of the pilot program? The ethnography generated through this study produced participant observations, field notes, and continuous self-reflexive analyses of the emic (local) and etic (outside) interpretations of the pilot. Ethnographic methods such as these enabled me to situate

my own knowledge actively, drawing from my dual positionality as an insider researcher (L.T. Smith) with ties to the Chicanx/Latinx community, as well as to the academic research community.

Previously, in my academic studies in the fields of human development and counseling psychology, I researched the gut-brain connection via a neuro-gastroenterological lens. Neuro-gastroenterology shows that a relative majority of neuronal information originates from the gut and that neuronal activity moves from the gastrointestinal tract up toward the brain. Because this research conflicts with mainstream notions of biology that locate the brain as the primary "thinking" organ in the human body, biomedical research of the gut-brain has opened cross-disciplinary conversations about biology, the mind, emotions, and the body. When I later moved my academic career to the discipline of Ethnic Studies, I began a comparative study of biomedical and non-Western healing practices. Still drawing from my foundations in applied and clinical biomedicine, I gained awareness and depth regarding the histories, sociologies, and cultural texts that coalesce around topics of race and gender. With a new disciplinary perspective, I found that the compelling knowledge about the gut as the "second" brain tends to be isolated from eco-social paradigms that acknowledge sociopolitical constructions of embodied health and explicitly interpret for the roles of race and gender systems. As a rule of thumb, concepts of race and gender have not been prioritized within neuro-gastroenterology and related fields (Gershon, 1999). *The Panza Knowing Workshop* is a way for me to build an environment for dialogue based on the embodied and intergenerational knowledge held by people in my multiple and overlapping communities to explore how the research connecting the gut to the brain could be interpreted if placed in the hands of the community itself.

Through the workshop, I found ways to respond to the unresolved questions surrounding cultural concepts of distress from the standpoints and experience of people in my own communities. I found it particularly productive to imagine how a conversation about "*nervios*" (meaning nerves, literally, or sometimes, anxiety) might look if we divested from concepts of race and gender and instead explored connections between the mind and body as well as connections between people in community. These priorities do not aim for colorblindness. In fact, the analytical and community engagement in the *Panza Knowing Workshop*s acknowledge the embodied realities of racialized and gendered notions of difference.

My priority through this pilot was to use my experience and locations of epistemic privilege—including my Westernized education, cisgender normativity, racial ambiguity, experiences of passing, and color privilege. From this imperative, I worked to create spaces that bring BIPOC people to the proverbial table of knowledge production through community action research. From the first iterations of the workshop through the various pilot events, I found that the workshop created an environment that was both educational and restorative. This workshop format—including psychoeducation, health education, and focused collaboration among participants—brought together 1) knowledge about each other's experiences of the mind-body connections through the gut as well as 2) meaningful relationships and long-lasting impressions gained from the workshop's moments of connection and relationality.

Analytical Phases

The paradigms that structure the analyses in this pilot result in multiple and cyclical processes of interpretation of primary and secondary data. Analytical processes were implemented before, during, and after the phases of ethnography and workshop pilot events. Analyses included research of public health data from academic and governmental databases and

websites regarding health inequities and neuro-gastroenterological research finding connections between mind and body. Additionally, analyses of archival and cultural texts were used in the development of the rationale for the pilot study and specific workshop procedures (e.g., drawing from *The Panza Monologues* to develop community-engaged methods). After the first *Panza Knowing Workshop* event, additional analyses refined the methodological and workshop procedures, requiring continued guidance from Grise and Mayorga's play ([2004] 2014) and research in the medical and health humanities (e.g. Charise, 2017). Following each workshop event, the original design was compared to both ethnographic field notes and feedback collected from participants at the end of each workshop. This pattern was repeated cyclically before and after subsequent workshops; and through this process, a general structure emerged that informs future recommendations for the development of decolonial methods and workshop procedures.

Analyses focused on evaluating procedures that fostered decolonial and feminist attitudes. Evaluation of workshop procedures involved coding for, recording, revisiting, refining, and reinterpreting the major themes drawn from autoethnographic reflections and field notes taken during the twelve cycles of facilitating the workshop. The coding procedure prioritized participants' self-reported feedback, conversations/interactions, group dialogue, and contributions to the workshop archive. Consistent with methodologies of action research, the coding scheme sought to articulate how knowledge embodied and produced by BIPOC people transforms Eurocentric biomedical interpretations of health and the body.

Conclusion

As a complement to the prior chapter on the dissertation, this chapter offers an overview of the *Panza Knowing Workshop* itself, which employs ethnography and workshop methods to value the experiences and knowledge of Black and Indigenous people of color. It does this through biomedical, feminist, and decolonial research and collaborative action research. It is this latter paradigm that produces knowledge and pushes the existing biomedical evidence base and its practice to expand beyond Eurocentric conceptual frameworks. As articulated by this chapter, the dissertation's theoretical framework relies on decoloniality using Indigenous, Black, and Chicana Feminisms as well as action research methodologies using interpretive paradigms. The chapter also outlines the workshop protocol and phases, during which participants engaged in brainstorming and group sharing, for example.

In the following chapter, I outline my observations: A) the "lightbulb moment" and B) a hunger for healing, ancestral knowledge, community, and social justice–as well as my theoretical conceptualizations: C) a world of YOUS and D) "pedagogies of knowing." These themes surfaced across workshops and illustrate participants' engagement with the workshop, their evolution towards trusting embodied knowledge, their empowerment to serve as experts of their own health, and their ability to make meaning in new ways.

Chapter 4

Ethnographic Discoveries: Epistemic Ruptures, Hunger, Lateral Knowledge Production, and Pedagogies of Knowing

The first iteration of the workshop was held in 2014 at the Empowering Women of Color Conference (EWOCC), in Berkeley, California. This was the first time that I saw workshop participants, as a collective, experience a lightbulb moment (or epistemic rupture) when introduced to a decolonial perspective on the neuro-gastroenterological science that posits the gut is the *second* brain. This workshop offers the possibility to view the rational, cerebral form of knowing *as well as* the corporeal, gut-felt form of knowing as equally valid and useful for creating knowledge about our bodies and health. Multiple participants vocalized, "I never thought about it until now, but my gut DOES tell me…" After leaving this workshop, I decided that this work deserved the careful attention of a dissertation and began to plan the pilot series using feedback from these first participants.

Multiple significant themes emerged from the ethnographic and workshop procedures carried out through the pilot series used to develop the *Panza Knowing Workshop*. Two observations surfaced during the ethnographic workshops: A) "the lightbulb moment" in collaboration and B) hunger for healing, ancestral knowledge, community, and social justice. After the event, I identified two theoretical interventions: C) a world of YOUS and D) pedagogies of knowing. Below I introduce and outline these themes that surfaced, demonstrating the knowledge production potential of this workshop modality. In Chapter 5, I further elaborate on what I call Stages 1 and 2, a transition from participants' literal discussions about gastroenterology to an understanding of the mind-body connection as operating through the gut. These stages were access points through which most workshop participants were able to identify the connection between their bodies, minds, and health. This then led them to Stage 3, a hunger for healing, ancestral knowledge, community, and social justice, which I also examine in Chapter 5.

In this chapter, I discuss my observations: "the lightbulb moment" in community and participants' hunger for healing, ancestral knowledge, community, and social justice. I also elaborate on a world of YOUS and pedagogies of knowing as two theoretical conceptualizations that highlight the significance of collaborating toward knowledge production in reciprocal, agentic ways that respect community members as interlocutors. These observations and the decolonial feminist theories that they draw on all showcase the potential for collaborative group methods (like those of the *Panza Knowing Workshop*) to create avenues for equity in health knowledge production processes.

A) "The Lightbulb Moment" in collaboration

After the storytelling presentation, I led the participants through *panza awareness* exercises, helping them to establish awareness of the gut itself. It was an invitation to break Victorian taboos that we should never discuss our guts or stomachs. I gave them permission to talk quite literally about their gut functions. I then supported participants to understand that we process emotions through our guts. This realization—of the connection between the mind and the gut—was a "lightbulb moment" for many. While it was certainly not the only time when a rupture occurred, it was significant because it was the first moment when many participants opened up to the concept and practice of *panza awareness*. Indeed, during each workshop, I

consistently witnessed participants experience epistemic ruptures or what Ethnic Studies theorist Ronald Takaki describes as epiphanies ([1993] 2008, p. 441) or "illuminating" moments. Participants had "light bulb moments" when listening to the story of how my educational and research journey led me to critique and deconstruct the way that research on biomedical culture is isolated from feminist, Black, Indigenous, diaspora, transnational, and decolonial knowledge produced by people of the global majority.

At the beginning of the workshop, I introduced neuro-gastroenterology, which provides evidence for gut knowing and *panza awareness,* even though it does not offer a practice by which to examine how interconnections between mind and body influence our sense of knowing. Part of my storytelling included a discussion of Michael Gershon's work (1999) on the connections between the gastrointestinal and neurological systems. It was during this part of the workshop that I witnessed participants first experience a lightbulb moment of realization that could be observed in their posture and eye contact. I told them that I found Gershon's research to be compelling in showing, for example, that a large majority of neural activity originates in the gastrointestinal tract and moves up toward the brain (and not vice versa, as commonly conceptualized in basic understandings of human biology). I explained that I am trained to challenge and deconstruct Eurocentric epistemologies from a decolonial, feminist perspective. And through this lens, Gershon's research still is limited, as it conceptualizes the mind in the Cartesian, rational sense expounded on by philosopher Rene Descartes. Sharing with them my knowledge as a Chicana of how the *panza* is a site of subversive humor (Paredes, 1977), I asked participants to consider an alternative interpretation of gut thinking, one informed by their embodied experiences or knowledge from their culture or elders. "What if the gut is not inferior to the brain?" I asked workshop participants. "What if we imagine how our body engages those 'higher' thinking processes that biologists deny?" The "lightbulb moment" represented for participants the beginning of a process of questioning our typical Westernized epistemologies while listening to my reframing of the gut-brain connection in a horizontal way. The moments of realization also demonstrated how the exercise of embodied "thinking," when reframed in a collaborative and reciprocal way, could be reproduced through the reflection, *testimonios*, witnessing, and dialogue in the *panza awareness*, *Panza* Popcorn, and archiving exercises.

Decolonial theorist Sylvia Wynter understands these "light bulb moments" or ruptures as essential for the progression of human existence. But these ruptures do not emerge without intentionality. As Black Studies scholar Bedour Alagraa shows, Wynter's concept of rupture (the antithesis) is always provoked by heretic statements (Alagraa, 2023, p. 284). Here, her definition of "heresy" is informed by philosopher Leszek Kolakowski's understanding of the "fundamental antagonism, whereby everything that is new grows out of the permanent need to question all existing absolutes," resulting in the establishment of "new orthodoxies" (Wynter, 1984, p. 21). In conversation with Alagraa, Wynter affirms her commitment to the Third Event (Fanonian rupture), whereby all of society will be transformed. Like any rupture, heresy provoked by language (like storytelling and poetry) tears at the fabric of our (neo)colonial reality (Alagraa, 2021). Breaking away from power, as Wynter explains, is preceded by "a transgressive… ground of understanding," which ruptures our thinking (qtd in Scott, 2000, p. 164). In the *Panza Knowing Workshop*, decolonial, feminist interventions are the heretic statements or the contractions that result in the birth of participants' epiphanies.

Throughout the workshops, I would repeatedly hear participants say, "I have never thought about this," followed by an interoceptive observation about themselves. For example, one Chicana participant expressed, "I never realized it, but I definitely know when my stomach

is off its because I'm stressed out or have too much drama going on" (NACCS). A queer participant realized for the first time that their gut had always affirmed their queerness *and* reflected back to them the fear they felt about coming out to their family: "I hadn't thought about it until now; but I always knew in my gut that I was queer, and when I came out it felt so bad in my gut—but then I was okay. I was scared of what my family would do" (NWSA). After reflecting on the gut-brain connection, as imagined through the biomedical lens *and* the embodied lens, participants made realizations that resulted from the embodied practice of thinking from their *panzas,* without first appealing to reason. The practice of *panza awareness* empowered participants to make unexpected realizations. For instance, in their feedback, a student activist wrote, "I thought I was going to learn about food and eating here, and this was so much more than that. It went a lot deeper, and I really appreciate that and the connections I was able to make" (Strike University). An undergraduate health sciences student said the workshop "really made me think differently about my gut and its health and how it is extremely important to my overall health" (CSU East Bay). A Chicana woman noted that she had never realized how much the teachings of the elders in her family accurately reflected the biological discoveries of the gut-brain connection (Galería de la Raza). These participants communicated how the workshop had helped them to make connections and realizations that reframed their understanding of their bodies and health.

B) Hunger for healing, ancestral knowledge, community, and social justice

Psychoeducational and collaborative aspects of the workshop were critical for enacting decolonial and feminist pedagogies in humanizing ways. A decolonial feminist attitude cannot be imposed; it must be introduced, contextualized, practiced, and reciprocally engaged (Maldonado-Torres, 2017). Indeed, the invitation to generate knowledge reciprocally was met by participants with zealous expressions of *hunger*. Participants shared hunger for the type of knowledge reflected in my autoethnographic stories and in the frameworks that I used to guide discussion. Specifically, participants expressed hunger 1) for healing, to talk about traumas such as eating disorders, 2) for ancestral knowledge, 3) for community, including wanting to be seen and heard, and 4) for social justice. I discuss these four hungers in depth in Chapter 5.

Hunger is taken up as a major theme in anthropologist Nancy Scheper-Hughes's foundational text, a *Death Without Weeping* (1992), which documents the ethnographic genealogy of hunger. She finds that the study of hunger has been taboo within medical anthropology and related disciplines. Scholars sometimes engage with it in metaphorical and symbolic ways but seldomly at the "times and places…where the threat of hunger, scarcity, and unmet needs is constant and chronic," where hunger becomes a "primary motivating force in social life" (p. 135). Scheper-Hughes finds that expressions of hunger and nervousness are in constant juxtaposition in Bom Jesus (her field site in Northeast Brazil), where, together, these utterances "come to seem natural, ordinary." She writes that the theme of "nervous hunger" and "nervous sickness" is universal among the people of her field site (p. 167). More specifically, she finds,

> [The metaphors of social conditions] used so often in the everyday conversations of Alto people mimic the physiological symptoms of hunger. There is an exchange of meanings, images, representations, between the body personal and the collective and symbolic body social…. [N]erves and nervousness provide an idiom through which they reflect on their hunger and hunger anxiety. (p. 169)

Scheper-Hughes identifies the paradoxical connections between physiological expressions of hunger (as hunger for food) and psychological expressions of hunger (as anxiety or *nervos*); and she traces the social implications across this interchangeability of hunger and *nervos*. She observes that patients found obtaining tranquilizers and sedatives to treat claims of *nervos* to be easier than getting food for claims of hunger. Given Scheper-Hughes's discussion of how hunger and *nervos* play out among starving populations in Brazil, it seems natural that hunger would emerge as a major theme in the *Panza Knowing Workshop*, which offers approaches to *nervios* beyond the standard biomedical methods, (e.g., pharmacology and psychiatry).

In a 2014 poster presentation about my decolonial deconstruction of *ataque de nervios* at an academic conference in Puerto Rico, a Puerto Rican senior passerby stopped to read my poster. She then asked me, "Do you know why you don't see *nervios* so much anymore?" She then answered herself, "*La pastillita* [the pill]." She commented that today, when a person complains of *nervios*, they receive a prescription that they take to avoid succumbing to *ataques de nervios*. My Puerto Rican interlocutor discerned the same public health strategy that Scheper-Hughes observes in Brazil: the treatment of social issues via pharmacology and psychiatry. In both cases, the underlying expressions of dis-ease or hunger (whether material/structural or social/interpretive) were subsumed by the medicalization of social and power relations. Scheper-Hughes notes,

> [T]he medicalization of hunger is symptomatic of a nervous system, individual and social. Hunger has made the people of the Alto [in Bom Jesus] lean, nervous, and desperate. Sometimes it has made them violent…. Doctors, nurses, pharmacists, and the first few timid psychologists to appear on the landscape are recruited in an effort to domesticate and pacify an angry-hungry population (1992, p. 211).

She adds, "strip away the ragged metaphor of *nervos*, and you will find the bare skeleton of 'hunger' shivering under its mantle" (p. 213). Scheper-Hughes finds that thinking critically about *nervos*, as a "pedagogy for patients (and practitioners)," allows a "new discourse (or an older one)–a discourse on nervous *hunger*–to take the place of *nervoso*" (ibid). Describing a liberatory medicine, Scheper-Hughes hopes that the return to a discussion of social relations of hunger will restore a struggle for justice. My observations from the *Panza Knowing Workshop* reflect a return to a conversation of hunger, from outside the medicalized surroundings that offer pills as the panacea for *nervios*-related difficulties. When given the opportunity to explore articulations of *panza awareness*, participants revealed the yearning and hunger at the core of their lived experiences of our globalized world.

Another way to understand this hunger is through yearning. Black feminist theorist M. Jacqui Alexander writes that "the work of decolonization has to make room for the deep yearning for wholeness, often expressed as a yearning to belong that is both material and existential, both psychic and physical" (2005, p. 281). For Alexander, this desire for wholeness is linked to re-membering the pieces of ourselves that were fragmented and dismembered by the ideological, social, and structural conditions of racial, capitalist, colonialist projects, a "forgetting so deep I had forgotten what I had forgotten," she proclaims (p. 260). Through prompts to remember the teachings of our elders, as well as prompts to retrieve the sensations associated with our rememberings, the *Panza Knowing Workshop* facilitates memory work in community. And via this personal and political transformation, participants access yearning. Alexander shows that the source of this yearning is "the deep knowing that we are in fact interdependent,

neither separate nor autonomous. As human beings, we have a sacred connection to one another, and this is why enforced separations wreak havoc on our souls. There is great danger, then, in living lives of segregation" (2002, p. 99). This desire for interdependence and connection is articulated in every one of the hungers expressed by participants in the *Panza Knowing Workshop*. From the hunger for healing to their hunger for social justice, each participant tapped into a yearning for restoration of a sense of self and of a lived experience of a body that is whole, viable, and empowered. Alexander also recognizes the power of doing this work in pedagogical spaces, with a "curriculum that brings a promise to satisfy some yearning, as faint or as well-formed as it might be, to imagine collectivities that can thrive outside of hegemony's death-grip" (2005, p. 8). Similarly, the potential of the *Panza Know Workshop* is to create a pedagogical process of reciprocity that satisfies a hunger and thirst for knowledge of self that is empowering and whole-making. It also creates opportunities to imagine modalities of health and healing beyond those prescribed by the hegemonic medical model.[1]

Theorizations of yearning by Black and Chicana women represent feminist interventions of oppositional consciousness and differential movements reflecting the methodologies of the oppressed, as described by Chicana feminist Chela Sandoval (2000). For example, bell hooks finds yearning to be a useful concept for conceptualizing the "common passions, sentiments shared by folks across race, class, gender, and sexual practice" (1990, p. 12). It is in this "shared space and feeling of 'yearning'" that we can come together and create movements (in social and in embodied ways) toward healing the dis-eases of modernity. We can channel the words of the women of Fuerza Unida (mainly Mexican and Mexican American women), who organized in 1990 to protest the closures of Levi Strauss & Co. plants in San Antonio, Texas. In the midst of a 21-day hunger strike in 1994, they occupied the company's San Francisco corporate headquarters and proclaimed, "*No tenemos hambre de comida, tenemos hambre de justicia*" (We're not hungry for food; we're hungry for justice!) (qtd in Louie, 2001, p. 63).

In the *Panza Monologues*, playwrights Grise and Mayorga take up the questions of morbidity and mortality caused by hunger in Chicano communities, noting the correlations between urban, food deserts and diabetes and obesity-related diseases. For this reason, they say that the "*panza* is political," and they represent the community's health by connecting poverty and a diversity of health issues (from nutrition to prenatal care to environmental pollution and segregation) through the lens of the *panza.* In response to facile accusations that fatness is a disease caused by greed and and gluttony, the play's main character retorts, "So, if obesity is a disease of capitalism, why is it that San Antonio is one of the largest cities in the nation…and at the same time on of the poorest?" (San Antonio, with its high percentage of Latina/o inhabitants is also one of the largest US cities in terms of people's body mass index, an index proven to be inaccurate and based in racist medical thought). The script interrogates this assumption by listing obesity and poverty statistics from local news media sources and showing that obesity in San Antonio is related to poverty, not to wealth. While food scarcity is not as pronounced in US populations as it is in Scheper-Hughes's Brazilian field sites, poverty and hunger remain salient themes in US health inequity. Even when people's hunger is not for food, hunger still expresses an existential fear that is backed up by death and disease statistics that characterize health inequities among people of the Global South and the disenfranchised in the US. As a signifier of the appeal to life and death, hunger represents a powerful expression of knowledge about what it means to be human along racial lines. Who is allowed to be a whole, true person or not? This is a

[1] I understand the hegemonic medical model in the ways it is used by Eduardo Menéndez (2020b) to mean the medical model that structures the healthcare systems of the Global North.

fundamental question in knowledge of Chicano/Latino and other BIPOC health (Mignolo, 2015, p. 106-123). It is significant that the theme of hunger emerged from the *Panza Knowing Workshop*, as hunger is a fundamental aspect of people's racialized experiences because of the ways in which race is dehumanizing for non-White people. In other words, people's racialized experiences determine who has access to sufficient food, wholeness, and knowledge about their health in humanizing ways.

In the *Panza Knowing Workshop*, when I offered my act of academic reciprocity via pedagogy through lecture and storytelling, I created an invitation into the unanswered questions surrounding *nervios*.[2] In posing the questions in the world-historical context of racial capitalist colonialism, I invited workshop participants in as be collaborators in research, validating and historically contextualizing for them how embodied and ancestral knowledge is currently missing from predominant biomedical frameworks. Discussions turned to the themes of hunger and yearning once participants took action as knowledge producers through the *Panza* Popcorn *diálogo* exercises–and as we continued to explore health and tease out the interconnections between the gut, brain, and *nervios*. Hunger emerged as a meaningful result of knowledge production that participants characterized as fundamental to health.

Hunger for healing in community was a recurrent and inevitable discussion theme in the *Panza Knowing Workshops*. For example, in the first pilot, two participants intervened in group facilitation by asking that the workshop protocol utilize gender neutral language and normalize other rhetorical feminist and queer interventions, like asking for each person's pronouns during introductions, or introducing trigger warnings (EWOCC). They vocalized how the hunger they felt and acted on through their bodies also led them to acknowledge a disembodied form of hunger. For them, this other form of hunger was a desire to be seen in their full, complex humanity through specific interventions via dialogue about the gut-brain in their communities, which were integrated into all subsequent pilot procedures. Expressed via a logics of hunger, collaborative group interactions transformed the group experience and informed future procedures; and they bridged embodied and disembodied forms of knowing. A logics of both embodied and disembodied hunger helped to identify steps vital to any healing group space, including clarity on what steps are required for the group to achieve its goals, unlike others that were more flexible (Drum, et al., 2011). A safe space for collaboration created opportunities for participants to articulate their needs in ways that proved empowering and were rooted in a heterogenous collectivity of their lived experiences.

Written feedback self-reported by participants consistently showed that they valued group facilitation that used mirroring (re-stating a person's comments in your own words) to engage with vocal participants and ensure that they feel "heard." They expressed that during their experimentations with knowledge production, it felt "nourishing" when the facilitator or another participant mirrored their comments. Archiving participants' contributions became a way to extend the nourishing capacities of the workshop collaborations. Procedural interventions emerged as vital to addressing the groups' hungers, most importantly: setting group expectations, modifying the workshop according to the expected audience and/or workshop setting, finding safe spaces to conduct the workshop events, and scheduling enough time to complete all workshop procedures. It proved important to make time for "closing" procedures out of respect for the sensitive topics that may emerge during discussion and also to leave ample time for participants to offer confidential feedback. Lastly, analysis shows the importance of a follow-up

[2] Examples of questions about *nervios*: What is it? What does it signify in biomedical terms? What does it signify in folk terms? How do we treat *nervios*?

structure that links workshop participants as collaborators in knowledge production and resources for community-based healing. The email listserv became one way to satisfy participants' hunger for continued engagement in the processes explored during the workshop.

C) A world of YOUS

One theoretical conceptualization I identified following the workshops was a world of YOUS. Decolonial theorist Nelson Maldonado-Torres calls attention to the clinical applications of Afro-Caribbean psychiatrist Frantz Fanon's decolonial notions of self-making (2017) and adds an "s" to the end of Fanon's concept, "world of YOU." He does this to help the reader better understand Fanon's self-making as one in which the self is connected to others in a relational way and not by a binary logic of difference and constructions of otherness (Maldonado-Torres, 2017; Fanon, [1952] 2007, p. 206). Published in the *South African Journal of Psychology*, Maldonado-Torres's article speaks to psychologists in South Africa, where decolonial movements in education have pushed back against neocolonial pedagogical structures. From within their field, Maldonado-Torres also seeks to connect psychologists with an intellectual genealogy that offers direction on how to be critical of *and* creative with Westernized methods for fostering a world of recognition, the Fanon-inspired, self-made world of YOUS.

Collaborations enacted with decolonial and feminist attitudes, like the *Panza Knowing Workshops*, contest the false binaries of evidence-based metrics that dominate the theoretical foundations of biomedicine and preclude horizontal knowledge relations. Collaborative transgressions horizontalize the epistemic hierarchies implied via false Eurocentric binaries. Even within the biomedicine and the Westernized university, European colonization's genocides and epistemicides in the Western hemisphere (e.g. burning the al-Andaluz libraries on the Iberian Peninsula or the medical codices of Tenochtitlan, modern-day Mexico City) continue to shape our systems of knowledge production and research (Grosfoguel, 2013). The global domination of institutions and structures that center European knowledge traditions produce the epistemic privilege of the West (Sousa Santos, 2017). Horizontalizing these trends can be conceptualized via an epistemology of ecologies of knowledge. I saw this in the *Panza Knowing Workshops* when participants took authority over their own bodies in how they described their experiences as true to them.

Ecologies of knowledge presented to participants exemplified how plural (multiple, coexisting) conceptualizations of knowledge can be located within heterogeneous, lay communities as well as within scholarly knowledge production circles. The collaborative analytic approach to the workshop, thus, created an understanding of health (and specifically the connections between mind, body, and sociopolitical contexts) via a rubric of plural truths. *The Panza Knowing Workshops* recognize overlapping, multiple, and shared realities based on a rubric in which sameness and difference coexist—and where difference is organized horizontally, not hierarchically. The ecological imperative toward plurality moves away from universalist/relativist binaries that inform race-based medical research. This framing deconstructs the hierarchies constructed in binary terms between "the experts" and "the subjects" of their research, and it recognizes the many forms of knowledge held by both sides of the dyad.

Adopting a decolonial attitude, according to Fanon, involves an ontological practice of "build[ing] the world of YOU" by employing conceptual and epistemological metrics of relationality and plurality ([1952] 2007, p. 206). I use Maldonado-Torres's word, "YOUS," to underscore how (in Fanon's telling) a decolonial psychology means that the logics and styles of relating to others are filtered through concepts of sameness (2017; Fanon, [1952] 2007; Fanon,

[1952] 1988). The community-engaged and collaborative aspects of the *Panza Knowing Workshop* practice this decolonial attitude, creating a space of YOUS by verbally and explicitly articulating a style of relating to workshop participants that expresses, "I am like you, and you are like me." Contrary to Eurocentric logics of difference (e.g., I am like me, whereas you are like you), Fanon insists on the primacy of such a decolonial attitude. This ontological and epistemological transformation offers healing to the psyche of the colonized subjects. It also carries methodological significance for the field of biomedicine.

One way this manifested in the *Panza Knowing Workshop* was through lessons taught by participants, who were empowered to serve as experts (lateral knowledge production). It is through lessons like these that biomedicine would benefit from by welcoming patients to examine and co-create knowledge about their health. For example, in the first workshop (as mentioned earlier), two participants (who had been in dialogue amongst themselves) requested that I employ gender-neutral language and ask for participants' pronouns to create a safe space for all participants to collaborate as knowledge producers as their full selves (EWOCC). They took seriously their role as co-collaborators in knowledge production and produced a methodological intervention from the queer/trans perspective. In this early development of the *Panza Knowing Workshop*, these participants fundamentally shaped all future workshop events, as I changed the protocol to ask for pronouns; and I added *Panza* Popcorn prompts to reflect questions of gender and sexuality. Additionally, at the time of the Foreman High School workshop, I was not yet a mom; and I had only briefly mentioned reproductive justice in my introductory storytelling presentation. A young mother in the workshop later spoke up during the *Panza* Popcorn *diálogo* and said, "If you're giving me space to interject my own ideas, here's what you're missing. Being a mother is *panza awareness*. As a mother, you know things that are going to happen because you have to take care of your child. You have to listen to yourself after you have a baby. The *panza* is not just for your food but also where you carried your baby, and it gives you awareness." This feminist intervention about the reproductive system, from one of the youngest participants in the workshops, showed awareness of how the *panza* is an expansive term that affirms the gut's relevance to the body and our lives, beyond biology and culture. This intervention also shaped future iterations of the workshop, as I began to consider the perspectives of parents and invited storytelling from this perspective as an example of *panza awareness* within the *Panza* Popcorn *diálogo* exercise.

The decolonial turn humanizes the perspectives of people of the Global South and invalidates the modern/colonial positivist assumptions that determine the norms of Westernized knowledge. Chela Sandoval refers to Fanon's epistemic and ontological interventions in biomedicine as "egalitarian social technologies" designed to interrupt the naturalization of colonial, biomedical, and/or racialized claims to legitimacy (2000, p. 86). In the *Panza Knowing Workshops*, adopting an attitude that recognizes and respectfully acknowledges embodied knowledge, lived experience, and healing knowledges of the Global South represents an important social technology that can be harnessed via existing methods. This pilot shows that a decolonial attitude may be applied at multiple levels of race-conscious medical research, from how we conceptualize the field to how we generate and present our knowledge to the public.

D) Pedagogies of knowing

Through the *Panza Knowing Workshop*, reciprocal engagement about healing and the body with people from my communities (geographic, social, religious, and academic) generated a pedagogical experience in which I (as the researcher) and the community (as workshop

participants) interchanged roles as teachers and learners. Participants responded eagerly to their overlapping roles as both learners and knowledge producers. They learned from my psychoeducational, storytelling lecture; and their involvement in the workshop was not simply absorbing what I shared. Through *panza awareness*, they also made connections between their *panzas*, health, and social relations (including matters of social justice) before cultivating knowledge in community, teaching me and each other in the process. Through this reciprocal exchange of knowledge from academic, embodied, and ancestral places, they corrupted the hegemony of pedagogy as hierarchical and socially unjust (Alexander, 2005). As M. Jacqui Alexander teaches us, these "oppositional practices" are key to "making the world in which we live intelligible to ourselves and each other–in other words, teaching ourselves" (2005, p. 6). Pedagogical frameworks like this enable us to think relationally and with historical awareness of the intersections that structure our experiences and understanding of belonging and difference. They also push us to learn about ourselves beyond the dominant psychic, political, Eurocentric, and heterosexist modes of being. What Alexander calls "pedagogies of crossing" disrupt the relations of domination and hierarchies of knowledge based on Eurocentric investments in power, alterity, separation, and secularity. For Alexander, "crossings" instead evoke the sacred, memory, convergence, possibility, and movement—whether embodied or disembodied (p. 5). Crossings also invoke mappings and critical geographies of knowledge located at sites of knowledge production. Alexander asks, "How will the knowledges of this critical geography become the epistemic frameworks that inform your teaching? Your research? How will you engage the different regimes of knowing, some of their dominant paradigms, and the apparently neat separations that result? ...What kinds of interdisciplinary, cross-border conversations are you willing to engage?" (p. 112). Engaged pedagogies, such as those used in the *Panza Knowing Workshop*, transgress the artificial hierarchies of knowledge that reproduce the Eurocentric cis-heteronormative logics of the racial modern/colonial world matrix within the biomedical health sciences.

Panza Knowing Workshop participants were desirous for knowledge and tools to understand how their minds and spirits interact with their bodies, but this information is so often denied to them because of Eurocentric epistemic privilege. This authority over knowledge is based on power hierarchies centered on the logics, religion, identity politics, and colonial practices of Europe. It is known by modernity/coloniality theorists as coloniality of knowledge (i.e., epistemic privilege of the Global North), yet it also extends to the coloniality of power and of being (i.e., institutional and ontological hegemony of the Global North) (Mignolo, 2002). Those with the authority to determine the assumptions, boundaries, and authors of knowledge valorize the provincial perspective of theorists and philosophies representative of five nation-states in Europe (Grosfoguel, 2013). The dominant discourse and practice of knowledge production in biomedicine also elevates the worldviews of fifteenth-century, Christian, European men (Wynter, 2003; Mignolo, 2011). The logics of a coloniality of knowledge, power, and being are relevant to the study of Eurocentric epistemic privilege because together, these facets of the modern/colonial world system shape the very conceptions of humanity and the body used in biomedicine today. In contrast to race-based medical approaches to research, the *Panza Knowing Workshop* creates space for participants to adopt a transmodern perspective that recognizes how social relations of power become embodied–and to reconceptualize their knowledge of the body in a liberatory way .

The work of the *Panza Knowing Workshop* contributes not just to the healing of individuals; it also fractures epistemologies of knowledge that valorize the perspectives of

Europe. Race-based medicine has historically harmed people of color communities and people of the Global South in countless ways through institutions and practices of biomedicine. Medical historian Harriet Washington documents widespread medical discrimination in the U.S., from the colonial era to the present, premised on the assumption that Black people have different bodies than White people. She reveals the practices by which racial pseudoscience justified medical experimentation and other methods of violent research with African American people, exemplified in the widespread use of enslaved people in medical research. Key examples are the case of J. Marion Sims, the nineteenth century physician who repeatedly performed surgeries on enslaved Black women to whom he denied anesthesia, and the mid-twentieth-century Tuskegee Syphilis Study–which maliciously withheld treatment from Black men with syphilis to observe the progression of the disease (Washington, 2006). The racially discriminatory practices of biomedical knowledge production were also reproduced globally, for example, in the U.S.-funded research that purposefully inoculated marginalized Guatemalans (including imprisoned people and sex workers) with sexually transmitted infections to assess the efficacy of penicillin (Reverby, 2012). These and many other examples of biomedical malpractice against BIPOC people and other marginalized healthcare consumers reveal the complicity between Eurocentric epistemic privilege and the systematic enactment of modern/colonial constructions of race. The *Panza Knowing Workshop* disrupts this racializing and medicalizing process by construing a liberatory health praxis via *panza awareness* in a community participatory setting.

Non-Western knowledge (like that generated though the *Panza Knowing Workshop*) represents a threat to power because it offers alternative epistemologies of mind, body, and spirit that allow us to rewrite the "existing dehumanizing stories" of ourselves constructed by biomedical sciences (Anzaldúa, 2015, p. 559). Understanding healing and the body via Indigenous and diasporic knowledge inspires what Chicana feminist Gloria Anzaldúa calls *movimientos de rebeldia* (rebellious moves), informed by the ability of third world peoples to reason using *conocimiento* of knowledge inherited in embodied and intergenerational ways. Representing a new kind of objectivity supported by others like philosopher Sandra Harding and liberation philosopher Enrique Dussel, Anzaldúa posits that *conocimiento* among borderlands people draws upon *la facultad* or an ability to be objective and see beyond false social, colonial, and disciplinary constructions (2002, p. 548). Anzaldúa and feminist scholar AnaLouise Keating note that "when you're in the place between worldviews (*nepantla*) you're able to slip between realities to a neutral perception" (2002, p. 569). Though Anzaldúa's writing does not fall within the scope of medicine, her theories of knowledge via literature and poetry apply pre-Columbian concepts in direct ways and reflect what Chicana feminist Laura Pérez asserts is the "healing function of art and culture" for Chicanxs (2007, p. 106). These Chicana feminists model how theorizing from the standpoints of people entrenched in their own healing journeys, as done in the *Panza Knowing Workshop*, is a generative way to produce liberatory pedagogies toward health and healing.

The *Panza Knowing Workshop* is just one example of interpretive designs that integrate feminist and decolonial theory alongside traditional biomedical knowledge, offering ways for BIPOC people to upend traditional pedagogical frameworks and learn, teach, cultivate awareness, and produce race-conscious medical knowledge all together in humanizing ways. For women of color and decolonial researchers, humanities and social science methods have produced alternative modes of understanding the relationship between social and cultural structures, nature, and the human body. Interpretive frameworks (like the *Panza Knowing*

Workshops) value these alternative modes of meaning-making and produce ways to understand health that also reflect lived experiences and embodied knowledge.

We see this shift toward alternate pedagogical movements reflected in the feedback to the workshops. A Chicana undergraduate commented, "One thing I have learned is that there are different ways to think about things" (Berkeley Connect). "The *Panza* Popcorn Questions helped me to see different perspectives," observed a health sciences student (CSU East Bay). "Thank you for your illuminating workshop!" expressed a Chicana *curandera* and herbalist (Galería de la Raza). These participants' main takeaway from the workshops was not any specific thing about *nervios* or the *panza*, but rather that alternative ways of imaging health and the body are possible. After a virtual *Panza* Knowing Workshop (in April 2020), a student activist wrote:

> I am so grateful for this [workshop] because I've been distracting myself (since not being in-person) [due to the pandemic]. And this workshop affirmed a lot of the things I'm learning in Counseling school about Indigenous, POC, queer, trans practices. It validated my 3 years in grad school and the practices that I've been doing…. [This workshop] has also made me question some of the things that I've been learning… [about] how Psychology has always been based on White men and then applied to POC. In sum, this was super great, and my *panza* feels super happy! (Strike University)

This student related with and felt affirmed by the decolonial, feminist framing of *panza awareness*. They noted, in particular, that this approach inspired critical questions about the pedagogical processes they are consuming as a graduate student. Putting *panza awareness* into practice at that moment of reflection, they exclaimed that these pedagogical aspects of the workshop made them feel good at the level of their *panza*.

Conclusion

This chapter examines four themes that emerged out of the *Panza Knowing Workshops*. It begins by exploring the "*lightbulb moment*," an epistemic rupture that many participants experienced as they thought about the connections between the gut, brain, and sense of knowing about their own bodies. After participants came to understand the gut as a place that does thinking work for the body-mind, they started to articulate a *hunger* for healing, ancestral knowledge, community, and social justice. This chapter also introduces two theoretical contributions that I identified once I was analyzing the data: world of YOUS (lateral knowledge production) and pedagogies of knowing (knowledge production as reciprocal acts of teaching and learning). These analytical themes emerged from my autoethnographic observations of how the practice of *panza awareness*, in a community participatory way, offers multiple interventions in the process of knowledge production about the body.

In the following chapter, I elaborate on the three stages of evolution through which many participants passed, as they transitioned from understanding the gut purely in terms of gastroenterology to recognizing the *panza* as a thinking place. I also further analyze the hunger participants expressed for knowledge.

Chapter 5

Coming to Value Our *Panzas*' Truths and Hungering for Knowledge

On a warm afternoon at a *Panza Knowing Workshop* at Laney College (Oakland, CA), I asked a group of 20 high school seniors, "When do you feel hungry? What makes you feel this way?" One eager student answered, "When I don't eat!" While not the most eloquent answer, this very literal association between food and the gut was the starting place for many workshop participants. They often began by responding to questions about the *panza*, quite literally discussing the gut as related to the digestive system (Stage 1). This was especially the case for the workshops with high schoolers. Younger people are over-represented in this stage because of the accessibility accommodations I made as well as the developmental stage of the students themselves. But eventually, after hearing my storytelling presentation (about decolonization and the mind-body connection), engaging in *panza awareness* exercises, and responding to directed questions, participants across workshops came to understand the mind-body connection on an embodied level (Stage 2).

By sharing their own experiences and hearing from others, a "lightbulb moment" would happen for them. And they would grasp that there is a link between the body and mind that works through the gut. In anticipation of participants' varying understandings of the gut's role in fostering our overall health, I purposefully scaffolded this lesson into the workshop to build participants' awareness. Once participants grasped that there is a body-mind connection that operates via the gut (Stage 2), they were prepared to articulate various types of hunger, as expressed through the *panza* (Stage 3). The *Panza Knowing Workshops* reveal that the mind-body connection is a necessary precursor to identifying hunger, broadly defined. At the same time, without a decolonial lens, people cannot identify these hungers, whether they are due to processed foods, food deserts, racial/gender inequities, socioeconomic status, or something else.

Stage 1: Fostering panza awareness

In answer to questions about the *panza*, it was not uncommon for participants to initially respond by speaking about gastroenterology—be it the physical discomfort they felt in or they heard noises coming from their guts. I call this Stage 1 of the evolution towards awareness of the gut-brain connection. In answer to the question, "What types of things disturb your belly?", a student activist responded, "I have chronic pain; and I notice that when I get pressure or discomfort in my stomach, my chronic pain and inflammation are also a lot higher—not just in my stomach but in the rest of my body as well. I feel it shooting to all these other parts of my body" (Strike University). At another workshop, a White (seemingly) participant answered the same question and said his "gut doesn't accept processed food or gluten" (Botánica Azul). For workshop participants, it was typically easy to express knowledge about their body and their physical health through the filter of the gut. "When my gut makes high sounds, it means I'm hungry; and low sounds mean indigestion," shared a recent college graduate. He added, "It has this way of speaking to me in particular ways that communicate what I'm feeling to me" (Strike University). A Chicano high school student told the group, "A growling stomach means I'm hungry; grumbles or bubbly noises mean I'm digesting or something is wrong." (Laney College). In these ways, participants showed awareness of, or perhaps rapport with, the biological functioning of their gastric system. They knew clearly how the gut communicated information to them about their body.

After identifying the sounds or discomfort originating in their guts, some participants said they would change their behavior, responding to these messages originating in their gastrointestinal tracts. “I can tell when I’m having stomach issues that my energy level is lower,” stated a Chicanx collaborator, “and if I eat slower and properly digest my food, I feel better and have more energy and motivation to do things in my day” (Strike University). When I asked, “When do you feel full’? What makes you feel this way?”, an eager high school senior volunteered, “We have to chew our food good. If you eat all your food *bien rápido* (really fast), obviously you are going to be full very fast; and it can send you right to the bathroom” (Laney College). Expressing their *panza awareness* in Spanglish, this participant made an important connection between not only what we eat, but how we eat. “My gut feels full when I’ve had too many carbs,” mourned a White male attendee, “so I need to eat less bread” (Botánica Azul). Participants’ gut knowledge, or awareness of their own bodily needs, influenced their actions and food intake decisions–based on a desire to alleviate physical discomfort.

When I queried participants about the memories and emotions that they carry in their guts, it was as if I gave people permission to identify the gut as a thinking place. And participants answered by divulging, often proudly, knowledge of their bodies. Predictably, high school students mentioned their gut emotions in more simplistic ways. One revealed, “I feel empty when I don't eat, less energetic; sometimes I get headaches when my gut is empty and I'm mad” (Laney College). A quiet peer in the same workshop simply noted, “I feel happy when I'm full of food” (Laney College). A PhD student, however, was more philosophical about a memory held in their *panza*.

> I have a memory of my dad when he married my stepmother because it was the first time I can remember having the stomach flu. I had to sit out most of the wedding because my stomach would not settle. Finally, after 24 hours, I could enjoy the event; I can’t remember the memories, but I can remember people touching me a lot. I don’t remember what happened, but I remember how my stomach felt (Strike University).

They spoke about being sick with the flu during their dad and stepmom’s wedding and unable to remember much of the event. Their limited memories included being touched a lot and the discomfort in their stomach. While we may assume that it was a coincidence that the student had the flu during their parent’s wedding, there remained in the participant’s memory a strong connection between a viral infection that affected the GI tract and their father’s wedding. The student did not explicitly mention if the marriage had been difficult for them to “stomach,” but the correlation between viral infection and wedding in their memory suggests an emotionally complicated event housed at the level of their embodied memories.

Stage 2: Awareness of gut emotions

The transition from Stage 1 (purely gastroenterological awareness) to Stage 2 involved a recognition that our emotional functioning is connected to our gut biome. Participants came to understand that the gut is more than just a place that digests food and articulates physical discomfort. A Black, Chicago high school student expressed how a biological feel can also translate into an emotional feeling: “I feel happiness in my gut when I go home and I get some food on my way home” (Foreman). In response to my prompting, participants also shared how their *panzas* stored emotions tied to memories. A Salvadoran immigrant woman spoke about needing to address her “*nervios*” before going into a healing role as a counselor, sharing that her

gut tells her when she's triggered by something she's studying in school (JFKU). This aspiring mental healthcare practitioner recognized that the feelings of her stomach were intimately connected to the psychological and emotional triggers of her past. She expressed knowing that she could trust her gut to alert her when these memories arose in academic contexts, serving as reminders that she needed to attend to herself. She noted how her *nervios* pointed to the memories that still needed healing. "My memories are held in my gut mostly," shared an Arab American student, "I remember tastes and smells more than I remember what happened sometimes. If it's a bad memory, I will feel it in my stomach, like a pit, like a sinking or aching" (EWOCC). This participant was able to identify a memory stored in their gut, even when their brain did not remember the event.

When I asked participants to answer the question, "What are some emotions that you experience in your gut?", anxiety was a commonly expressed answer. A health sciences undergraduate explained, "I get anxiety in my gut, especially with pressures of school and family. I get sick in my stomach, and I have to take things to feel better (like tea and medicine)" (CSU East Bay). A Panamanian student was comfortable enough to share some embarrassing moments related to her gut: "I had never thought about it as a *panza* sound; but when I was really nervous, I'd start farting. That was a problem for me in ballet, knowing 'OMG. I have to get all these farts out before I go on stage.' It was definitely a problem" (Strike University). This share prompted sympathetic smiles and laughter from the group, likely due to the participant's humorous retelling. In this example, the student drew a connection between her pre-show jitters, or performance anxiety, and what was to her an unmistakable gastroenterological reaction manifesting as gas. Significantly, this participant had not made the connections between her performance anxiety and gut reactions until prompted by the *Panza* Popcorn questions. In another workshop, an Arab American undergraduate detailed that his anxiety and *panza* were intimately linked. In his post-workshop feedback, he wrote, "Personally, I'm a really anxious person; but when I feel my anxiety, it's like a whole-body type of experience. When I get really, really anxious, my stomach just begins to feel really upset and just off. So, I've always associated my *panza* with my anxiety!" (Berkeley Connect). This student illustrated for the group how a person may live with deep awareness of the connections between their gut and their emotions, though they may not always know what to do with that awareness.

In this last example, an Arab American participant purposefully employed the term *panza*–rather than gut or stomach–in their feedback. Other non-Chicano/Latino participants also adopted the word *panza* and used it during their shares. It was powerful to see them doing this. *Panza* is a colloquialism that does not translate perfectly as "gut" or "belly," and some people were sensitive to this distinction, even if they were not Spanish speakers. I see this as a Chicana feminist intervention that illustrates how a decolonial turn may be mobilized through language. Introducing the term *panza* as an untranslatable concept relating to, but extending beyond, the GI tract itself was freeing for participants who then adopted the term to put into words some of their heretofore-indescribable embodied knowledge. Throughout, non-Spanish speakers humbled themselves through their articulation of the word, which is not easy to pronounce in English. (In Spanish, "s" and "z" are often spoken using the same sound, and English speakers were aware that their pronunciation of the "z" in "*panza*" sounded different than when I said the word out loud.) This issue of articulation and pronunciation also exemplifies how the workshop provided alternate modes of knowledge production. Participants adopted the term *panza* to show that they were using my decolonial, Chicana feminist frameworks to think through their embodied knowledge.

Even when participants did not identify anxiety as an emotion carried in their guts, they were quick to mention other painful or uncomfortable emotions, like anger or unhappiness. An Asian American student shared that she gets constipated if she hasn't processed her emotions about a difficult situation; and she insightfully noted that her gut does the thinking work for her until she is able to "catch up."

> I notice when I'm having difficulty processing certain emotions—like if something just happened and I'm shaken up by it—it totally affects my gut. I'll have constipation, which is this real physical manifestation of not being able to process my emotions. It's like the gut is starting my emotional experience for me until I can catch up (Strike University).

For this student, the gut feeling preceded the emotional feeling. She recognized that her gut adopts the psychological work that she may not consciously be able to engage at the rational level. Indeed, participants repeatedly pointed out the psychological work embodied in their gut system. "Rushing [around] disturbs my belly," admitted a Chicana student (Ethnic Studies, UCB). In a culture where rushing is expected and even praised as an indicator of a strong work ethic, this student admitted that she felt it was disruptive–at the level of her *panza*. A high school senior seemed to be thinking out loud and grasping the body-mind connection for the first time when she reflected, "Some emotions [I experience in my gut] are maybe if I feel guilty about something I did, or if I feel sick or hungry; but I'm not really sure. Also feeling tired or unhappy for things that are going on" (Laney College). This student made an on-the-spot inventory of the variety of sensations felt in her gut. She thought about some complex emotions (guilty, unhappy) alongside some biological feelings (sick, hungry); and in this process of thinking aloud, she seemed to comprehend that her gut may hold emotions in a way that she had not previously recognized.

When I asked the question, "What memories do you carry in your gut?", people responded not just with their memories but always the awareness and feelings some of those memories gave them. A high school student at Laney College simply stated, "The [memories I have are the] good ones; also the sad/bad ones." Another high school student said, "Some memories I carry in my gut are the taste of certain foods, also the places where I eat those foods" (Foreman). Almost every woman in the workshop at John F. Kennedy University said that they hold memories in their *panzas* about childbirth, illustrating the gut-womb connection. We might also recall (from Chapter 4) the interjection made by the young mom who asserted, "Being a mother is *panza* awareness.… The *panza* is not just for your food but also where you carried your baby, and it gives you awareness" (Foreman). These students noted that memories held in the gut extend beyond the gastrointestinal and involve the relational experiences of *panza awareness*.

Participants did not simply hold memories of past experiences in their guts; their *panzas* also contained guidance and warnings. A queer man at the Botánica Azul workshop admitted that he knows in his gut when a partner is cheating on him. "My gut tells me when someone is not good," an insightful high schooler confessed, "It tells me I shouldn't be there [with them]" (Laney College). Indeed, our *panzas* hold valuable knowledge that sometimes transcends what we can grasp with our brains. Of course, recognizing the merits of our *panza*'s knowledge is not easy in a world that identifies the brain as the only thinking place in our bodies. A Middle Eastern woman said she has always known her gut was sensitive, but she saw it as weakness and not as information that she should pay attention to (Botánica Azul). For her, it was a relief to take

her *panza* seriously, to see it as something sacred to be valued (Alexander 2005). As one Chicana student reflected at the end of the workshop, "I learned that someone's *panza* story is a sacred story" (NAACS). This was an example of how participants were integrating the beginning of the workshop (decolonial and Chicana feminist psychoeducation) with the end of the workshop (dialogue through *Panza* Popcorn).

In their feedback for the workshop, participants repeatedly commented how powerful it was to grasp that our guts do biological and psychosocial thinking work for us—and that we should appreciate that information. "One thing I learned is that your stomach can really identify and take in your feelings. Your body takes in all emotions and displays them," wrote an Oakland high schooler (Laney College). Another high schooler in Chicago shared, "I learned to appreciate your *panza*" (Foreman). A Chicano/Latino man said that the event was "really empowering, as I didn't value my gut in many ways at all before this" (Galería de la Raza). These participants clearly internalized the storytelling presentation on Chicana and Black feminist knowledge that shows us that embodied and felt knowledge coexists alongside rational, objective knowledge in real embodied ways.

Stage 3: Hunger for healing, ancestral knowledge, community, and social justice

Once participants understood the mind-body connection and the value of gut knowledge, a door seemingly opened for them to explore various types of hunger. Indeed, after I had introduced to them the concept of a body-mind connection that aligns with–yet transcends–their neurobiology, I asked them to consider whether this theoretical concept resonated with them. And for most of them, it did. They were then able to transition from, "I feel hungry when I forget to eat" to "I feel anxiety in my body." I call this Stage 3, the evolution from a literal understanding of the gut-brain connection to a conceptual and bio-social application of gut-brain knowledge. Hunger emerged as a repeated signifier for this third stage of knowledge production. Sometimes, it was expressed explicitly through the language of "hunger"; but at other times, it emerged through language valenced with emotions like desire, yearning, hope, regret, or disappointment–which carried connotations of hunger that extended beyond nutrition or appetite. Below, I outline four categories of hunger, as expressed by the participants: hunger for healing, ancestral knowledge, community, and social justice.

Hunger for healing

An *unanticipated* outcome of these workshops was the hunger for healing that people expressed as they reflected on their traumas–especially eating disorders. Indeed, participants struggling with eating disorders seem to have self-selected in high numbers to participate in the workshops, as they were dealing with an illness related to the gut.

There emerged a link between childhood and trauma that was felt in the *panza*, trauma that was caused by adults as well as healed by adults. (This correlation also found expression in a hunger for ancestral healing, which I will explore in the following section.) One participant confessed, "There was a lot of hitting from my parents when I did something 'bad.' I would feel it in my stomach; and I knew I would get hit, like I would brace for it, but my *panza* would feel sick" (EWOCC). While some participants recalled feeling pain in their stomach during the moment of trauma, others identified trauma as stored by the *panza.* "I remember all of my childhood in my gut," recalled another, "especially the good parts and the bad parts also" (Ethnic Studies, UCB). A small-business owner said that all her "trauma memories" are in her gut and that it still hurts when she remembers the abuse from the adults in her life (Botánica Azul). But

just as adults caused pain that children felt in their *panzas*, they could also help children to have a more positive relationship with their stomachs. One student activist joyfully remembered, "I just have these vivid memories of my mom touching her stomach and showing and how I was amazed at how free she was and it was so big but the rest of the world tells us we need to shrink it and this pressure to get rid of it" (Strike University). As onetime children now grown into adulthood, we can be the adults we need to care for our body-minds. An older "returning" Psychology graduate student, a White woman, described how the inflammation she experiences is intimately tied to the baggage and trauma from her lived experiences. So, taking care of her gut has been at the center of all efforts to heal her body (JFKU). Time and again, participants offered evidence of how, in their lives, the practice of caring for their whole selves (mind and body) worked through the health of the gut. Their responses also showed that they lacked frameworks through which to make connections between the biological, the felt, the thought, and the practiced. From within this interstice, I saw the common thread of hunger emerge.

People in active recovery from eating disorders (often anorexia and bulimia) found their way to the workshops, hungering for healing. I did not explicitly advertise these events as of benefit to people struggling with or recovering from eating disorders. But this topic came up repeatedly. Participants articulated their eating disorders as responses to trauma as well as traumatic illness in and of themselves. A Black student disclosed, "I have so much anxiety and shame in my gut. I put things inside my body to be thinner and to get rid of my *panza;* and I have had to work to learn how to put good things, good food into my body. Society makes us think we are so ugly and need to be something different than what we are" (EWOCC). As this quote illustrates, people came to recognize their embodied experiences as extending beyond their biological functioning. These reflections of hungering for both healthy foods and a healthy sense of self-acceptance are connected to a range of social structures and cultural representations. On the one hand, we see social structures as yoked to material conditions that shape an individual's knowledge of and relationship to food and their own biology. On the other hand, we see how cultural representations structured by Eurocentric norms shape the individual's knowledge of and relationship to their self-image. A particularly forthcoming woman revealed that she was in recovery from anorexia and bulimia and expressed that conversations on the "*panza* are healing because I've hated my *panza* for so long" [holding her stomach with her arms] (Galería de la Raza). "I'm also recovering from an eating disorder," added another Chicana participant at the same workshop, and "learning/practicing eating better/more" (Galería de la Raza). By acknowledging multiple pathways to health, we understand that social structures and Eurocentric values are part of the disorder. But holding these discussions about eating disorders–in community–helps to break some of those cycles that people are stuck in by themselves. It helps to open up possibilities for healing.

Participants hungered to talk about their traumas–in a productive way–not simply to disclose but to synthesize, learn from others, and use their experiences as knowledge for others. This generative, pedagogical function of hunger is exemplified by a series of exchanges at the workshop held at the Galería de la Raza, an interdisciplinary Chicanx/Latinx space for art, thought, and activism in San Francisco's Mission District. The workshop was an emotionally heavy one. A woman in her 30s spent time detailing her sexual assault and healing journey; and in her monologue, she expressed a desire for restitution that she had not known how to articulate until finding healing spaces like what she found in our workshop. When describing the memories she had stored in her gut, she beat her chest and wailed, "The violences that were done to my body!" during her share. Her testimony was triggering for many, and I could feel the group brace

itself as the disclosure of sexual and psychological abuse continued. I noticed the room somehow grew quieter, and I observed several people shift in their chairs and fidget with their hands and hair. I mirrored back the participant's share and affirmed that her disclosures were safe and confidential according to the group agreements we made at the opening of the workshop.

After the disclosure, an elder *santera* (like me) stood up to address the group. She made it clear that she wanted to respond to the woman's emotive testimony by reflecting on community healing, and healing over time, saying, "We cannot do things alone, even though we usually suffer these violences alone all along the way." This older woman assumed the role of a facilitator; and with her tone, posture, and perspective, she was able to calm not only the younger woman but the whole group too. She added:

> I've lived in San Francisco for 35 years and have watched the city grow and change, but healing spaces are here for us when we look for them. It's just a shame that not everyone has what they need to be able to seek help. And that's not our fault, it's the system that fails us time after time, making us isolated. This is why we need to call on each other and on the ancestors to come together and heal together (Galería de la Raza).

Part of what this elder did was to validate the work we had just done for each other in that moment of trauma disclosure, the witnessing we did for this woman survivor of sexual and gendered violence. It was as if, through her comments, the elder acknowledged that it had been an uncomfortable *testimonio* for our group to witness, but that this woman's passionate expressions were an example of what becomes possible when people come together for healing. This elder was able to help bring the group together as she supported the young women through processing her trauma. Her contribution was very much informed by her age, and perhaps also by her religious practice as a *santera*.

Throughout this and other workshops, age, religion, and spiritual practice informed the type of contribution the participants provided. Indeed, older people were able to give more advice to younger people; they had the capacity to do so without being pedantic or patronizing–mobilizing their experiences in service to others. Religious or spiritual practice also shaped participants' contributions to the more conceptual aspect of hunger contextualized by psychosocial trauma. For example, one participant noted that she was able to connect to the sore and wounded spaces of her body that hold trauma when she was practicing certain yoga asanas (poses)–like the "wheel pose" and "child pose," in which you expose and hide the stomach, respectively (JFKU). Another participant commented that she had turned to the Mexican Traditional Medicine spiritual system, specifically *limpias* and *sobadas* (spiritual cleansings and massage), when her daughter was struggling through a separation and divorce from an abusive husband (EWOCC). A young student noted that Feng Shui principles were helpful to her during her healing process because they created a living space that felt energetically safe for her (Ethnic Studies, UCB). Overall, the range of spiritual traditions noted during discussions of healing cited participants' practices of: Vedic yoga, meditation in Buddhist traditions, Feng Shui, Mexican Traditional Medicine, Afro-diaspora religions, Islamic customs, Judaism, and Catholicism and Christianity. Participants describing these spiritual practices drew from their own ritual traditions to express their hunger to heal from trauma.

Hunger for ancestral knowledge

Out of their hunger to heal from trauma, some people expressed a hunger for ancestral knowledge. This yearning to recover knowledge from the old world hails the two theoretical conceptualizations outlined in Chapter 4: pedagogies of knowing and a world of YOUS. Participants very much wanted to learn about new things in different ways (pedagogies of knowing), but many came into the workshops believing that they could only "buy into" biomedicine, not the wisdom of their elders. Once I introduced the option of horizontalizing knowledge (a world of YOUS)–or trusting both embodied wisdom and biomedical knowledge– participants began to speak about the knowledge imparted to them from their families, elders, and cultures. In this way, participants claimed to embody, not only a hunger to heal from trauma, but also a hunger to reclaim the knowledge they carry from their ancestors, who live through them via their recipes for healing the mind and body, even when their ancestral perspectives may not be represented or validated in biomedical conceptualizations of the mind-body connection.

It was as if participants needed permission from me or at least benefited from me (an academic) sharing conceptual frameworks (from decolonial and women-of-color feminist thought) that encouraged them to trust their ancestral knowledge. I began the workshop by providing an intellectual, decolonial framework (situated within the context of racial capitalism) for how and why embodied knowledge is valid. Through this lecture, participants began to trust me as an informed scholar. I explained to them that the reason why we do not value ancestral knowledge is because White supremacy and colonialism purposefully demonized it. Ancestral knowledge is linked to embodied knowledge because ancestral knowledge lives on through the knowledge that we embody, despite Eurocentric views that invalidate its veracity. In outlining the intersections between ancestral and embodied knowledge, I positioned embodied knowledge as knowledge and not folklore or superstition, a positioning that created epistemic ruptures for some people.

By the time we transitioned to the *Panza* Popcorn Questions, participants were eager to invoke the ancestral knowledge already available to them. A Berkeley undergraduate student admitted to the group, "I'm Indigenous, and I always was taught that I had to believe in biomedical knowledge and science and not the knowledge of my people. But I've begun to realize that my Indigenous knowledge is also valuable (Berkeley Connect). "I didn't used to value *abuelita* knowledge," shared a Latinx mother who was there with her children, "but I have begun to as I age; and find myself going back to the remedies and advice my mother, grandmother, and aunts would give" (EWOCC). A health sciences student later reflected that the workshop's focus on "decolonization, cultural awareness" was their favorite part (CSU East Bay). Some participants were learning to value the contributions of the people who came before them, while others recognized that their life experience had already led them to defer to the teachings of their elders.

This foundation created space for other participants to reflect on the complexity of preserving cultural traditions, particularly around food, when there are so many other demands on their time and expectations around their relationships with food as a cultural practice. A Filipino woman in a counseling psychology graduate program shared that in her culture, the center of the family is the kitchen, where everyone eats together. But because she works and goes to school, she has "struggled to maintain both cultural acts that center food and eating alongside school and the need to make money for [her] family to get ahead in the world." The woman described wanting to reap the opportunities of being a "woman who works, studies, and does it all without having to be stuck in the kitchen like in the old days." Interestingly (and

perhaps unexpectedly), she also described that although it is stressful, making food in a loving way is worth the effort, and she had learned this lesson from the elders in her life (JFKU). We also heard from a student activist, who said:

> I was vegetarian for 8 years; and every time I visited my mom, she would make bomb Mexican food. But I just wasn't attracted to it, and then when I stopped being vegetarian to eat my mom's tamales at Christmas, oh my God! The tamal took me to so many memories, like when I was a kid and when I was a teen; and it was intense. And I felt a little guilty, because for eight years I stopped eating food that was so attached to my culture. I wasn't eating my mom's food, so I was missing out on all the parts of my culture and my family by not eating my food (Strike University).

As this student activist remembered her time practicing vegetarianism, she described how the memories carried in her gut conveyed the cultural traditions of her people. She reclaimed her traditions and ancestral practices when she was able to appreciate her mother's cooking, and the practice of eating it, as a cultural act. While these women were compelled by the "progressive" social movements they were exposed to in a US context, they also found themselves navigating their social and food practices in intersectional ways. Perhaps in spite of the US influence, participants still attended to their geographic, cultural roots, perhaps because of the power of their ancestral embodiments.

When I asked the groups, "What is your go-to remedy when you have an upset stomach?" participants sometimes responded by recalling Indigenous or Global South remedies (or remedies from their families), helping to sate each other's hunger for ancestral knowledge. A Latinx high school student at Laney College confidently listed off, "un *té de manzanilla* [chamomile tea], un *café* [coffee], *avena* [oats], hot chocolate," remedies used by their parents and grandparents. Other participants shared that they use a warm compress or tea. An Iranian woman community member discussed addressing stomach pains by using traditional Persian medicines–from before Iran was even a country. She noted that traditional Iranian medicines, used by Muslim and non-Muslim people alike, have origins in Zoroastrian principles. Even though Persia later became the Muslim state known as Iran, the Zoroastrian medicines and healing traditions used by its people survived these political and religious shifts (Galería de la Raza). With this analysis, the participant offered a compelling critique of biomedical perspectives that devalue ancestral knowledge from the Global South. In answer to the same question, "What is your go-to remedy when you have an upset stomach?", a student at the Strike University workshop disclosed, "Mine's cannabis. It's the only thing I can use. I'm allergic to Western medicines that are supposed to help with pain, so it's the only thing that I can use to help with my gut issues. I smoke it because it's fast acting. Sometimes consuming it can actually be too hard on my gut, and I've had to experiment with edibles that my stomach will accept." This student reflected an understanding that herbal remedies for healing (in this case cannabis) predate biomedical pharmacology. Their comment showed that time-tested remedies learned by our forebears continue to be a viable and necessary avenue for healthcare.

In my storytelling presentation at the beginning of the workshops, I suggested that we value our embodied wisdom *and* biomedical knowledge, and some participants were able to lean into the value of holding both these things to be true. I asked them later, "When do you trust your doctors, and when do you trust yourself?" A NAACS conference participant answered, "I trust my doctors when I don't know what's wrong with my body. I trust myself when I know what's

wrong with me." She presented her observation as a simple statement of practicality but put an emphasis on the second statement, confirming that what she knows to be true from her embodied perspective is valid even without the approval of a formal biomedical authority. In answer to the same question, a Laney College student said, "I don't really trust my doctors, and I don't really believe in them. I trust myself all the time, even though I sometimes make bad decisions." Some participants responded by sharing that they value plant medicine. At the Botánica Azul workshop, for instance, an older queer femme of color announced excitedly, "Plant medicine is all around us, and the gut knows how to process it!" At the same event, a Chicane Indigenous participant and fellow academic-practitioner presenter expressed, "*Curandera* knowledge also shows us that the plants that we need are growing around us, whether we are in Mexico or not…. We have to find the medicines near us." Their statements shed light on how traditional, ancestral knowledge systems contain logics that enable people to utilize their healing modalities in future diaspora contexts. Ancestral healing logics are not antiquated, but rather, offer dynamic healthcare modalities that can be adapted in new world settings.

At John F. Kennedy University, a Black woman instructor described the need for healing spaces and ceremonies in pedagogical settings, like the one we had created during the workshop. In this workshop, I had performed an Ifa-Orisha cleansing ritual (*omi tuto*). During the grounding activity, I had also offered participants *ori, a* medicine used topically for nerves in Orisha religions. The same instructor said that in her own teaching, she sets up "a ritual circle with new age elements, including scents to make teaching a healing space as well" (JFKU). By sharing her approach, this Counseling Psychology educator was teaching us avenues through which ancestral knowledge and healing practice can be made compatible with biomedical contexts and spaces. Conceptually holding multiple realities to be true, she embraced the both/and paradoxical duality. In other words, both ancestral, Global South knowledge and Cartesian philosophies of the body can and do coexist in our lived experiences. Additionally, pedagogical spaces can achieve a more holistic conceptualization of the body by finding ways to integrate ancestral knowledge into knowledge production, as well as into *practices* of healing and healthcare.

While some participants were open to the benefits of cultural traditions (e.g., plant medicine), others struggled to recognize them as legitimate. This was particularly the case for high school students, some of whom pushed back against magic and mythology as knowledge systems. When I asked, "How does the idea of magic make you feel in your stomach?" a student answered, "Nothing, as the stomach isn't as powerful as the brain, and magic is a figment of our imagination" (Laney College). Other high school students at the same workshop likewise struggled to connect with their *panzas*. For example, in answer to the questions, "How do your bowels feel? Do your bowels have a character of their own?" a participant repulsed simply, "They feel normal. I don't think that they have a character of their own" (Laney College). In their reply, they challenged the decolonial logics and frameworks that I introduced and insinuated a belief in the biomedical logics that we learn in mainstream pedagogical contexts. I also queried, "Does your body do things that you do not understand according to medical or rational logic?" In response, a student commented, "I don't think so, I understand what it means when my stomach feels some type of way" (Laney College). While this comment seems less contrary than the previous, it still shows the participant had not yet advanced to the stage of trusting their embodied knowledge and other parts of their lived experience. In these and other moments when I received some pushback from participants on the decolonial turn at the conceptual level, I wished for more time to speak with them. And I recognized that these high school students, in particular, had not self-selected to attend my workshop. Rather, they were

completing course attendance requirements for a class in which I was a guest facilitator. In future iterations of the workshop, attended by participants in a decolonial mode of knowledge production who have not self-selected, I may need to provide additional context, historical evidence, and critical dialogue so they can benefit from and participate in the decolonial knowledge production fostered by the workshop.

Hunger for community

Participants' hunger to heal from trauma as well as their hunger for ancestral wisdom were closely tied to their hunger for community, including wanting to be seen and heard. As feedback to the April 2020 workshop, a South Asian student asked,

> Would you consider tailoring the *Panza* Knowing workshops for social distancing and COVID 19? I feel that with the pandemic, people would really benefit from connecting with intuitive knowledges, like with this hoarding of food and toilet paper, to help people not panic, to sustain themselves during this precarious time (Strike University).

The first iteration of the workshop to be held online, the Strike University event underscored the hunger for community at a time of great social and psychological distress. It was as if the pandemic conditions amplified the felt repercussions of isolation in an individualist society. The behavioral changes of quarantine made people hyper-aware of their loneliness and fear in the face of a major threat to people's physical and social health. In feedback from a workshop with health sciences students, multiple participants expressed gratitude for the community space we created together. One wrote, "I enjoyed the group activities and self-exploration with gut feeling." Another stated, "I liked the interactive activities! And thank you for coming to speak; our gut is very important" (CSU East Bay). I want "even more group activities," scrawled an undergraduate student (Ethnic Studies, UCB). In these in-person workshops, prior to the outbreak of the COVID-19 pandemic, students were already expressing the desire for knowledge production and pedagogical activities that put them into dialogue and social contact with each other. At the same time, my facilitative approach resonated with some workshop attendees–even on Zoom. "I loved the way that you responded to each student after they answered a question with such interest," celebrated an undergraduate student in their feedback (Berkeley Connect). Whether online or in-person, participants expressed appreciation for being seen and recognized for their group contributions.

A hunger for connection also emerged from people's guts, as we explored together the memories and feelings in our *panzas*. One particularly poetic participant articulated a gut memory: "I have a couple childhood memories where I remember cousins and [other] people. I have that emotional memory of feeling extremely content, but I don't have images or dialogue; I don't have a proper memory. I just remember what I was feeling; I have a nice foamy feeling in my gut and not in my brain" (NWSA). A high school student shared a similar gut memory of childhood, "Some memories I carry in my gut are somewhere in Mexico or with my family. Sometimes I get nostalgic when I remember things in the past" (Laney College). From these comments emerged a sense of longing for connections with people close to them. "I feel that my *panza* sometimes communicates with my boyfriend's *panza*," shared a Chicana student, "so when we're sleeping or just sitting together, they're having this talk; and I know it's happened, and we've noticed and said, 'Our *panzas* are talking about us'" NWSA). What appears to be a light-hearted inside joke between this couple, emerged in the workshop as information about

how we connect to the people in our lives through the gut. Uncannily similar to this share is a scene in *The Panza Monologues*, where they depict the memories of a child who remembers listening to the noises of her parents' *panzas*, reflecting the intimacy of a childhood connection between child and parents. The sweet nostalgia of family and intimacy represented in these examples shows an aspect of our gut-brain connection that serves social and interpersonal ends. By reflecting on the intersection of their guts and their personal relationships, participants illustrated an awareness of the *panza* as a social space beyond the bio-functioning of the organs within it.

If we recall the Galería de La Raza workshop and the *santera* who helped contain the grief felt by our group after a participant's disclosure of sexual violence, we can also identify in that space a hunger for community connections. As an elder observing a group that was unsure of how to process a heavy topic, she appealed to our sense of community and reframed our group work as an act of healing. She helped us understand how witnessing someone in a group setting designed for emotional safety and group dialogue sated a hunger community that often goes unmet in our daily life.

At other workshops, I was both surprised and pleased by how much appreciation participants informally expressed to me for curating a space that brought them together to share and witness each other. I noted repeated conversations with people, some who had not even participated aloud in the *Panza* Popcorn discussions, who vocalized gratitude for the chance to participate in our group work. An effusive high school student even wrote me a thank you card and said, "I thought what you presented was something we should really be conscious about because it is very important to take care of your body. You should have come earlier; still more times" (Foreman). I perceived that the community space appeased a hunger for connection that felt to participants like relief, or joy–even in the context of sometimes-difficult discussions.

Hunger for social justice

Once participants came to value the mind-body connection, they were more easily able to acknowledge how issues of social justice intersect with issues of the body. In my storytelling and presentation at the beginning of the workshop, I had spoken about how the *panza*'s knowledge is not limited to the realm of the emotional–deviating from neurobiologist Michael Gershon (1999), who asserts that the gut remains the *second* (rather than the first) brain because it is not capable of the "higher" processing of the mind (e.g., religion, philosophy, and poetry). I guided the participants to imagine ways to interpret the spiritual, theoretical, and creative through awareness via the gut. After I opened a space for constructive critique of the biomedical health landscape as intertwined with Eurocentric projects, participants were faced with their own embodied awareness that some of their knowledge of the body was influenced by inequities along the lines of race, gender, sexuality, class, and other intersections of oppression. By exploring how their minds and bodies connect at the *panza*, they identified socioeconomic injustices that affect their lived experiences and obstruct them from attaining or maintaining health. Without being prompted to specifically do so, people responded to these subjects during the *Panza* Popcorn Questions. They began to articulate a hunger for social equity, specifically pointing to the structural conditions that shape their embodied realities and the resources necessary to access health and healing.

At the workshop hosted by Galería de la Raza, a Chicanx/Latinx art gallery and collective in San Francisco, a Chicana professor and participant (whose work I had coincidentally highlighted in the handouts) spoke eloquently of the social and institutional structures that shape

our ability for ourselves. She stood up and answered the question, “When do you feel ‘full’? What makes you feel this way?”:

> I feel full when I have nourishing foods to eat, but also when I have all the conditions I need to obtain and prepare and digest that food. This means that I am doing okay in my work. I am getting paid. I have a place to buy foods that aren’t genetically modified. And I have access to time to prepare food in the ways my ancestors taught us. I did not inherit all of this from my mother or grandmother, some yes; but some I have had to look for in my community. So I feel full when I have not only food to eat, but community and the resources I need to eat food that is good for me and connects me with my ancestors. I feel like this is the only way to survive in a context that is toxic to so many people who do not check certain boxes.

In this share, the participant mapped out for us the structural conditions that she encounters (as a queer Chicana) and how they impact her at an embodied level. She articulates the necessity of logistical resources and psychosocial resources for survival in the context of health inequities that uniquely impact BIPOC communities.

Other participants expressed a hunger for comprehensive healthcare, which they had not found within the biomedical system. One woman mentioned that she had an eating disorder that was better resolved through community work (like the *Panza* Knowing Workshop) than with doctors: “I felt that when I went to the doctor’s I was not the owner of my own story” (NWSA). Biomedicine’s inability to attend to the mind and the gut was the reason for another participant’s frustration.

> Over the last five years, I’ve been on antidepressants and anti-anxiety medication. Usually, the way we think about anxiety and depression is that they exist in your head. And while [the medication] did help… my gut did not like it. It burned off my stomach lining. It's just interesting that I was taking medication for things that supposedly exist in my head and instead I reacted negatively in my gut. The reason I got off [the medication] was because it was causing a lot of gut problems (Strike University).

For this Chicana student, there were serious contradictions in the biomedical care that she received for her psychiatric disorders. She identified a blind spot at the intersection between people’s minds and bodies, an intersection that is not considered in biomedical approaches to mental health care–ironically, as biomedical solutions prescribe medications that are processed through the gut.

Participants also hungered to be free of the pressures of Eurocentric conformity. “There is so much pressure to look a certain way to prove you're cool or worthy,” lamented a queer Chicana undergraduate (CSU East Bay). This sentiment was echoed by a Chicano immigrant high school student, who admitted, “My gut tells me if I am man enough or not. To be a man you have to look like you have a six pack or something” (Foreman). This young person clearly articulated the barrage of messaging he and other high schoolers are routinely subjected to and influenced by. This quote also exemplifies how he is negotiating this messaging around how his body should look as a cis man. In her feedback to the workshop, a high school student said that her favorite part of the event was the storytelling presentation because I emphasized that “we shouldn’t be shamed” of who we are, regardless of what society wants (Laney College). A

Chinese American health sciences student narrated how he had gone from being embarrassed about his mother's cooking to valuing it. He said, "I used to be ashamed to eat Chinese food at school; other kids made me feel bad about it. I wanted white bread sandwiches, but now I like my mom's cooking and usually eat like an Asian person and not like an American person" (Ethnic Studies, UCB). This student shared his evolution from a desire to conform to Westernized standards about only eating specific food in public to an appreciation for the cultural traditions to which he belongs. In this participant's comment, we also see reflected the broader hunger for freedom from Eurocentric standards that police and shape their lived experiences at multiple intersections.

An unexpected theme that emerged was LGBTQ+ participants' hunger to be seen and included, to have their experiences and identities considered as part of the *Panza* Knowing Workshop. As I wrote in Chapter 4, two participants in the pilot workshop requested (with much emotion) that I employ gender-neutral language and ask for participants' pronouns to truly welcome them to the workshop as whole people. In one case, a queer, butch-presenting woman was visibly upset when she said, "If we're talking about the *panza* from a decolonial point of view, [the workshop] also has to be a safe space for queer people. We have to be sensitive to people's pronouns. It's important to ask how people want to be referred to and not assume–or else we're just doing the same thing as always. It's not okay to assume someone's gender or misgender them" (EWOCC). At the moment, I felt ashamed yet grateful for the intervention from this participant. This student articulated how these cis-normative assumptions are so ingrained that they pop up even in these curated healing spaces. She expressed a passionate hunger for respect surrounding the basic ways in which we categorize and refer to people.

Two participants in the Strike University workshop brought up anal sex and rimming as sexual activities intimately tied to the *panza*. One was explicit that any conversation about the gut as a sentient organism needs to include a discussion of "the layers of sensation that come with anal sex: before, during, and after, which no one talks about it–especially in gay sex." Another queer participant added, "One of the things that public health has been telling people not to do is anal rimming and eating ass because it can actually be one of the major ways you can contract COVID 19… but it got flack in the media because they said, 'Don't be having intimate relationships; but in particular, don't eat ass right now'" (Strike University). They vocalized an understanding of the heteronormativity inherent in biomedical conceptualizations of the body and of health–as well as a sense that the queer perspectives on health, even when recognized, remain taboo topics in the public eye. As decolonial feminist María Lugones avows, "The gender system is heterosexualist, as heterosexuality permeates racialized patriarchal control over production, including knowledge production, and over collective authority" (2007, p. 206). These participants queered the idea of the *panza* and identified it as a site of pleasure at the intersection of health. They likewise articulated a hunger for recognition of their embodied experiences of pleasure and sexuality that emerge as *panza* knowledge. Reflecting the biosocial upheavals resulting from the COVID-19 pandemic (starting at the time of this online workshop in early 2020), queer and trans participants emerged as voices that held key embodied knowledge at the intersections of pandemic health, gender, and sexuality.

As an academic examining knowledge about the body from the heteronormative spaces of medical anthropology and the psychological sciences, my framing of *panza awareness* and gut knowing hid a weak spot. I neglected to incorporate a politics of pleasure and of the erotic so crucially modeled by Black feminist theorist Audre Lorde, herself a writer and practitioner of her own style of *panza awareness*. In her influential exploration of the "erotic as power," she attests,

"For having experienced the fullness of this depth of feeling and recognizing its power, in honor and self respect we can require no less of ourselves" ([1984] 2007, p. 54). Lorde describes sexuality as a site of "fullness" and something we should demand of ourselves once we identify it. The *Panza Knowing Workshop* participants who brought up anal sex likewise expressed a desire to fully inhabit their sexual selves. Their comments were also an example of how I (and other researchers) do not have all the answers, but people in our communities hold many of the critical interventions that we need. Indeed, people stepped up to produce knowledge together–not simply to dialogue together.

Conclusion

This chapter has outlined the three stages of the *panza awareness* journey that many participants traversed during the workshops. I identify Stage 1 as a metaphorical location where participants viewed their gut exclusively through a gastroenterological lens, as capable only of digestion. Participants who passed to Stage 2 recognized that a mind-body connection exists and communities through the *panza*. By Stage 3, people came to understand how gut knowledge could help them communicate hunger beyond the biological, including hunger for healing, ancestral knowledge, community, and social justice.

This expansive sense of hunger for healing points to functions of the gut-brain system that are more complex than the gut's contribution to simply producing human emotions. This hunger extends beyond the individual's biology and psychology and illuminates the structural, historical, and the socio-cultural intersections that shape our gut experiences. The social conditioning in a society dominated by Eurocentric thought creates avenues for trauma experienced at multiple levels of our body and lived experience, from how we see ourselves to how we are treated by others. This hunger for healing and knowledge shows us that for neuro-gastroenterological knowledge to draw connections between the mind and body in a helpful way, we need only to engage a decolonial turn that acknowledges the interplay of multiple, overlapping systems and intersections at the level of the body. Existing neuro-gastroenterology as a biomedical field does not offer a decolonial intervention, but the workshop shows examples of how these two modes of knowledge production can work together to address the health and healing needs of our diverse communities.

In the *Panza Knowing Workshop*, we see how the *panza* articulates a plurality of hungers. From this pilot program, the gut emerges not necessarily as the first brain but rather as the connection between the mind and the body; we must consider the knowledge production of the gut when we discuss the mind-body connection. At the same time, the oppressions that people experience are also carried in and expressed through the gut. This claim is similar to the argument made by Black feminist theorists (e.g., Combahee Collective, 1977; Crenshaw, 1995; Collins, [1990] 2009), who assert that any consideration of the body requires a concurrent consideration of social structures and the multiple oppressions that people experience (based on their identities and positionalities). To reconceptualize health disparities and their expressions in our bodies, we must take seriously the hungers articulated by the *panza*. As queer, Chicana, feminist writer Cherríe Moraga expressed more than forty years ago, "To date no liberation movement has been willing to take on the task. To walk a freedom road that is both material and metaphysical. Sexual and spiritual. Third World feminism is about feeding people in all their hungers" ([1983] 2000, p. 123). The *Panza Knowing Workshop* heeds Moraga's call to satisfy people's hunger. However, it is only through community that we gain the tools and the knowledge to sate each other. African American and South Asian Studies scholar Natassja

Gunasena reminds us, “Together, we can feed all our hungers. Together, we need not endure the long night alone” (2019). She echoes bell hooks, who asserts, “[O]ne of the most vital ways we sustain ourselves is by building communities of resistance, places where we know we are not alone” (1990, p. 227). This chapter showcases examples of knowledge production generated via *panza* awareness. Significantly, these interventions all emerged in a community space. Through the action research of this pilot program, participants became co-collaborators in knowledge production and worked alongside me (the facilitator) to value and listen to the *panza*’s messages. Participants in this workshop used group dialogue and sharing/*testimonio* to give shape and visibility to the various conceptions of hunger that emerge from a collaborative practice of awareness about the embodied and ancestral knowledge carried by the diversity of people in our communities.

This Conclusion that follows outlines future directions of the *Panza Knowing Workshop* and provides suggestions for further health sciences research that likewise mobilizes decolonial, feminist methodologies.

Conclusion

Mapping New Methodologies: Future Directions for the *Panza Knowing Workshop*

This dissertation responds to the lived experiences of queer Chicanas, like me, and other BIPOC people, who navigate biomedical healthcare systems and the work of caring for ourselves in a racialized context of life and death. In her powerful, performance manifesto, *Your Healing is Killing Me* (2017), Virginia Grise lists the many things that are killing her in the search for healing. Processed food, Monsanto, BPA, and plastics are killing her. So too are rising rents, reimbursement paperwork, "health care that is not universally free," and "prescriptions that address the symptoms but not the cause." Grise adds,

> Not being paid on time and checks that arrive late in the mail are killing me… White supremacy is killing me…. The lack of political imagination in this country is killing me…. Any and all roles defined by prescribed notions of gender and/or family and domestic obligation, including doing the fucking dishes, are killing me. I blame gay marriage…Being put on hold is killing me.… Pan-Latino(ism) is killing me, as Latino is not a politic nor an ideology and does nothing to prepare us to defend ourselves against what is actually killing us (2017, p. 56-57).

She catalogs the various ways that the quotidian and invisible injuries of the medical industrial complex (and its various raced and gendered socio-economic entanglements) emerge as life-threatening for her queer, Chicana body and community. This list is followed by grief-stricken recognition that caring for ourselves is an act of self-preservation and political warfare (recalling Audre Lorde). Grise follows this tally by listing the circumstances of death for some of our most beloved Black and Brown ancestors. She laments, "Audre Lorde died of cancer before she turned 60. June Jordan died of cancer. Sylvia Rivera died of cancer…. Octavia Butler died of a stroke. She had high blood pressure and suffered from depression. Gloria Anzaldúa died of complications due to diabetes. It took them two days to find her dead body" (p. 61). Just like the earlier example, Grise uses the power of listing to repeatedly remind the audience member of how deadly healthcare stakes can be for BIPOC women in particular. For Grise and her interlocutors, it is imperative to take seriously the health of our communities. The stakes are so high. Acts of healing, in community and from the knowledge of the Global South, represent a revolutionary fight for life and self-preservation. In the name of these teachers and creatives taken too soon from the face of this earth, Grise asserts that her work is a manifesto "toward a politic of collective self-defense, instead of individualized self-care" (p. 19). The *Panza Knowing Workshop* echoes Grise's declarations that we need to make collective, radical departures from the way knowledge about non-White bodies is created, circulated, and put into practice.

Since the fifteenth century, (neo)colonization has been stripping the world's communities of ancestral knowledge about our own bodies. This can be observed as epistemic, methodological, and pedagogical processes of racial aggression in biomedical research and practice, where health systems and their actors are placed in a hierarchical position of power over their patient. The *Panza Knowing Workshop* is one way that we can reclaim our ancestral knowledge in a collaborative setting. By engaging with people as equitable collaborators in understanding their bodies, we depart from scientific methods that do not account for the spiritual aspects of human life. Thus, the *Panza Knowing Workshop* is a tool for bridging

biomedical and ancestral knowledge about any group's parameters for what it means to be a "healthy" person/community. Additionally, this workshop is but one of many ways that we can collaborate to address root causes of the negative effects of race-based medicine.

This Conclusion is an overview of the workshop's interventions and findings and includes recommendations for decolonial feminist research in the healing sciences based on the *Panza Knowing Workshop*. It emphasizes the possibilities of knowledge expansion by working transdisciplinary across Ethnic Studies and the health sciences. The chapter is divided into three parts. First, it highlights the *Panza Knowing Workshop*'s prioritization of constellations of knowledge, whereby biomedical research can benefit from transdisciplinary (including qualitative) approaches and the introduction of Indigenous liberation pedagogies. Second, by proposing methods for enacting an embodied practice of *panza awareness*, the chapter shows how the *Panza Knowing Workshop* facilitates collaborative knowledge production or the overlooked knowledge about the body that is held outside of academia. Third, the chapter highlights the *Panza Knowing Workshop'*s community engaged scholarship–specifically graduate and academic research that works with community in ethical, relational, and reciprocal ways.

Constellations of Knowledge

Leanne Betasamosake Simpson relies on Nishnaabeg thought that conceptualizes the "skyworld" as an important organizing principle for human/natural existence (2017). In Nishnaabeg cosmology, constellations represent doorways that give a physical presence to the spiritual world (p. 212). Simpson adds that constellations also act as conceptual doorways or "coded mappings" that position individual stars in a relational way, organizing them into networks within a greater whole (p. 217). She represents conceptual, interrelated notions of constellated knowledge that draws directly from Indigenous cosmologies and experiences. With this Indigenous thought as a conceptual framework, Simpson writes that knowledge production must be implicated in movements of resistance (or rather co-resistance) and must be willing to "take on white supremacy, gender violence, heteropatriarchy, and anti-Blackness" from within spaces of movement (p. 231). The *Panza Knowing Workshop* illustrates that co-resistance within a decolonial, feminist research in the health sciences is possible and must likewise include Black Feminist Theory and Indigenous liberation pedagogies. As psychologist Hussein Abdilahi Bulhan observes, "For whatever contributions may derive from accumulating biomedical and traditional psychological research, and there are undoubtedly many, the problem of madness and oppression will nonetheless continue to elude us so long as the questions of *inequity*, *power*, and *liberty* are evaded" (italics in original, 1985, p. 272). This project values knowledge produced in resistance to such oppressions of power and analyzes health knowledge production using a decolonial, feminist lens that refuses to be bewitched by the so-called objectivity of biomedicine.

Panza awareness is a conceptual and practical intervention that seeks clarity and truth about health inequities and knowledge of the non-White body from beyond the scientific method. In utilizing, but departing from, biological knowledge of the body, the *Panza Knowing Workshop* acts as a constellational co-resistance. Feminist psychologists Floretta Boonzaier and Taryn van Niekerk define a "decolonial feminist community psychology" as one that:

> takes questions of activism seriously, begins with decolonial and feminist theorising from the global South, engages critical reflexivity and critical ethical reflexivity, is anti-essentialist, acknowledges multiplicity and intersectionality, centres the voices and

> concerns of the disenfranchised, deconstructs notions of community, [and] considers issues of representation and whose interests might be served by the work (2019, p. 8).

Community-engaged psychology that is oriented by feminist and decolonial thought must enact multiple theoretical and applied interventions, like these enumerated by Boonzaier and van Niekerk. It must actively deconstruct existing epistemologies and social relations of power, and it must practice a continual process of reflexivity to control for the insidious and ubiquitous iterations of sociopolitical domination that emerge in healing practices today. These deconstructions must aim to serve the needs of the community, not of the "field" or even the individuals. At the same time, by integrating Indigenous theory, researchers can imagine alternative constellations of interrelatedness in which individual thoughts and experiences act as doorways for understanding when joined in relation with other knowledge formations (e.g., Simpson, 2017). Constellations of co-resistance through pedagogies of knowing (knowledge that is active and reciprocal) create bridges and points of connection by which we may interpret the experiences of the individual and of the community toward healthier futures.

Through ethnography and community-engaged methods, this workshop humanizes the experiences of BIPOC people, an approach that is key to race-conscious medical research. Indeed, "decolonization entails more than racial and linguistic representation," observe decolonial psychologist Kopano Ratele and colleagues. They add, "Numbers are attractive because they are easily quantifiable; however, decolonization must extend beyond counting to something more slippery" (2018, p. 340). It is in this slipperiness that the possibility exists for qualitative knowledge production in the health sciences. Decolonizing approaches in community psychology all share—in the words of psychologists Mohamed Seedat and Shahnaaz Suffla—"attitudinal orientations that affirm situatedness, marginal voices, liberatory modes of knowledge creation, ethico-reflexive praxes, non-hierarchical learning and teaching, and dialogical community engagements, constantly intended to transcend the obsession with formulaic methods" (2017, p. 428). These academic voices from the Global South pose a potent critique of biomedical standards of teaching and learning, showing how the thought and action from within patient populations can be resituated within psychology. In the *Panza Knowing Workshop*, I turn to "the pedagogies of the everyday, the mundane, and the ordinary" to explore health knowledge production, as modeled by Chicana feminist theorist Ruth Trinidad Galván, who identifies in small groups of rural, Central Mexican women "organic pedagogical forms of spirituality, well-being, and *convivencia* as interrelated modes of teaching and learning, knowledge creation and identity production" (2001, p. 603, 605). These interventions from people whose knowledge is typically considered "folk" is valuable not only for the anthropological study of cultures but also within applied health practice settings.

The workshop's collaborative and psychoeducational components were essential to carrying out decolonial and feminist pedagogies—and for supporting the participants to tap into their embodied knowledge. These approaches revealed that participants require a grounding in decolonial praxis to identify with their *panza* as the point of connection between the mind and the body. This *nervios*/gut connection, then, serves as the conduit through which participants can channel their various metaphorical hungers. In the *Panza Knowing Workshop* pilot program, four types of hunger emerged from conversations with interlocutors: hunger for healing, ancestral knowledge, community, and social justice. As Black feminist theorist M. Jacqui Alexander teaches us, this hunger or yearning is informed by the "deep knowing that we are in fact interdependent" and desire true connection with each other (2002, p. 99). Alexander's

conceptualization of yearning highlights the knowledge of the Black diaspora, which includes a non-Western logic of intersectionality, relationality, and the collective conscience. *Panza awareness* and the *Panza Knowing Workshop* tap into these alternate logics of a collective self. For example, through storytelling about my academic journey from the health sciences to Ethnic Studies, I encourage participants to create space in their lives for both embodied wisdom and biomedical knowledge; indeed, practicing *panza awareness* does not require them to abandon biomedicine.

However, in the pilot program, not all participants could welcome the decolonial turn and struggled to abandon Eurocentric "reason" and science. This was particularly the case for high school students, who were younger and also did not voluntarily elect to participate in the workshop. (I was a guest facilitator in their classrooms.) They reacted with resistance to my challenges of science and biomedicine, adopting a "seeing is believing" logic in response to *panza awareness*. In a way, they were being good students, taking the teachings of their primary and secondary education (vis a vis the Eurocentric epistemologies of the body in their conceptualizations of mind, body, and health) and applying them in a context where I offered alternative ways of knowing. From this experience, I learned that future iterations of the workshop, when held with these younger interlocutors, should be longer and include additional historical evidence and critical dialogue to allow participants to fully engage with knowledge production informed by decolonial epistemology.

High school students were not the only people to push back against the *nervios*-gut connection, as I also encountered resistance from graduate counseling psychology students at a predominantly White institution. While some participants were able to connect with their *panzas* and with the workshop's decolonial orientation, I also felt a lot of push back (and perhaps jealousy) from some participants—notably White women and White-minded women in the group. They clearly wrestled with decolonization- and the race-conscious orientation of the *Panza Knowing Workshop.* It was perhaps the first setting in which their worldviews were not assumed and centered, perhaps the first setting in which they themselves were not centered. On my way home from the event, I got food poisoning and vomited. While some might say this sickness was a coincidence, Ifa-Orisha practitioners in Cuba say, "*No hay casualidad, hay CAUSAlidad*." This *dicho* is a play on words that means, "There is no such thing as coincidence, there is only causality." With this saying, they refer not to an objective-rational cause, but rather to an underlying spiritual or socio-relational cause. Through this lens of understanding, my *panza* had something to express after my "Whitest" workshop, and it was unfavorable. After I returned home, I recalled an experience narrated by Black feminist theorist bell hooks (1994), who describes a class "full of 'resisting' students who did not want to learn new pedagogical processes, who did not want to be in a classroom that differed in any way from the norm." She continues, "To these students, transgressing boundaries was frightening" (p. 9). My own experience with "resisting" students is a reminder that these workshops need to center BIPOC people at all costs and that the pedagogical movements made to center Black and Indigenous people in the workshop effectively disrupted the conventional social relations of power of academic spaces. Also, introducing a reciprocal and horizontalizing pedagogical experience to initially intransigent participants can sometimes lead to breakthroughs or "lightbulb moments" for them.

Collaborative Knowledge Production

The *Panza Knowing Workshop* taps into knowledge about the body that is held beyond academic conversations. It values the embodied and ancestral knowledge that Western knowledge lacks and creates space for BIPOC people to produce knowledge about themselves and their experiences. The necessity of reciprocity and relationality in pedagogies of knowing is articulated by Black feminist theorist Toni Cade Bambara, who writes, "We have to get to know each other better and teach each other our ways, our views, if we're to remove the scales ('seeing radical differences where they don't exist and not seeing them when they are critical'– Quintanales) and get the work down" ([1981] 2002, xlii). One way that the *Panza Knowing Workshop* empowers people to "teach each other our ways" is via interpretive frameworks that upend traditional biomedical research methods and instead focus on creating health knowledge in creative, community-centered ways. Through action research, ethnography, and group methods, the workshop centers people of the global majority to unearth the knowledge embodied and remembered by the community. By grounding these methods in feminist and decolonial frameworks, it centers gender and race in qualitative research on race-conscious medicine.

The pilot program resulted in powerful moments of group work and knowledge production, which emerged from a workshop design that centers decolonial psychoeducation and a heterarchical power structure. This type of collaborative action research provides data that benefits race-conscious medicine, which researchers are increasingly demanding as a replacement for race-based medicine (e.g., Cerdeña, et al., 2020; O'Brien and Clare, 2023; Barrett-Campbell, et al., 2022). Through dialogue, stories, and observations, participants shared how spirituality, religion, health, and medicine all intersected in their lived experiences with the mind-body connection. These "street scholars" cultivated relationships with each other and with me and co-created knowledge about the healing modalities they used to survive as racialized, gendered people at the intersections of multiple oppressions (U. Taylor, 2006). These plural truths gleaned through qualitative measures (and with grounding in feminist and decolonial methodologies) underscore the ecologies of knowledge present outside of academic spaces. A similar result emerged from a feminist participatory action research project conducted with Andean women in rural Peru, where psychologist Gabriela Távara reveals that participants rejected outsiders' perceptions of them as passive subjects and instead defined themselves as the primary knowledge producers about their own lives (2019). This lateral knowledge production also improved the *Panza Knowing Workshops* pilot program, as participants encouraged me, for example, to use gender-neutral language, request people's pronouns, incorporate an awareness of pregnancy and childrearing as *panza awareness*, and adapt the workshop to the developmental and accessibility needs of the participants.

Once participants tapped into the knowledge of their *panzas* and accepted the gut as a conduit between the mind and the body, they began to articulate hungers above and beyond the physical. "Even though yearning is usually tethered to a long history of capitalist formations and ambitions/aspirations to 'make it' in the realms those formations rule over," writes Black feminist theorist Andrea N. Baldwin, "there are creative and worldmaking possibilities that come from working to satisfy that yearning outside of institutionally preordained ways of university-sanctioned education" (2022, p. 127). Baldwin mobilizes queer theorist José Esteban Muñoz's definition of worldmaking or the "ability to establish alternative views of the world" through "both theatrical and everyday rituals" (1999, p. 195); and she asserts that articulating and satisfying our yearnings beyond academic spaces has the capacity for transformative worldmaking. With a grounding in Black and Chicana feminist knowledge that recognizes the

presence of both felt and objective knowledge, *Panza Knowing Workshop* participants together expressed a *hunger for healing*, specifically a hunger to heal in community with others. People struggling with eating disorders self-selected to attend the workshop, as the subject repeatedly came up in conversations. But it was not just this gut-related illness for which participants sought healing. They hungered to talk about their traumas, not simply to disclose but to synthesize and learn from others in the group. A *hunger for ancestral knowledge* also surfaced in these conversations, as participants expressed an openness to learning about health and the body from sources outside the biomedical norm–including family members, older workshop participants, and their families' non-Western cultures. As people became more grounded in the messages of their *panzas* (after my storytelling presentation on decolonial epistemologies), our conversations inevitably explored how issues of the body are social justice issues. And participants articulated a hunger for social justice, a yearning to come together to support the healing needs of our BIPOC communities. In these discussions, participants simply needed guidance or permission to value their embodied knowledge and to create space for other ways of being fed and feeding others.

Community Engaged Scholarship

The *Panza Knowing Workshop* makes a case for graduate and academic research committed to working with community in ethical, relational, and reciprocal ways. Participants were eager to learn from me and to produce knowledge together. They were emboldened and empowered to disrupt the health discourse that views them as consumers at best; but more often, this discourse construes them as ignorant about their bodies and certainly unable to produce health knowledge about themselves beyond the frameworks authorized by their doctors and health institutions. The lens of biocommunicability allows us to trace these discursive movements of racial hierarchies in health knowledge production and, by extension, health practice (Briggs and Hallin, 2007). Nearly forty years ago, Bulhan wrote:

> We have seen how much violence is unleashed in the name of scholarship, science, and healing. A psychology of liberation would give primacy to the empowerment of the oppressed through organized and socialized activity with the aim of restoring individual biographies and collective history derailed, stunted, and/or made appendage to those of others (1985, p. 277).

His statement emphasizes the power of purposeful community to counter the harms done by Eurocentric science and medicine and empower people of the global majority to take up health as a matter of self-preservation and self-determination (in a collective sense). The knowledge produced in the workshop has its foundation in the psychoeducational, storytelling presentation I give at the beginning and that introduces biomedical as well as embodied thinking about "gut instinct." To be sure, my role as facilitator and teacher is essential to the success of the workshop, as it requires someone knowledgeable about feminist, decolonial frameworks to structure an epistemic and ontological intervention around thinking about health and the body. It is also important for us as scholars to give back to people in our communities. Academic dialogue about health happens in a detached way from the people it serves. In this way, it systematically reproduces racial constructs and hierarchies that become embodied in people's experiences of health and illness. The *Panza Knowing Workshop* enacts knowledge production as a pedagogical act of reciprocity and an act of knowing from embodied and ancestral

perspectives. It presents concrete ways for academic thought to contribute to the subjects of its gaze.

At the same time, my use of collaborative and engaged pedagogies (as well as action research) means that I do not situate my scholarly or intuitive knowledge as superior to the participants' embodied knowledge (e.g., hooks, 1994). Rejecting the impossible role of neutral researcher, I call on my own experiences and education to be objective to "control for" socioeconomic factors (Harding, 1995). I also humanize my participants (many of whom were BIPOC people) and place value on the knowledge we produce together from their *panza awareness.* Indeed, I view the knowledge that emerges from the *Panza Knowing Workshop* as generated collectively rather than simply collected by me (Schwartz-Shea and Yanow, 2013). One way that I model this for participants is through mirroring or reflecting to them their comments in my own words. In other words, I practice a "politics of listening," described by new media scholar Wendy Hui Kyong Chun as attending to "the victories, defeats, and silences" of others, while maintaining a distance so as not to involuntarily relate these experiences to my own life (1999, p. 139). After the pilot program workshops, participants commented in their feedback that this practice supported them to feel like I was truly listening to them, that they were seen and supported. My approach helped participants to think through how their shares were examples of *panza awareness*, knowledge from *panza awareness*, or both.

Panza Knowing Workshop participants and I are all concurrently learners and teachers of our own experiences, as we co-devise a pedagogy of knowing or research as knowledge production. As participants connect with their *panza awareness*–which aligns their mind, body, and spirit–they can share embodied knowledge and help others synthesize their own experiences. This relational pedagogy eschews hierarchy and cultivates knowledge production from within the BIPOC communities, generating knowledge that bypasses the coloniality of power and engages people as their full selves in collaboration toward knowledge and, more importantly, toward healing. Rather than assuming biological difference where none exists (as race-based medicine does), the *Panza Knowing Workshop* humanizes participants and affirms the embodied knowledge we all carry, drawing out our sense of situatedness via both embodied and ancestral/intergenerational positionalities. Throughout, participants experience slippage across moments when they are learning empirical content, making connections, and producing knowledge. The workshop's epistemic and ontological work enacted toward a decolonial, feminist turn recuperates for participants a sense of self-making and a collective sense of self-determination.

Community is central to this process; after the workshops, participants articulated both gratitude and a hunger for more interconnectedness, as well as a desire to come together again. In both online and in-person workshops, people were grateful for a safe space to articulate knowledge of their bodies and lives, which they had not previously been able to put into words. They were appreciative that I and others valued their contributions to the group dialogue, and they expressed thanks that I had organized and curated a space for them to share and witness together.

My experience conducting this workshop at the Galería de la Raza in San Francisco, CA stands out as a good example of the community healing potential of collaborative approaches to healing knowledge production. The workshop was a part of a Galería event about "*abuelita* knowledge" (grandma knowledge) and Indigenous foodways. This workshop in San Francisco's Mission District brought together a diverse group of 40 community members (with fewer academics and students than in other settings). People contributed an amazing array of

knowledge about their embodied experiences as racialized, gendered people. Their contributions also reflected the ancestral knowledges represented by the San Francisco community. In attendance was a couple–both queer, Chicana theorists, Catriona Esquibel and Luz Calvo. I was pleasantly surprised to see them, as I was already aware of their research on food justice; and I had already included *remedios* (remedies) from their co-authored cookbook (2015) in the *panza* archive. (Esquibel is now an ancestor, as she transitioned during the writing of this dissertation.) Having Esquibel and Calvo unexpectedly participate in the workshop was a wonderful gift from my community toward the evolution of this dissertation research.

However, not all workshops cultivated the same level of community. Academic classrooms did not lend themselves as well as other spaces (e.g., community collectives) to exploring *panza awareness* through ancestral spiritual/healing traditions. Despite the generative outcomes that emerged from the institutional workshops, it was clear that these educational spaces were not entirely able to welcome the workshop's decolonial, feminist, interpretive framework. For example, in academic spaces, students sometimes seemed to intellectualize the *diálogo* about *nervios* and/or the gut-brain connection. I was also unable to burn incense and did not always guide a spiritual cleansing, as I did in community and conference settings. The absence of this ritual felt symbolic of the limitations of disciplinary engagements with the community. To provide a liberating workshop experience for participants, particularly BIPOC people, the event should not take place in academic spaces. Indeed, for BIPOC people to build community and access *panza awareness,* the orientation of the *Panza Knowing Workshop* must prioritize them. My findings parallel those of feminist psychologists Angeline Stephens and Floretta Boonzaier, who found in their study of Black, South African lesbians that their interlocutors felt *uncomfortable* in LGBTIQ spaces that were White, middle-class, and masculinist. At the same time, the women felt alienated by Black community members who spoke with a White accent (2020). As feminist psychologist Catriona Ida Macleod and colleagues write, "This kind of nuance in understanding the coloniality of power is, we believe, important in forging a clear feminist decolonising psychology" (2020, p. 295). The *Panza Knowing Workshop* too must remain aware of the spaces and the group dynamics that it cultivates. In this self-reflexive modality, the workshop is an example of a community-engaged mode of knowledge production toward new, transmodern ways of approaching the health of the world's people.

This dissertation, and the *Panza Knowing Workshop*, has been a conversation about knowledge production that, by necessity, pulls from multiple disciplines. It reminds us that caring for our bodies requires a holistic approach and that creating knowledge about the body requires the same. It is only together in community that we cultivate healthy, more humanized knowledge that can foster health and healing in sustainable ways. The people of the global majority still carry the ancestral knowledge that has been suppressed by colonization and that we must carry into the future with us. *Panza awareness* is one example of this knowledge, and it represents an act of liberation that brings Black and Indigenous diaspora peoples into a future of new possibilities for race-conscious healing.

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Appendix A: Locations and Dates of *Panza* Knowing Workshops

Setting	***Description of event/context***	***Date***	***Location***	***Participants on sign-up sheet***	***Estimated number of participants***
Conference	Empowering Womxn of Color Conference (EWOCC)	4/20/2014	Berkeley, CA	11	15
	National Association for Chicana and Chicano Studies (NACCS)	4/9/2016	Denver, CO	15	20
	National Women's Studies Association (NWSA)	11/10/2016	Montreal, Quebec	11	15
Classroom	Undergraduate Health Sciences Program: CSU East Bay	3/20/2019	Hayward, CA	21	23
	High School "Special Ed" Bridge Program: Foreman High School	6/12/2019	Chicago, IL	32	32
	(High School) Ethnic Studies Program: OUSD students at Laney College	9/10/2019	Oakland, CA	18	20
	Graduate Counseling Psychology Program: John F. Kennedy University	12/31/2019	Pleasant Hill, CA	10	10
	Undergraduate Mentoring Program: Berkeley Connect, UC Berkeley	11/19/2020	Berkeley, CA	37	37
	Undergraduate Ethnic Studies Program: UC Berkeley	4/11/2022	Berkeley, CA	15	20
Community	Chicanx/Latinx art gallery and collective: Galería de la Raza	10/20/2018	San Francisco, CA	33	40
	Healing arts and counseling collective: Botánica Azul	1/27/2018	San Francisco, CA	11	15
	Community-focused, student-activist coalition: Strike University	4/10/2020	Berkeley, CA	58	60
Totals:	12			272	307

Appendix B: *Panza* Popcorn Questions

1. What's one thing you have learned from your panza?
2. What memories do you carry in your gut?
3. How do your bowels feel? Do your bowels have a character of their own?
4. What types of things disturb your belly?
5. What things do I do to offer healing to myself *through* my panza?
6. When do you feel "full"? What makes you feel this way?
7. When do you feel hungry? What makes you feel this way?
8. What are the sounds of your panza? Do you know what different sounds of your gut mean?
9. What are your favorite foods? Why? Or perhaps…when?
10. Are you aware of your gut feelings? What are some things your gut has tipped you off to?
11. What are some emotions that you experience in your gut?
12. Are there mysteries in your spirit, mind, and body that your doctors and therapists cannot solve?
13. When do you trust your doctors and when do you trust yourself?
14. How does the idea of magic (things 'science' can't explain) make you feel in your stomach?
15. Does your body do things that you do not understand according to medical or rational logic?
16. What strengths, what weaknesses do you embody in the places and spaces of your gut?
17. How does your panza intersect with your gender identity and sexuality?
18. How does your gut intersect with your race, ethnicity, and/or nationality?
19. What is your go to remedy when you have an 'upset stomach'?
20. How often do you rub your belly

Appendix C*: Panza* Archive

***Panza* Awareness Recipe: Breathing**
Breathing box for anxiety
SOURCE: Panza Knowing Workshop Participant

Create a safe space for yourself within, through your own breath.

Close your eyes.
- Breathe in from your belly, taking in the air through your nose while counting to four slowly. Try to feel the motion of the air as it moves up over your top lip into your nostrils.
- After you've finished filling up with air, slowly release the air by exhaling while counting to four.

Repeat steps at least three times.

***Panza* Awareness Recipe: Beans!**
White Bean and Kale Medicinal Soup
SOURCE: Catriona R. Esquibel and Luz Calvo, www.facebook.com/decolonizeyourdiet

Health Benefits: All beans have high levels of antioxidants and fiber. Tepary beans have added benefits.

Ingredients
1 lb white tepary beans (substitute small white navy beans)
1 onion, quartered
1 tomato, quartered
3 cloves garlic
1 dried chipotle pepper
1 handful of fresh herbs (SEE NOTE)
Parmesan Rind
1 bunch kale
1 lemon
3 TBSP olive oil
1 tsp salt
1 tsp agave syrup
Pepper
Grated Parmesan

Directions: Put onion, tomato, garlic, herbs, and 5 cups water in blender. Blend until smooth. This is your broth. Put broth, beans, rind, and dried chipotle in a crock pot. Cook on HIGH heat for 5 or more hours.

Here's the secret to getting the kale to taste good: About an hour before dinner, wash kale and remove stems. Finely chop the kale. Whisk together juice of one lemon, olive oil, salt, and agave syrup. With your hands, work the lemon/olive oil mixture into the kale. Spend several minutes massaging the kale. Put the kale in a small baking dish and cook at 400 degrees for 10-15 minutes. Add kale to the crock pot and let simmer for about 10 minutes. Remove chipotle and rind. Add salt and pepper to taste. Serve topped with grated Parmesan.

NOTE: For herbs, use a combination of 3-4 fresh herbs that you have available, such as oregano, thyme, sage, rosemary, lemon balm, mint, basil, cilantro, parsley, etc. The trick is to not use too much of any one herb, especially strong herbs like rosemary. The herbs provide the medicinal value of this soup as they have many healing properties. Because you will be cooking the soup over low heat all day, you are in effect brewing an herbal tea to use as your stock. Honor the healing properties of the herbs.

***Panza* Awareness Recipe: Raw Food**
Coconut Yogurt
SOURCE: Elissa Goodman, http://www.mindbodygreen.com/0-11078/raw-recipe-a-coconut-yogurt-your-gut-will-love.html
This coconut kefir yogurt is a total powerhouse recipe in my book. It boasts the following benefits:

- **It's probiotic-rich:** The extra dose of probiotics will leave your gut loaded with beneficial bacteria that will have a dynamic effect on your digestive system.
- **It's high in protein:** The coconut meat is packed with protein to keep you satiated longer.
- **It's dairy free:** Skipping the dairy will help you avoid feeling gassy and bloated throughout the day.
- **It's sugar free: T**his recipe has no sugar added but still has a sweet, tangy taste. You won't crash and feel hungry an hour after eating it.
- **It couldn't be easier to make!** I have eaten it almost every day for over a year and I still crave it daily. I top it with my homemade gluten-free granola, but you could also just toss on some crushed sprouted nuts or fresh berries.

Ingredients
- 16 oz coconut meat (if frozen, thawed)
- 1 T coconut kefir (I like Tonix)
- 1 capsule dairy free probiotic (I use Garden of Life 100 billion)
- Juice of 2 freshly squeezed lemons

- Juice of 1 freshly squeezed lime
- Half cup raw coconut water

Blend all ingredients in your Vitamix or blender until creamy and smooth. Pour into a glass jar or glass and cover with cheesecloth or other breathable fabric and secure with a rubber band. Leave out at room temperature overnight (I leave mine for 12 hours) and then refrigerate and enjoy! *Note*: the yogurt should be creamy and have the consistency of a normal yogurt. If it looks chunky after sitting out overnight, put it back in the blender until it gets creamy.

***Panza* Awareness Recipe: Fermented Food**
SOURCE: Catriona R. Esquibel and Luz Calvo, http://decolonizeyourdiet.org/category/blog

What is fermentation? (Food as Magic) Fermentation occurs when the sugars and carbohydrates in a food convert into something else. For instance, juice when fermented can turn into wine, grains can turn into beer, and carbohydrates turn into carbon dioxide to leaven bread. In short, fermentation is alchemy, that is "a power or process that changes or transforms something in a mysterious or impressive way."

Tepache Recipe

Tepache is a fermented pineapple drink popular in Mexico. Originally made with corn, *tepache* is a Nahuatl word derived from *tepiatl* (meaning "drink of corn"). Today, *tepache* is generally made with pineapple rinds, which ferment to produce a tart and refreshing drink.

Ingredients
The skin of one pineapple
4 cones of pilloncillo
4 cloves
1 stick of cinnamon (preferably Mexican canela or Ceylon cinnamon)
Approx. 6 cups filtered water

Wash pineapple well and then cut away the skin. Eat the delicious pineapple, you won't be using it in this recipe!

Bring water to a boil and add cinnamon, cloves, and *pilloncillo.* Stir until *pilloncillo* dissolves. Turn off heat and allow the mixture to cool COMPLETELY.

Put pineapple peel and *cooled* water mixture (with cinnamon and cloves) in a large jar. You want the jar to be full so add more water if necessary. Cover jar with a piece of cloth tied with rubber band (or canning lid with center removed as pictured below).

Put the jar in a warm sunny place. I put mine outside. Wait several days until bubbles start to form. Taste. You want a kombucha-like flavor—a bit tangy. If the taste is still overwhelmingly sweet, it is not done. Wait a few more days and taste again…Depending on the weather and other factors it can take anywhere from 3-10 days to get your brew going. You need to taste it regularly.

Once you get the flavor you want, strain the *tepache* and put it in the refrigerator. I like to let the *tepache* "rest" in refrigerator a few days before drinking, as I think the flavor continues to develop and mellow.

To serve, you can add sweetener or some lime juice, as desired. It tastes best with ice. If it is too strong, you can water it down a bit.

NOTE: Don't throw away the pineapple rind after making the tepache. You can make another batch of *tepache* with the same rinds! The second batch is often even tastier than the first. You can even try a third batch, but you start to get diminishing returns.

***Panza* Awareness Recipe: Fermented Food**

What are health benefits for fermented foods?
SOURCE: "Fermented foods bubble with healthful benefits" By Casey Seidenberg, *Washington Post,* November 19, 2012.

Fermented foods aid in digestion and thus support the immune system.
— Imagine a fermented food as a partially digested food. For instance, many people have difficulty digesting the lactose in milk. When milk is fermented and becomes yogurt or kefir, the lactose is partially broken down, so it becomes more digestible.
— Organic or lactic-acid fermented foods (such as dill pickles and sauerkraut) are rich in enzyme activity that aids in the breakdown of our food, helping us absorb the important nutrients we rely on to stay healthy.
— Fermented foods have been shown to support the beneficial bacteria in our digestive tract. In our antiseptic world with chlorinated water, antibiotics in our meat, our milk and our own bodies, and antibacterial everything, we could use some beneficial bacteria in our bodies.
— When our digestion is functioning properly and we are absorbing and assimilating all the nutrients we need, our immune system tends to be happy, and thus

better equipped to wage war against disease and illness.

I am not claiming that fermented foods are a panacea, but I do believe these foods encourage effective digestion and — along with sleep, exercise and a nutrient-rich diet — help nurture a strong immune system.

Are you turned off by the idea of a fermented food? Don't be. Fermented foods are valued for their health benefits and as a means of food preservation, but they wouldn't have been part of our diets for so long if they weren't tasty as well. For some, a fermented, stinky cheese is a delicacy. And it pairs nicely with a glass of fermented red wine.

Incorporating fermented foods into your diet

To receive the health benefits and the flavors of fermented foods, you don't need to make an entire meal of them. Just a little bit will do. A spoonful of sauerkraut on your sausage offers benefits and adds flavor. So do a few sips of miso soup to begin a meal or a few pickles on a turkey sandwich.
Incorporating fermented foods into the diet is simple.
— Replace regular bread with a fresh sourdough variety.
— Choose kefir and yogurt over regular milk. Both work well in smoothies.
— Kombucha is a fermented drink found in many grocery stores.
— Look for naturally fermented vegetables such as pickled cucumbers, beets, onions, sauerkraut, salsa and kimchi. These are sold in the refrigerated section of your grocery store, not with the shelf-stable foods. Add a spoonful to any dish.
— Use miso to marinate fish or in soup.
— Add a tablespoon of fermented chutney to cooked meat.
— Use naturally fermented condiments (found in the refrigerated section of your grocery store). Because my kids love ketchup and would put it on everything if I allowed, I have started making my own using the recipe in the cookbook "Nourishing Traditions." My variety is fermented and thus has all the associated benefits, unlike most commercial ketchup, which is made with sugar or corn syrup and other additives.
— Look for a book about fermentation if you are inspired to try it yourself.

We have heard repeatedly that we should eat as our ancestors ate. There is evidence that people have been fermenting foods since 3000 B.C., so if fermentation isn't going back to our food roots, I don't know what is.

***Panza* Awareness Recipe: Body and Touch Medicine**
Castor Oil Packs
SOURCE: indigenama.com/videos by Panquetzani

Panquetzani introduces the method of applying woolen "packs" saturated with castor oil to the body for releasing and healing inner organs, including the womb. See "Caster Packs for your Womb" on YouTube, https://youtu.be/GNeVWhzEuYY

***Panza* Awareness Recipe: Body and Touch Medicine**
Chi Nei Tsang Self-Help Massage
SOURCE: Karen Pearle, http://www.chineitsangnow.com/abdominal-self-massage.html

Self-Help abdominal massage is very simple. I suggest that you practice steps 1-4 each day and take a whole hour once a week for the full routine.

1. Lie on your back with feet flat, knees raised, supported by pillows.
2. Breathe long and deep, sending air pressure down to your sacrum all the way to your pelvic floor. Continue up all the way up your back to your shoulder blades. Exhale, dropping your chest first, then your abdomen. Breathe gently this way throughout the session.
3. Using the fingertips of both hands, gently massage the skin around your navel. Do this for 5-10 minutes every day to improve digestion and elimination and to relieve nerve, back or neck pain, water retention, and excess body weight.
4. Detox- now move away from the navel, massage by pumping the belly, alternating with both hands (5-10 minutes daily.)
5. Starting from your left side under the rib cage, firmly but gently massage and pull down toward your navel from under your ribs. Repeat on your right side.
6. Massage your lower abdomen by rubbing clockwise a few times, then counterclockwise. Alternate pumping with both hands. Massage deeply, but gently, from inside your pelvic bones toward your navel.
7. Finishing touch - lay your hands flat and send heat to your abdomen, breathing softly for a few minutes.

***Panza* Awareness Recipe: Emotional Writing**
Expressive Writing (as developed by James Pennebaker and uncountable numbers of emotion-feeling people everywhere)

Journaling and writing can be a grounding, healthful practice. When you sit down to write, whether pen and pencil or electronically, try to leave yourself around 15-20 uninterrupted minutes. Do not concern yourself with grammar, handwriting, or formalities, but rather, focus on writing freely and in stream of consciousness. Focus on feelings, emotions, and sensations. Try to avoid inserting logics, opinions, or judgments. Write it down, even if it doesn't make sense. When you finish, reflect on how you feel: Are you charged? Relieved? Tired? Frustrated? Decide whether to leave what you wrote on the page, throw it out, or develop some other ritual for sending it out into the world, or decide if you will keep it to revisit it at another time. Repeat as often as possible!

***Panza* Awareness Recipe: Touch and Paint Exercise**
Tummy Finger Painting

Materials
Finger Paint (non-toxic store bought, or homemade using beet juice)
Poster board/Butcher paper (Rags or a sink with soap and running water available for clean-up.)

Alone, with your child/children, or with friends and loved ones, paint on each other's bellies. Feel the coldness of the paint as it warms up between your panza and your own or your loved ones' touch. Be aware as you become self-aware, hide, doubt, laugh, and giggle…

If you want, you can transfer the paint from your belly to the paper (that means smushing, smearing, plopping, and/or dotting your actual tum-tum onto the paper!); or use your belly as your first draft and then complete the designs, ideas, and expressions you've "brainstormed" on your belly, and paint them with your fingers on the paper.

Benefits: Tactile exercise is therapeutic for the belly and bowels. Touch releases feel good chemicals in the brain(s). Art, color, and paint offer outlets for expressiveness and creativity, which together have boundless healing potential!

***Panza* Awareness Recipe: Talk Medicine**
Panza Popcorn Talk

Talk medicine is one of the most effective healing remedies, and one that we can all do by ourselves or in the company of others. Nothing complicated here, this can be done at any time of day and during any activity: with a friend over coffee, with a family member during a car ride, with your children during daily chores, etc.

Try out some of these critical thinking and discussion points:

- What's one thing you have learned from your panza?
- What does your panza mean to you?
- What memories do you carry in your gut?
- How are your bowels feeling?
- Do your bowels have a character of their own?
- What types of things disturb your belly?
- What things do I do to offer healing to myself through my panza?
- When do you feel "full"? What makes you feel this way?
- What are your favorite foods? Why? Or perhaps…when are certain foods your favorite?
- Are you aware of your gut feelings? How are your gut and your intuition connected?
- What are some things your gut has tipped you off to?
- What are some emotions that you experience in your gut?
- When do you feel proud of your stomach?
- When do you feel ashamed of your stomach?
- In what ways does your panza speak for itself? Against you? Against your doctor? Or against friends/family?

***Panza* Awareness Recipe: Tummy Medicines and Foods I Already Know!**
Use this space to collect recipes, reminders, and exercises that you already know for caring for your gut and stomach, in mind, body, and soul.

Ideas and questions that might jog your memory:

- What foods do you eat when you have constipation, diarrhea, bloating?
- Think about which makes you feel better and which makes you feel worse.
- Think about the onset and duration of these effects and make note of them.

- How does spirit manifest through my belly?
- What does my spiritual practice offer my belly?
- What spiritual knowledge do I have about my own belly?
  What do my elders teach me about my panza, both my gut intuition and my gut health?

- What medicines are effective remedies for your stomach concerns?
- Are they obtained with a physician's prescription?
- Do you find them at the pharmacy?
- Do you find them at a grocery store or farmer's market?
- Can you find them in nature?

- What exercises do you know for the abdominal area?
- Do they involve muscles and strength training? Stretching? Massage?

- Do certain clothes make you feel comfortable?
- Confident? Excited? Self-aware?
- Intersectional? Queer? Alive? Beautiful?

Notes from your belly
What panza medicine do you know of and/or practice?

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***Panza* Resources and References:**

The language of *panza awareness* and *panza* and *nervios* was inspired in part by the play written by Chicana feminists Virginia Grise and Irma Mayorga called the *Panza Monologues* (2004). Please support their amazing work on the *panza*!

On the neuro-gastroenterology of the gut as the second brain by Michael Gershon: *The Second Brain: A Groundbreaking New Understanding of Nervous Disorders of the Stomach and Intestine* (1999)

My favorite Instagram panza-positive figure is Gloria, @nalgonapositivitypride

On afferent nerves, which show how information moves from the gut to the brain and central nervous system, see:
https://www.biologyonline.com/dictionary/afferent-nerve

For Bay Area (CA) QTPOC mental health care services, check out the Resource Page of the Peacock Rebellion: peacockrebellion.org