Title

Walking in a Very Dangerous Space: An Ethnography at the Edges of Adolescence and Psychosis

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Walking in a Very Dangerous Space: An Ethnography at the Edges of Adolescence and Psychosis

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Melina Salvador

Abstract

This manuscript is an ethnography about people, typically young (14-25) but not exclusively so, and families seeking care in early psychosis clinics, and the psychiatric professionals who provide them with services. I offer insight into living and working in the midst of potential psychosis. I attend to psychosis as experience rather than psychiatric symptom, as something beyond a label that can be assigned to individuals correctly or incorrectly. This study neither tests nor tables the question of what early psychosis is or whether or not early psychosis can be identified and treated. Instead, I show how experience comes to be declared or dismissed as psychosis iteratively through conversations between young people, clinicians, and family members. Diagnosis then proceeds both formally and informally through processes that attempt to order odd, fleeting experiences by chronology and conviction, thereby rationalizing what resists making sense**.** And yet, in early psychosis clinics diagnostic uncertainty continues to simultaneously demand and destabilize the clinical application of psychiatric categories. I attend carefully to moments of failure, resistance, and destabilization in early identification and intervention. It is within these sites of profound uncertainty that alternative possible explanations and desires emerge—to be personally addressed by a voice that no one else hears, to be worthy of trust and psychotic, to be listened to.

Anthropology widely theorizes psychosis as a condition of madness and as extraordinary, most typically through the lens of schizophrenia. This literature highlights the spectacular and unusual aspects of psychosis, its ruptures. Psychosis emerges as an extreme of human experience, distinct from the ordinary and as something that threatens subjectivity across multiple domains. This study, based on 12 months of ethnographic fieldwork access to specialized US early psychosis clinics, shows that in the scene of early psychosis, the symptom evades discernment in its ephemerality, its subtlety, its truth. Psychosis continues to evade rationalization not necessarily because of its extraordinary character, but also in its proximity to reality. I look to the accounts of psychosis shared herein as helping to elucidate ordinary experience not because they are extreme or opposing versions, but because they are in fact ordinary. The widely maintained premise of psychosis as extraordinary, bizarre, and spectacular leaves much of psychotic experience unrecognized and establishes in advance the fact of its unfamiliarity. While anthropology has widely theorized psychosis as extraordinary, my fieldwork poses a new question: if psychosis can be so ordinary, how mad must the ordinary be?

Keywords [psychosis, adolescence, psychiatry, early intervention, madness, mental health care, diagnosis, United States]

Table of Contents

List of Figures

CHAPTER ONE | Introduction

The tears welling in Katherine’s eyes did not make it obvious that we needed to stop the interview, but they did raise the question again and again. I wanted to hold space for her to be upset, but I could not stop the feelings that were rising in me. Each time her eyes welled up, mine would begin to sting and fill with tears as well. We sat across from each other, apologizing for the way our emotions betrayed us. Katherine told me she was just about to graduate from college and applying to graduate school. The psychosis had remitted. Her troubles were all pretty standard—college roommate problems, strained family relationships, and too much stress. But there was something else there and it kept making us almost cry.

Katherine’s life was not all that much different from that of other people her age, she said, except for all the therapy and medications. She thought about it more, and then explained: “I guess I’m more cautious… being more aware, you know, like paying more attention to what I’m thinking, maybe a little less carefree.” If anything makes Katherine’s life different from her peers’, it is her psychiatrically mediated carefulness, not madness or even an extraordinary difference. Whereas I began my study with the question of alterity, how “otherness” is established and experienced, Katherine and others taught me to account not only for the spectacular but also the mundane aspects of living in the midst of psychosis. The widely maintained assumption of psychosis as extraordinary, bizarre, or spectacular leaves much of psychotic experience unrecognized.

Anthropology widely theorizes psychosis as a condition of madness and as the extraordinary. This literature highlights the spectacular and unusual aspects of psychosis. Much theorization of psychosis operates through the lens of schizophrenia even though psychosis is commonly related to a wide range of psychiatric conditions and is common in the general population. In such analyses, psychotic experience emerges as an extreme of human experience, perhaps not always categorically other, but distinct enough that understanding psychotic experience is mobilized as a way to understand ordinary experience (Jenkins 2015). As an extreme version, it is still distinguishable as different. Building on such frameworks, I set out on what I thought was a fairly straightforward anthropological task, studying the threshold between ordinary and extraordinary experience in order to elucidate the institutional practices, both psychiatric and familial, through which individual's access to modern subjectivity becomes threatened.

What I found was that marking the threshold between ordinary and extraordinary experience was difficult for families and in the clinic. I thought this difficulty was because in these clinics treating early psychosis, psychotic experience is by definition attenuated and fleeting—easy to miss. But, what I will argue is that the difficulty also arises because psychotic experience is so often mundane, everyday. People hear peers saying negative things about them. They toil over considerations of the meaning of life, or perceive themselves as at risk for being shot in school, being raped, suffering racism. They see bugs and shadows—they sense that a song on the radio is speaking to them. I argue that the accounts of psychosis shared below help elucidate ordinary experience, not because they are an extreme version but because psychotic experience is often itself fundamentally ordinary.

Katherine continued our conversation by explaining that she has to pay attention to her thinking because she gets "suspicious thoughts." They come up when she experiences significant stress or anxiety. She could not recall an example when I asked for one. She just said, "A lot of like strange things. I don't really remember what they were. I probably tried to forget them. Just things that didn't make sense."

She told me her diagnosis was “psychosis” which, she explained, worked better for her than the clinic’s original diagnosis that she had now forgotten. Katherine frames her condition as a stress vulnerability disorder. For her, psychosis is a response to a problem, not the problem itself. She told me she was reluctant to accept services under the original diagnosis, but eventually she agreed. I asked her what changed her mind. It mattered, she said, that it had been clear that the clinicians cared about her.

I asked about her initial reaction to learning that what she experienced might be psychosis. She explained, “I think it freaked me out at first. I almost felt ashamed that I had it and, like, embarrassed.” Katherine told me that it was the multi-family groups that ultimately helped her. She could relate to what others shared, and slowly she was able to extend the empathy she felt for them to herself. Katherine said she was glad she accessed services when she did. “I think that it’s good that I caught it earlier rather than later because I guess there is a higher chance of getting back to your normal, or normal but different, self.” The promise of “catching it early” is not so much prevention for Katherine, but rather maintaining the possibility of a transformed return. There has already been a loss and resulting distress. As with so many people with whom I spoke, her experience of early psychosis not only foreshadowed future illness but also nostalgically reflected back on a normal that no longer seemed viable. The condition is itself a form of grieving.

I asked what her normal-but-different self looked like. She replied:

> Maybe I feel like I’m back in an awkward stage because I don’t know how to disclose. But at the same time, I’m a more thoughtful self, one that kind of knows what improvements she has to make. I think everybody could think about how they could improve themselves or improve the world even.

The normal-but-different self that emerges for Katherine in this scene of early psychosis may not be able to declare an identity or name a condition or experience, but she knows what needs to be made better. What emerges is not a particular type of person, but rather an orientation to the world that makes her capable of undertaking the ethical task of ongoing improvement of herself and her environment. This description felt familiar. It was very much in line with depictions of the standard modern subject available in much of contemporary scholarship, especially that building from Foucault (e.g. 2005), which privileges indefinite pursuit of self-knowing. Emily Martin's *Bipolar Expeditions* (2007) complicates this notion of modern subjectivity by tracing how, for people living under the designation of a bipolar disorder, maintaining the everyday practices of self-management and improvement continues alongside sociocultural milieus that tout, even demand, mania.

Katherine's new normal is not merely an attempt/failure at modern subjectivity as Foucault provides. Instead, she offers an *awkward*, timeline-transgressing version that highlights ethical commitments to improvement but also a not knowing how to name herself or her experience. Her new self is a corollary to dominant forms of subjectivity that ask the subject to be knowable and coherent, but one that persistently resists doing so. The possibility of this awkward modern subjectivity lies not in Katherine mastering technologies of the self, but in what she might disclose when she learns how. In part, this dissertation is an act of listening for indications of what such awkward modern subjectivity might entail.

I then asked Katherine what she thought prevents psychosis, and she responded simply, "Healthy habits, healthy behavior, and empathy." And so, for Katherine, psychosis produces empathy, perhaps the same empathy that can prevent psychosis. At first I did not see the significance of Katherine's invitation to think about psychosis as producing empathy. I only heard what was obvious about her claim—that going through psychosis would make a person more empathetic to the ordeals that others suffer and that, in turn, would make her more empathetic to herself. My fieldwork has taught me that such initial interpretations rely on the comfort and certitude of the very practices of psychiatric diagnosis that my work is attempting to interrogate. They question (only) her reality as the premise. As I (re)read her provocation now, I notice something more in what she was telling me. If I refuse to know in advance that her empathy is *caused* by her having recovered from psychosis, of no longer being in it, what else could psychosis be? What would it mean if psychosis itself could generate rather than foreclose shared understanding?

In US psychiatry, psychosis is defined as "a brain disturbance that impairs a person's ability to discern reality" (Tyson et al. 2020:1). It refers to a pathological state that is not itself a particular illness or disease, but can be a symptom of one. The presence of psychotic symptoms (delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms) characterizes a number of psychiatric diagnoses known as Psychotic Disorders, with perhaps the most well-known being schizophrenia. Psychotic symptoms can also present as features of other psychiatric conditions, including depression. In this way, psychosis is not an "official" psychiatric diagnosis. Even so, it is often informally used as one.

This ethnography extends anthropological considerations of psychosis by attending to the domain of psychotic experience at the edge of adolescence. In *Madness and Civilization* (1965) Michel Foucault uses childhood as an analogy to describe the infantilization through which madness is not only disempowered but relegated to a minority status vis-a-vis reason. He explains, "Madness is childhood. Everything at the Retreat is organized so that the insane are transformed into minors" (1965:252). Anthropological inquiry on madness and psychiatric phenomena has extensively examined this radically other adult, who is often infantilized, resituated, and cared for as a kind of ward in structures modeled on the family. The prioritization of an adult subject was echoed in an interview I conducted with a child and adolescent psychiatrist who works in early psychosis. He lamented the lack of a "developmental approach where we would be looking at a growing kid—what do they need if they are developing psychosis? Rather, we are just dumbing down for early teens what we are doing for people with chronic schizophrenia." Since both anthropological and psychiatric knowledge rely on notions of psychosis that are refracted through a retrospective lens of the chronically ill adult, it becomes critical to ask, what is psychosis in childhood and adolescence? This question guided my study.

For Katherine and many of the other young people whose stories fill the following pages, psychosis is neither merely a disorder nor a symptom. It is a "good enough" diagnosis among psychiatric diagnoses that feel wrong, especially schizophrenia. In the following accounts, psychosis is what happens when people do not sleep, or get overwhelmed. It is when things don't make sense, an impetus to act when stuck, to change. Psychosis is, in Katherine's words, what you "probably try to forget." From this perspective, psychosis can be seen not as a particular kind of experience (i.e., one that does not cohere to reality or is categorically extraordinary), but rather as a relationship between a person and what they notice that produces a connection to experience that is difficult to escape or leave behind. As Katherine's definition suggests, psychosis is experience she cannot, but must, forget. Not being psychotic means successfully rewriting experience as memory.

If, as Lacan argues, "a subject originally represents nothing more than the following fact: he can forget. Strike out that 'he'" (1992:224), the stakes of this relationship are not only perception, but also existence. The pronoun is instantiated by the forgetting, not the other way around. For Lacan, subjectivity is a certain forgetting—of being in *that* moment, of its reality. There is an imperative to forget, not only whatever *it* is, but also that we forgot. Katherine probably tries. The threat here is not in return, as it would be with repression. Instead, what torments is a stubborn persistence, something that cannot be forgotten even as it must. Risk of psychosis therefore is psychiatric and existential, a threat to mental wellbeing and subjectivity.

I will show how psychiatric rationality attempts to make sense of psychosis, even prevent it, through practices of this kind of forgetting. In the following chapters, you will read about how psychotic experience is circumscribed as a warning sign, not itself inherently pathological, when it can be attributed to a certain developmental period (childhood), temporalized as fleeting (not long enough to count as fully realized psychosis), or personalized as existing in one's own mind (lacking conviction). Through such psychiatric practice, the subject is preserved as she can maintain distance between herself and the vitality of experience that does not cohere or resonate with others.

Perhaps psychosis then is what must but can neither be forgotten or commensurated. Descriptions of thoughts that linger, feelings that will not go away or that incessantly return, difficulty in getting beyond the afterward of an experience—all of these characterize the torment of psychosis, not only for individuals but for families. In line with Katherine's thinking, psychosis is no longer defined exclusively by an extraordinary quality, but rather by an enduring affective presence—not just an extreme version of the ordinary, but an idiosyncratic response to something ordinary that refuses to resolve into memory. The aberrant residual. Such a notion troubles and expands the widely held conceptualization of psychosis as episodic, something that comes and goes. The rupture is more wave than event.

Extensive scholarship on psychosis builds on Foucault’s depiction of madness being contained, confined, and silenced through historical processes that include hospital ships, asylums, and more recently, medications and prison. My study of early psychosis and adolescence shows that psychosis continues to evade rationalization not necessarily because of its extreme otherness—its extraordinary character—but in its proximity to reality. In the space of early psychosis, the symptom evades discernment in its ephemerality, its subtlety, in its ability to hide in the everyday, to be “true.” Although anthropology has widely theorized psychosis as extraordinary, my fieldwork poses a new question: if psychosis can be so ordinary, how mad must the ordinary be?

This ethnography joins a long anthropological legacy in the study of psychosis and mental illness more generally. Since its inception, anthropological inquiry has worked to reveal how institutions, including psychiatry, establish and reform notions of normative and pathological mental experience and how these attributions are culturally influenced (e.g., Benedict 1934; Luhrmann 2000). Anthropologists have shown that the experience of mental illness and the trajectory of its manifestation and impact are tied to sociocultural factors and subjective experience (Good 1977, 1992, 1997; Kleinman 1988). Anthropology has contributed to a rich understanding of psychosis as related to political and economic disenfranchisement (Scheper-Hughes and Lovell 1986; Scheper-Hughes 1979), social dispossession (Hopper 1988), and political violence in postcolonial settings (Pandolfo 2010, 2018). Anthropologists have also explored the ways in which individuals craft identity in relation to psychiatric diagnoses and treatment (Estroff 1981, 1989; Estroff et al. 1991); the subjective excentricity of psychosis (Corin 2007); how treatment facilities not only isolate individuals from community but also create space for mental illness in community (Nakamura 2013); and how people endure these extraordinary conditions (Jenkins 2015; Jenkins and Csordas 2020). This scholarship establishes mental illness, particularly psychosis, as a complex and dynamic phenomenon influenced by political, social, cultural, and psychological factors.

From this nuanced consideration of mental illness, anthropologists have extensively engaged with psychiatric efforts to reduce and fix psychological suffering into discernible diagnostic categories. Anthropological inquiry shows that psychiatry's external status in relation to medicine depends largely on its inability to scientifically stabilize its object (Lakoff 2005; Martin 2007). As definitive disease biomarkers remain elusive, psychiatry knows its objects through psychometrics and clinical history. In mainstream US psychiatry, the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) provides rubrics to support consistent psychiatric diagnosis. It is used to standardize treatment, measure accountability, process financial reimbursement, and conduct research. Anthropology has described how these diagnoses are stabilized by processes that conceal: the role of historical contingencies in the formation of the Post-Traumatic Stress Disorder (PTSD) diagnosis (Young 1995); the institutionalization of pharmaceutical reason into psychiatric knowledge production and use (Lakoff 2005); the influence of the cultural life of diagnostic concepts outside of biomedicine (Martin 2007); and the political and economic influences on the development and dissemination of scientific findings (Lock 2013).

Walking in a Dangerous Space is about the intersection of two fields of concern in the US where reason comes into question—adolescence and psychosis. Building from the robust canon referred to above, I attend to the way diagnostic criteria for early psychosis, or the earliest stage of psychosis symptom onset, attempts to mark the incipient line between reason and unreason and to the effects of such attempts. As the early psychosis field attests and the ethnography illustrates, applying diagnostic criteria is difficult, if not impossible, through standard clinical practice. Within this fieldwork, this difficulty was attributed to limitations of the diagnostic criteria themselves, to training limitations and practice inconsistency across providers and institutions, to the insufficiency of self-report and memory of patients and family members, and most commonly, to the lack of a singular, fixed, or stable biomarker. Such attributions hold steady the idea that psychosis is fundamentally a discernible phenomenon that, with adequate technology, can be distinguished from experience that is not psychotic. By closely attending to the attempts, clinical and otherwise, at discerning the earliest symptoms of psychosis, this dissertation offers another possibility—that definitively distinguishing psychosis from reality may be impossible, at least partially because reality already contains the possibility for errant thoughts, false images, senselessness, and erroneous hearing.

By detailing diagnostic practices that individuals, families, and psychiatric professionals use to identify psychosis, particularly in its early stages, I show how tenuous the distinction between normal adolescent experience and early psychosis is. Diagnostic practices use highly nuanced and relational distinctions (paranoia/fear, delusion/belief, depression/sadness, real/not real) and mix different forms of knowing (parental, lay, professional) to ascertain whether or not a person has experienced psychosis that is attributable to a psychiatric illness. Identifying psychosis early entails making distinctions between misperception and imagination, grandiosity and ambition, flatness and apathy.

I will argue that such distinctions operate not only as identification but also as intervention. Establishing a timeline (Chapter 5) or determining conversion (Chapter 2) operate not only for diagnosis but also as pedagogy—a lesson for the subject on cultivating and maintaining distance between herself and experience, on forgetting. As such, they not only mark a distinction between psychosis and adolescence, as a biomarker might, but rather constantly, through attempts and failures, (re)establish what constitutes psychotic and adolescent experience. Tracing the quandaries of such attempts not only broadens characterization of psychosis beyond the spectacular but also extends the possibility for mad realities, magical timelines, edgy lives, and authoring unreason without discounting the anguish of such endeavors. Such attention also highlights the harm enacted by the distinction itself, or maybe even of taking for granted the possibility of distinction at all. The practices that are required to maintain one's status as not, or not yet, psychotic take constant vigilance and exact significant losses, including sacrificing laughter and even of a part of oneself. In part, this manuscript is an ethnography of that toll.

I explore moments when reality comes into question, when unreason first demands that reason demonstrate itself as real and reason comes up short, but maybe not short enough to be explained away as pathology. Martin ends her *Bipolar Expeditions* by making a connection between the darkness of manic depression and the darkness we all face:

> People living under the description of manic depression have keen experience of this insight; indeed, they cannot avoid it. They cannot help wondering whether the dance will ever be incandescent enough, the lawn thick enough, to banish the darkness. This perspective, as much as the wild energy of mania, is the essential resource contained in manic depression (2007:280).

Along with Emily Martin and others, I understand that such perspectives tell us more about not only psychosis (i.e., misperception, hallucination, delusion) but also our social world.

Now, as much as ever, it is incumbent upon us to pay attention to the keen insights of those who live on the edges of experience. This effort should not seek to find Truth, but rather other "faulty plentitudes."[1] Such representations attain their truth not necessarily in validity but rather through a rigorous incompleteness, an openness that hints at the excesses that categorical knowledge necessarily forecloses. What follows is an attempt at such a representation of the promising anguish of early psychosis clinics, what I think kept bringing Katherine and me almost to tears. I am not attempting a true representation of psychosis, but rather a volatile truth,[2] one in which I am necessarily implicated.

This project is about how institutions, primarily psychiatry and family, come to know psychosis. Therefore, it is epistemological to some extent, and premised, on the notion that early psychosis marks a limit of epistemology. As my fieldwork continued, I became increasingly attuned to the potentials of unstable epistemologies. I began to recognize them not as a not-knowing, but rather a refusal of knowing already. This lesson, learned in the course of ethnography, not in anticipation of it, most closely describes what I now understand to be the anthropological method of this study—prolonged engagement with the particular, the surprising,

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[1] I am inspired by the way James Boon describes the dangers of catalogues in his *Verging on Extra-Vagance.* He explains, the dangers "lurk whenever a list's selectivities start exuding diagnostic undertones that seem foundational (or, some would say, 'essential')" (1999:272). He offers the reader an alternative engagement, a kind of (re)reading, to "help a catalogue transmogrify into something like a 'second' faulty plenitude" (1999:272). The concern here is not with the objectivity of the categorization (is it actually a hallucination) nor its translation between "cultures" (delusion here/belief there). The concern is with the way the categories start to confuse possible definitions with exclusive ones, shutting down dynamic and relational formations.

[2] Here I am guided by Boon's consideration of Thoreau's discussion of the limitations of description. Boon quotes Thoreau:

> I fear chiefly lest my expression may not be extra-vagant enough, may not wander far enough beyond the narrow limits of my daily experience, so as to be adequate to the truth of which I have been convinced. Extra vagance! It depends on how you are yarded… I desire to speak somewhere without bounds; like a man in a waking moment, to men in their waking moments; for I am convinced that I cannot exaggerate enough even to lay the foundation of a true expression (Thoreau 1985:580-81, as cited in Boon 1999:xiii)

True representation escapes. Even preservation of the object itself, in one case leaves as they change color in the fall, is inadequate. Preservation stops death and therefore as a representation cannot accommodate the true symbolic value of watching leaves changing color because part of the experience is witnessing them die. In this way, scientific representations, even or perhaps especially objective ones, fall short in describing something like autumn hues. Approximating the volatile truth, the unstable ground that both defines and goes beyond the object of inquiry, necessarily exceeds description and requires instead an always inadequate exaggeration.

confusing, to what refuses explanation or generalization but also to what is too easily clear or obvious. The method of this study is more ethics than procedure, a practice of decidedly unresolved attention.

Fieldwork

The fieldwork for this project was rooted in early psychosis clinics in the US, but this ethnography is not about clinical practice. Rather, the clinics offer a point of entry a space where the interaction between psychosis and adolescence becomes overt. I collected the stories featured in this ethnography during 12 months of fieldwork across two specialized early psychosis clinics housed in psychiatry departments at academic health centers in the western United States. This dissertation fieldwork stems from a time between 2007 to 2013 when I was involved with a Robert Wood Johnson Foundation study called Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP). EDIPPP not only helped compel me toward this current research but also had an impact on the formation of a prodromal diagnostic practice in the US.

During my fieldwork I observed daily clinical operations, including team meetings, diagnostic interviews, medication management visits, family psycho-education events, and therapy sessions. I interviewed young people receiving services, their family members, clinicians, and trainees. While in a few instances I was able to follow young people in a more consistent way, in most cases I was only able to observe each individual in clinical interactions once or twice throughout my fieldwork. Additionally, I attended early psychosis conferences and education events. I also conducted a series of interviews with clinicians at a third clinic similarly situated at a health science center of a university.

The clinics focus on serving adolescents. For more than a century, psychiatry has understood the onset of psychosis to occur in adolescence, broadly defined as 12-30 years old. Providing services to adolescents defined in this way requires that the clinics extend across typically distinct domains of child and adult psychiatry. The distinction is not in name only. There are often deep and rigid structural divides between the domains instantiated by reliance on entirely different funding streams, insurance arrangements, and credentialing requirements. Additionally, psychiatric subjects are positioned differently within each domain, impacting how ideas such as responsibility, insight, and capacity are advanced in diagnosis and treatment. Transgressing this division in the interest of providing services to youth as they “age out” of the child system is often exceedingly complicated. In fact, the only time anyone used the term “madness” in an interview, it was a mother describing the experience of dealing with her daughter turning 18 in the context of US psychiatry.

Neither of the two clinics where I conducted observation accepted Medicaid, which means all of the patients accessed services through private health insurance. For this and other reasons, including the geographic context, the clinics typically served a higher socioeconomic population. In both cases, young people and families seeking out services for early psychosis who do not have private health insurance were referred to nearby state-funded clinics that are generally public-private partnerships. These programs use grant dollars to support services provided to young people in the at-risk stage and also bill Medicaid for diagnosis and treatment for first-episode psychosis as well as other mental health issues that commonly present alongside early psychosis (i.e., depression, trauma disorders).

Young people arrived at these clinics because someone suspected they were experiencing “early psychosis.” Early psychosis is a broad term meant to describe the period wherein a young person has either just experienced a first episode of psychosis or is experiencing early warning signs of psychosis characteristic of an at-risk stage.[3] The clinics also served a handful of individuals with more protracted mental illness that extended beyond a first episode and often into a recovery stage of schizophrenia or other psychotic illness. These individuals tended to have long-term connections with clinic staff, demonstrating that diagnostic boundaries between clinics tend to be blurry and relational rather than clearly demarcated and inflexible. Since I was only in outpatient clinics, I did not observe anyone who was assessed through involuntary mental health treatment mechanisms, although many of the young people openly objected to the idea that they had a psychiatric condition. Young people are typically offered two years of services through the early psychosis clinics.[4] Young people served by the clinics were often also offered participation in multiple research studies, providing access to treatment innovations such as nutritional and exercise interventions, pharmaceutical trials, imaging studies, and other studies, including mine.[5]

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[3] In US psychiatry, early psychosis roughly comprises two stages: (1) at-risk for psychosis and (2) first-episode psychosis. These two stages share a sign and symptom profile distinguished by severity and duration. First-episode psychosis delineates an event of sustained psychotic experience (e.g., hallucinations and delusions) during which the person experiencing the episode has full conviction that what they are experiencing is real despite the counter perspective of clinical or research staff. When a person is at-risk for psychosis, signs and symptoms are more brief and attenuated. They do not meet the criteria for severity and duration of a diagnosable psychotic disorder according to the DSM-5. Clinically, young people in an at-risk phase are seen as having maintained insight into the potential that what they are experiencing may not be “real.” Even in the midst of significant clinical research over the last decade, there is a lack of validity for predicting psychosis onset. More young people who are identified as at-risk for psychosis do not go on to experience a psychotic episode than those who do (Cannon et al. 2008).

[4] Both clinics were guided by a coordinated specialty care (CSC) model that is considered evidence-based for first-episode psychosis (Dixon et al. 2015). In this model, patients are seen by a multidisciplinary team that provides a range of services, including medication management, individual therapy, occupational and educational support, psycho-education, and group therapy such as multi-family group therapy (MFG). As part of the early psychosis movement, the clinics operated from the viewpoint that psychosis is common and treatable and that identifying psychosis early in its course improves outcomes and promotes recovery. Since each of the clinics was housed in a department of psychiatry at a health science center, the institutions also offered other out-patient psychiatric services (e.g., depression or eating disorders clinic) as well as limited (number of beds) in-patient facilities. Coordination between the early psychosis clinics and other departmental clinics was common, but in no way seamless.

[5] The clinics worked in direct partnership with ongoing early psychosis research projects within their departments. In both cases, there were staff who worked as part of the early psychosis clinic in addition to working on independent but related early psychosis research studies. This cross staffing created opportunities for cross referral.

The "clinic"[6] is a gathering together once or twice per week of attending psychiatrists, psychologists, psychiatric nurses, therapists (e.g., social workers, counselors), training psychiatrists (residents and fellows), medical students and other professionals (e.g., occupational therapists). None of the clinics I worked in had designated space in the institution, and few of the clinical staff had positions dedicated full time to early psychosis.[7] After an initial clinical team meeting, team members would either gather for a collaborative intake assessment[8] or disperse to private offices spread across multiple floors to begin seeing patients.[9] Throughout the afternoon, young people and families would sit in a designated waiting rooms until their clinician came and personally walked them back and forth between offices. The movement of patients, family members, and clinicians through all these appointments was coordinated through texting and with the help of front desk staff. This process resulted in the clinics feeling rushed but eerily

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Such partnership allows clinical staff to benefit from information produced through the more intensive assessments characteristic of psychiatric research (e.g., Structured Clinical Interview for DSM) and for clinical researchers to extend their study participants with psychiatric services not included through research.

[6] Both clinics I observed ran as half-day and started with a lunchtime meeting where the team went through their patient rosters, carefully attending to "hot spots" (situations where there was a concern of some sort) and successes (e.g., graduations, getting a job). The teams often used this time to plan or process group therapy or psycho-education sessions as part of an ongoing effort to expand and enhance services beyond one-on-one treatment. The teams would conduct an overview of any intake appointments scheduled for the afternoon by reviewing information gathered about the young person and their family, including especially any prior experience with psychiatry, and any results from research assessments (Structured Interview for Prodromal Syndromes, SIPS, scores).

[7] Most of the staff who make up the clinical team, and certainly the trainees, are also assigned to other clinics (e.g., continuity care clinic, inpatient) or other departmental duties (e.g., education, research). This means only a fraction of their work week is dedicated to the early psychosis clinic. Therapist more often maintain a full case load specific to the clinic, scheduling patients for therapy more continuously throughout the week.

[8] Intake procedures differed slightly across the two clinics. In one clinic, intake interviews were conducted directly after the clinical team meeting by the entire team assigned to the young person. In the other clinic multiple intake interviews were done with each incoming patient by individual team members or smaller groups. In each case intake interviews last multiple hours and include conversations with young people alone, the parent alone and then everyone together.

[9] In and around the intake interviews, psychiatry trainees (residents and fellows) would meet with patients for medication management (typically 15-30 minutes) and therapists would have weekly appointments to provide therapeutic interventions, most typically Cognitive Behavioral Therapy (CBT). The attending psychiatrists would alternate between seeing their own patients and rotating in and out of trainee appointments to give supervision.

quiet, a scene of hushed but important conversation along long hallways of closed offices with white-noise machines whooshing outside every other door.

Some Notes on the Text

Pseudonyms

This ethnography focuses on clinics that serve a very small population of people accessing services for a condition that is widely stigmatized and often disorienting. As such, I see the need for extra precautions in recounting this fieldwork. All names are pseudonyms.

In a further effort to obscure the identities of participants in the study, I have also decided not to identify the clinics where I completed my research or their locations. I considered creating pseudonyms for the clinics, which would have allowed me to describe the ways in which they are distinctive (e.g., staffing structure, clinical organization), but I have elected to refer generally to both of them as *the clinic* or *the clinics.* This decision forecloses much-needed structural analysis of the clinics and the institutions in which they are housed, but doing so allows me to better protect the identity of individual participants.

Additionally, I have altered or omitted some details in some of the descriptions for the same reason. These alterations include not providing a gender in some instances, adjusting age slightly, or modifying other contextual information**.** I have attempted to adjust details that are less critical to the particular narrative or analysis, but I recognize that the factors that make up identities always influence experience. I only comment on the race/ethnicity of individuals if it came up in their self-narration. In clinical observation, I was often not privy to such information and so any attribution would be my own and therefore vulnerable to misrepresentation and bias.

Verbal Consent

I gained general permission for observation directly through the medical directors of each clinic. As part of that process, I attended a team meeting at each site to introduce my study to clinical team members. At this point, I encouraged the clinicians to discuss the study with myself or the medical director and to let either of us know if they would prefer to opt out of the study. I acknowledge that it would have been difficult for any one clinician, especially a trainee, to opt out of the study when the rest of the clinic agreed.

Once I had gained institutional permission, I used verbal consent to attain permission from individuals for observation. Verbal consent is an informed consent process that does not require a signed consent form. Instead, the researcher introduces themself and the study and then circulates a study information form that includes basic information. They then ask individuals to verbally agree to participation. It is a common practice in observational studies where risk for adverse effects due to study participation are minimal and attaining written consent would negatively impact the interaction being observed. Verbal consent practice is challenging but necessary in psychiatric clinics in ways that have been detailed elsewhere (Reyes-Foster 2019). Principally, comprehensive descriptions of the study and distribution of study materials are sometimes impracticable in situations where people rotate in and out of ongoing interactions and when the process would infringe upon or negatively impact clinical services.

In an effort to protect young people's and their family's right to decline participation in the study, I asked clinicians to give them a chance to decline being observed when they checked into their appointment before meeting me. If they agreed to my observation, I then introduced myself and the study, highlighting the voluntary nature of the observation, and offering an information sheet. Very few participants were interested in the sheet. Refusals were very rare, but they did happen. In the vast majority of cases, everyone quickly agreed, saying "hope it will help" or something similar, and then quickly returned to the clinical business that my consenting procedures had intruded upon. I worried constantly about the balance between attaining what I thought would constitute "real" informed consent and impeding clinical practice. I was relieved when, for the first time, a mom refused to have me observe her intake interview. I remember her apologizing and saying something like, *just not the first day*. It is a good reminder of the imposition that my presence surely made on these interactions. Because I was not always able to obtain basic verbal consent, I do not present data from interactions I observed when I was not able to at minimum introduce myself as a researcher, highlight that my observing was optional and not clinically useful, and offer to leave.

Quoted Material and Observation

I have edited quoted material to enhance legibility, but only as minimally. Any translation from spoken to written stories runs the risk of appearing more coherent or final than how they were offered. In this field site, this concern is doubly important in that the young people I spoke with are being seen in the clinic under the premise that what they experience and say may not make sense. Therefore, there is a risk in representations that edit too little or too much in the interest of legibility. As I write I must worry about instilling both too much and not enough coherence in each of the exchanges highlighted in the stories that follow. As a reader, I invite you to worry about that too. Interviews were tape recorded and transcribed. As such, I was able to check quotes from those exchanges for accuracy. Exchanges collected during observational research (e.g., clinical team meetings, intake interviews, and therapeutic visits) are based on field notes I took during the interaction. As such, this material is especially vulnerable to error. If I have used quotation marks in those sections, it indicates that I was able to capture, to the best of my ability, verbatim dialogue. Otherwise, I use summary language.

Madness/Psychosis/Mental Illness/Alterity

With the exception of the mother I mentioned earlier, none of the interlocutors in this study used the term *madness* to describe their experiences. Therefore, I am reluctant to use the term in this representation of their experience. I am concerned that would not only be a misrepresentation, but potentially a particularly harmful one. And yet, this work builds on robust scholarship that advances a concept of madness that connects the experience of psychosis to historical, cultural, aesthetic, and juridical movements in important ways. Additionally, while my work does not attend directly to the advocacy work that is foundational to the recovery (Deegan 2002; Myers 2016), peer support, and lived experience movements (Jones et al. 2013), I am inspired by this work and entities such as Mad in America (https://www.madinamerica.com). Following these scholars, I see the concept of madness, not the label, to be a potential tool for rethinking US psychiatry. As such, I build on the work of Michel Foucault, Gladys Swain, Stefania Pandolfo, and many others to use the term “madness” specifically in reference to the sociopolitical subjectivity of experience that exceeds rationalization. One example is the work of Laurence Ralph that shows how a particular elevation of madness, one that removed its stigma and shame, enables a collective practice of care (2015). Psychosis then can be considered through madness, but in this study they are not synonyms. Psychosis can also be part of a highly rationalized psychiatric apparatus. I use “mental illness” to refer to this apparatus. My use of “alterity,” inspired by the work of Michael Taussig (2017) and Stefania Pandolfo (2018), refers to the condition that arises for subjects as they endure practices, psychological and political, of othering. Such practices are necessary to subjectivity (subject formation) but also destabilizing and violent.

Walking in a Dangerous Space

This ethnography is about people, typically young (14-25) but not exclusively so, and families seeking care in early psychosis clinics and the psychiatric professionals who provide them with services. I offer insight into living and working in the midst of potential psychosis. I take Katherine up on her invitation to think of psychosis as tied to but beyond psychiatric categorization. Doing so means attending to psychosis as experience rather than psychiatric symptom, as something beyond a label that can be assigned to individuals correctly or incorrectly. My study neither tested nor tabled the question of what early psychosis is or whether or not early psychosis can be identified and treated. Instead, I show how experience comes to be declared or dismissed as psychosis iteratively through conversations between young people, clinicians, and family members. Diagnosis then proceeds both formally and informally through processes that attempt to order odd, fleeting experiences by chronology and conviction, thereby rationalizing what resists making sense**.** And yet, in early psychosis clinics, diagnostic uncertainty continues to simultaneously demand and destabilize the clinical application of psychiatric categories. I attend carefully to moments of failure, resistance, and destabilization in early identification and intervention. Adequately describing these psychiatric practices runs the risk of seeming equivocal or even inchoate. Resolving this problem in the writing feels unrigorous and unethical especially because it is within these sites of profound uncertainty that alternative possible explanations and desires emerge—to be personally addressed by a voice that no one else hears, to be both worthy of trust and psychotic, to be listened to. I have constructed chapters to open up to such alternatives.

In Chapter 2, I introduce prodromal psychosis as a spatiotemporal scene in which individuals are located depending on how they relate to symptoms of psychosis. I trace observation of intake assessments and therapeutic appointments to show how experience recounted to clinicians by young people and their family does and does not become a symptom of psychosis. Diagnosing early psychosis relies on *conversion*, a determination of how convinced (convicted) a young person is/was in their suspected psychosis. In order to assess conversion, young people are asked time and again to reflect rationally on irrationality, to qualify, quantify, and temporalize experience that resists such management. Within efforts to identify early psychosis, symptoms move and morph between the "normal" and "abnormal," seemingly refusing to either vanish or concretize—they are (im)material, or as one clinician describes, *everything and nothing*. For diagnosis, symptoms of psychosis must be made to materialize through practices of collaborative noticing that attune to temporal (i.e., frequency, duration, but also age), affectual (i.e., psychotic feel, distress), and everyday (i.e., school attendance, texting practices, pot smoking) information. This attunement, best achieved through structured scientific instrumentation, at once relies on and doubts various forms of knowing, including knowledge of self as well as parental and clinical knowledge. Tracing one such assessment, I show how the demands of identification reach into every crevice of life, revealing unreason not only in the individual but also in their sociocultural environment.

In Chapter 3, I consider what one clinician called the "edge of adolescence." This edge between normal adolescent experience and early psychosis is marked and maintained in scenes where familial, clinical, and scientific knowledge and practice work in dynamic ways to retain, form, and reimagine livable, ethical lives in the midst of staggered worlds. Interviews with young people, family members, and clinicians provide multiple views of, and from, this edge, highlighting its looming influence and impossible demands. Highly nuanced deliberations of risk proceed against the backdrop of childhood unreason, offering the possibility that adolescence is a scene where psychosis comes on but also where it is supposed to be made to go away. Early psychosis then becomes a consideration not only of new and emerging symptoms but also of experience that becomes concerning because it endures, making the condition a question of onset but also history. The edge emerges as both precipice and action, a very dangerous space where trustworthiness, curiosity, and ways of relating are carefully reconfigured over and over through practices of worried hopefulness. Those caught up at the edge must walk the line between avoiding risk and allowing everything to become circumspect.

Throughout my fieldwork I watched as young people were asked again and again to describe their experiences at this edge. Their responses felt earnest but truncated. In Chapter 4 I wonder what it was that was missing. What was being silenced, and to what effect? Tracing diagnostic interviews and therapy visits, I show the pernicious way figurative description is deadened in service of literal characterization, even when poetics and metaphor may be uniquely up to the task of “true,” or adequately extravagant, representation. Extending from Foucault’s archaeology of silence, I show how such quieting of certain forms of explanation operate beyond the well-known culprits of neoliberal individual responsibility and medicalization. Mobilized as protective, these silencing practices permeate experience in a way that not only makes it hard for young people to describe their experience to others, but for those suspected of experiencing early psychosis it mitigates the potential for catharsis. Inspired by Stefania Pandolfo’s “Cervantes Stage” (Pandolfo 2018), I raise a concern that within the space of early psychosis, access to such descriptive possibilities is refused at the very moment it may be most necessary.

In Chapter 5 I shift attention to how psychiatric practices rationalize experience suspected as psychosis through practices that attempt to order unreason into timelines. I consider how timelines are fashioned, how they are used, when they become problematic, and what they do. I then look to the extraordinary experiences of time that people on the incipient edges of psychosis described to me to open up the possibility that timelines, a technique compromised by their reductive tendencies, could become expansive enough to accommodate radical difference. The chapter is about clinical timelines, but more than that, it is an attempt to better understand how people process experience in and through institutions such as psychiatry, family, and time. It asks how we might learn from the extraordinary to apprehend experience in another way.

By framing psychosis as a symptom of mental illness(es), rather than a disease itself, providers in early psychosis clinics are able to refute a definitive connection between psychosis and schizophrenia. And yet, this effort, an attempt to mitigate stigma, also fixes young people and their families in an interminable, if slightly removed, relationship with psychotic illness. In Chapter 6, I show how diagnosis of everything and nothing manifests what one mother calls not-yet psychosis. Building on Elizabeth Davis (2012), I consider the diagnosis of prodromal psychosis as a truth game to demonstrate the ambivalence of the practice of determining psychiatric risk status. I argue that this relational and doubting quality in the attunement to symptoms may render this psychiatric diagnosis uncertain and unstable relative to an ever-sought-after biomarker, but perhaps “more true” in efforts to approximate a characterization of psychosis. Through the lens of the truth game, psychiatry’s commitment to preemption reveals diagnosis within early psychosis clinics as an ambivalent practice where the terms of institutional belonging are contingent upon determinations of pathology and potential alterity.

In Chapter 7, a conclusion of sorts, I recount a conversation I had with a young woman, Josephine, as an illustration of living in such ambivalence.

CHAPTER TWO | Everything and Nothing: The (im)materiality of prodromal psychosis

I spent one afternoon observing medication visits with an attending psychiatrist. People were ushered in one after another to check on medication side effects or worsening symptoms. That day, there were too many of us in the cramped office. I sat on a folding chair just behind two other other researchers in training. The patients graciously accept the tight and overly scrutinized conditions.

Visit after visit, the psychiatrist casually chatted with his patients. He knew everyone well. There were odd delays in the conversation as he toggled back and forth between talking and reviewing the patient file displayed on the large computer screen sitting between them. The sound of his rapid typing, interspersed with long pauses, signaled that something worthy of notation has been said and noted. Throughout the day, medication dosages were sometimes increased or decreased. New medications were added. But, by and large, most of the treatment plans were upheld. In general, the psychiatrist used the time to address symptom management or issues with medication or treatment adherence through various approaches to problem solving (e.g., what makes it hard for you to make it to therapy?) or offering solutions (e.g., switching to an injectable).

After one visit, the attending psychiatrist rushed off to another office for a consultation on an ongoing diagnostic interview. He suggested I follow. As we hustled along the hall he remarked on a young woman we had just seen: “She would be perfect for your study. She has everything and nothing.” He knew I was focused on the prodrome (the stage prior to onset). His comment captures particularly well the (im)materiality of psychosis in an at-risk stage or during a prodrome. Early symptoms of psychosis can be so subtle and brief that they are at least partially characterized by their observable absence. They disintegrate before capture and hide in the past or behind other phenomena (e.g., psychiatric symptoms of depression, anxiety, obsessive/compulsive disorder [OCD], or adolescence). In this way, they are nothing. And yet, for the people who seek out treatment, as well as those who care for them, they are often highly distressing and vast. They affect many domains of life, seriously impacting social relationships, behavior, and functioning. Recognizing the prodrome demands not only noticing what is no longer or not nearly present, but also wading through an array of behaviors (e.g., substance use, excessive spending), experiences (e.g., hearing voices talking about you, rumination, racing thoughts), concerns (e.g., unmet parental expectations, compounding mental health issues), and social phenomena that may or may not be something, but are already everything.

In this chapter, I take his comment as an invitation to think about prodromal psychosis through the lens of *everything* and *nothing*. First, I will describe how psychiatry attempts to reify everything and nothing into a clinically meaningful category. Next, I describe how an acknowledged lack in the predictive validity of early psychosis warning signs renders prodromal psychosis present in its absence as a qualified/unqualified codification for psychiatric diagnosis in the most recent version of the DSM, DSM-5[10]. The *nothingness* of prodromal psychosis then operates on multiple valences, at the level of category and symptom. Rendering everything and nothing is difficult if not impossible in the clinic and requires scientific instrumentation. After briefly introducing one such instrument, the Structural Interview for Prodromal Syndroms (SIPS), the gold standard instrument for prodromal psychosis, I trace a diagnostic interview where it was used. Highlighting various forms of relationality in that diagnostic interview as well as those embedded in diagnostic concepts themselves (e.g., conversion), I transgress a long-held threshold between views of the individual and “social” nature of psychotic symptoms, offering

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[10] DSM-5 is the first issue to not use a roman numeral in the title.

instead the potential of a reparative reading that opens up to multiple, simultaneous, and perhaps most important, relational possible explanations of psychotic experience.

The Psychosis Prodrome

The US has seen a proliferation of early psychosis clinics designed to serve young people who may be experiencing warning signs or early symptoms of psychotic illness. Until recently, an initial psychotic episode was understood as marking the onset of a psychiatric disease, typically schizophrenia. Today, researchers are attempting to establish ways to recognize psychotic illness in a risk, or prodromal, stage, with the goal of intervening early and possibly preventing the marked onset of psychosis altogether (McGorry et al. 2009). Existing psychiatric evidence endorses the efficacy of a wide range of preventive interventions in this early stage, including psychosocial rehabilitation, family therapy, nutrition supplementation, such as omegas, and medication management. Medication treatment in the prodrome can include conservative use of low-dose antipsychotics, although many experts now discourage the practice.

The prodrome places young people in a particular scene represented visually in psychosis stage models such as the one featured below, depicting the natural history of schizophrenia. In these models, symptom experience is charted temporally (often by age) to visually represent the deteriorating course of psychotic illness. Such models support the idea that a person on a psychosis trajectory whose symptoms are not detected or addressed will progress from having no or few symptoms of psychosis to having fleeting and/or weak ones to experiencing fully realized psychotic symptoms and finally into a phase of chronic or residual illness characterized by compounding symptoms and functional disability.

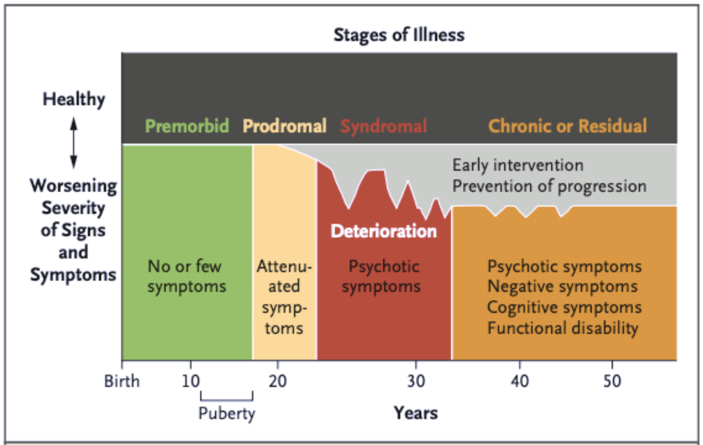

Figure 1. Natural History of Schizophrenia and the Rationale for Preventing Chronic Disease.

Shown are the stages of illness in schizophrenia, the prototypical idiopathic psychotic disorder. Detection and treatment in the early stages of illness, ideally close to the onset of the first episode of psychosis, shorten the duration of psychotic episodes, reduce recurrences, and limit the progressive decline in functioning (deterioration) that occurs in the syndromal stage and leads to the chronic effects of the disease. The syndromal stage begins with the first episode of psychosis and continues through the progressive stage.

Figure 2.1. Natural history of schizophrenia and the rationale for early detection and intervention (Lieberman and First 2018).

In **Figure 2.1.**, early intervention, noted by the light grey space, cuts into worsening symptoms, offering the possibility of thwarting the otherwise inevitable progression toward psychosis symptoms and/or functional disability. In this visual, detection during the syndrome or chronic or residual phases promises to lessen the worsening of symptoms. Detection and intervention in the prodromal stage offers the unique and time-limited possibility for preventing the course of illness before a precipitous decline in "healthy." In such representations, the uncertainty of the earlier moment (no or fewer symptoms) is somehow disavowed by containing the certainty, and stakes, of the later condition. Inchoate experiences become harbingers, carrying a fate even in their negated status as "no" or "few."

Much debate exists in the field regarding whether the psychosis prodrome is a prodrome of any mental health disorder that involves psychosis (e.g., mood or personality disorder) or of schizophrenia specifically (McGorry et al. 2008). As such, *prodromal psychosis* can be used in reference to a stage in a specific disease course, as it is in the visual above, and also in reference to a high-risk phase of various syndromes, as it is below in **Figure 2.2.**

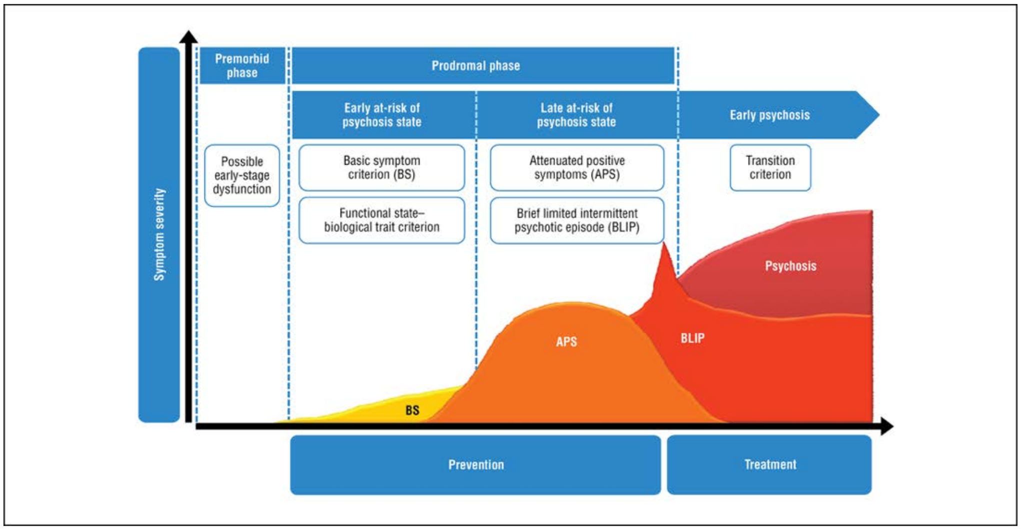

Figure 2.2. Model of psychosis onset from the clinical high-risk state. The higher the line on the y axis, the higher the symptom severity. (Fusar-Poli et al. 2013)

It is no longer under debate that making treatment available during early phases of psychosis is important (Estroff 2012). Within the context of such staged models, psychiatry marks out two fields for intervention—prevention and treatment. The prodrome's boundaries are marked at one end by a premorbid phase with no associated intervention and *early psychosis* at the other end which instantiates the need for "treatment." According to such disease modeling, prodromal psychosis is the only stage in which prevention is possible, which makes its detection critical, especially in the context of the intractability—despite treatment—of fully realized psychotic symptoms.

In the observed clinics, prevention's threshold was most often maintained by diagnostic determinations of conversion.[11] Conversion is an assessment of the degree of conviction a psychiatric subject holds in relation to an idea or experience suspected to be a symptom of psychosis. Placing a young person diagnostically within the prodrome requires differentiation on two sides of a continuum. First, subtle and brief early warning signs must be distinguished from "psychotic-like" experiences common in the general population on the premorbid side. And then, frank psychotic symptoms must be teased apart from fleeting and attenuated (doubted or weak) symptoms on the syndromal end. Within psychiatric logics, a person converts to psychosis when they have full conviction for a sufficient duration in the actuality of an experience or thought that is incommensurate with a shared perception of "reality" or they have a noticeable drop in functioning alongside sustained symptoms that take away motivation, communication, or affect. Conversion is a point at which a person stops doubting a perception, belief, or experience understood to be psychosis as irrational or unlikely to be "real." If an individual is found to have converted, they are no longer in a prodromal stage. If they have maintained doubt that their experience is real, they stay in the prodrome.

If psychosis is a continuum, conversion marks a limit. From a psychiatric perspective, conversion marks the conclusion of the prodrome and start of the syndromal phase of psychotic illness. Conversion indicates that a person is having or has had a first episode of frank psychosis. It is a point of no return after which the best possibility is recovery.[12] Conversion has long been used in the characterization of psychosis as life altering. Along with the less formal, but widely

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[11] Decline in functioning also marks the threshold for individuals who presented with negative symptoms, but this was not as common.

[12] See Meyers 2015 for a discussion of recovery in US mental health.

recognized, “psychotic break,” the psychiatric concept implies a temporal point on a unidirectional process after which one cannot return to an earlier state.

While common in the clinic, these notions do not go uncontested. One psychiatrist lamented the use and implications of such language as he casually turned to me and said: “I hate when people say “psychotic break.” I mean, what broke? Nothing.” These damaging notions are the legacy of psychosis being long considered a component of a severe and incurable biological condition with a rapid and marked onset. Healthy adolescents were thought to transform entirely as a result of the disorder. Emil Kraepelin’s original articulation of dementia praecox, the precursor to contemporary descriptions of psychotic illnesses (e.g., schizophrenia), characterizes the condition by a rapid onset of confusion, depression, delusion, hallucination, headaches, and bizarre behavior. He described dementia praecox as affecting mostly young men ages 16 to 22 and causing permanent and debilitating disability with dismal hope of recovery (Noll 2011). Historian Johnathan Metzl roots Kraepelin’s diagnosis in descriptions by Phillipe Pinel and John Haslam, explaining:

> In 1809, Haslam described an insanity that afflicted adolescents of prompt capacity and lively disposition who suffered a “diminution of the ordinary curiosity” and a marked reduction in “affection toward their parents and relations.” In its most severe cases, according to Haslam, the illness transformed “promising and vigorous young intellects into slavering and bloated idiots” (2009:27).

From the outset, the psychiatric characterization of psychosis has found onset in adolescence and contained the notion of failed promise, ruined intellect, and severed social ties. Contemporary reconsiderations of psychosis increasingly disabuse such overdetermined characterization, offering instead a psychiatrically reimagined psychosis that is not a direct index of a discrete brain disease. Rather, psychotic symptoms are now considered indicators, among other indicators, of a wide range of conditions that are neither untreatable nor necessarily pathological, part of "normal" experience (Van Os et al. 2009). And yet, framed within the historical context, conversion continues to denote a before and after, a transformation from one state to a fundamentally different one.

In contemporary US psychiatry, prevention remains the only hope for disease modification. Existing treatments for fully realized psychotic symptoms, primarily antipsychotic medications and psychosocial interventions, are symptom-reducing rather than "disease" modifying, making early detection and intervention the primary strategy for impacting the onset and trajectory of psychosis (Lieberman and First 2018). When I asked one clinical specialist why so much attention is paid to prodromal psychosis, he responded, "It gives us hope—hope after a long time of nothing with schizophrenia."

This hope drives early psychosis research and the proliferation of clinics. In a 2007 editorial in the *Early Intervention in Psychiatry* journal, Thomas Insel, then director of the National Institute of Mental Health (NIMH), sets his hopes on what he calls preemptive psychiatry. Borrowing from the revisioning of clinical care from medicine, he proposes that the future of clinical care in psychiatry should also be characterized by the four Ps: participatory, personalized, predictive, and preemptive. He calls preemptive psychiatry "the most exciting vision for the future of our field." Acknowledging that it is conditioned on the possibility of predictive psychiatry, an as-yet-unrealized effort to establish biomarkers for psychiatric conditions, his hope is framed in the imaginary, both aspirational and conditional. He argues, current treatments are necessary but insufficient to the task of cure. Rather, he explains, "New treatments may yield greater palliative effects, but one can imagine that our best hope for a ‘cure’ for schizophrenia or autism or mood disorders will come from preemptive interventions” (Insel 2007:05). In the face of centuries of disappointing results altering the trajectory of major mental illness, psychiatry has turned to preemption as the best, perhaps only, chance for cure.

The prodrome is an aspirational concept that is both spatial (a place you can be in) and temporal. The lack of disease-modifying treatment imbues the space of the prodrome with significance and urgency which mobilizes care on both political (e.g., funding for research and services) and personal registers. In this way, prodromal psychosis operates through anticipatory logics where predicted symptom onset demands intervention in the present. In fact, not-yet psychosis may vitalize action in the present even more than fully realized symptoms. The possibilities of anticipatory action not only propel political support for early psychosis services[13] but also influence personal care decisions in interesting ways.

Examples of anticipatory thinking were common throughout my fieldwork, perhaps best illustrated by one mother explaining to me her willingness to accept the psychiatrist’s prescription of medications for her son. She told me the family had reluctantly accepted the increased dose of an antidepressant and the addition of a medication for sleep saying: “[it] really freaked us out because we, you know, we eat organic. Medication was not, not even aspirin. So, suddenly to shift to this heavy medication was a bigger deal, but we saw the need and how important that was.” I asked her what helped her see how important it was. She explained:

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[13] In a 2018 IEPA preconference event I attended titled, Advancing Early Psychosis Clinical Care in the US: Innovations from the Field, Robert Heinssen, director of the Division of Services and Intervention Research at NIMH, declared the past ten years a “decade of progress” for early psychosis intervention in the US. The decade of progress has meant significant expansion of early psychosis services across the US. Heinssen described how in 2008 CSC services were only available in two states. There were fewer than 100 trained clinicians and less than 500 people receiving services. By 2018, CSC services were available in 49 states. There were more than 1000 trained clinicians and close to 10,000 people receiving services.

> [the clinicians] wanted to put a lot of effort to avoid the conversion, and that made us feel more comfortable pushing the [anti-depressant] medication all the way to the top, bringing the sleeping medication to really work as hard as we could. So, one was to avoid the conversion, and two was to get him into the best possible shape before he steps out of the house. And of course, saying if he does convert into psychosis there are many functional people, there are treatments and all that, but if you can avoid that, even better. So, that's something that we were using to go more intense, or kind of be more focused on the task to avoid this conversion, to go the extra mile. Yes, let's accept more medication. Let's accept the sleeping medication. Let's kind of accommodate what we need to accommodate to support him over the next few months that are crucial for this.

The temporality of the prodrome is urgent and anticipatory; it demands action before there are fully realized psychotic symptoms. In this example, anticipatory logics inspire additional use of medications in a more powerful way than symptoms of fully realized, diagnosed, and *treatable* conditions such as depression and insomnia. Anthropology has extensively demonstrated the ways an anticipation framework associated with the contemporary demands action in the present based on concerns for the future through logics of prediction, prevention, and preemption (Koselleck 2004, Adams, Murphy and Clarke 2009).

In this example, it is the threat of conversion to frank psychosis, not the actual symptoms of depression and insomnia, that compels the family to accept a new psychotropic treatment strategy. The family medicates not to treat what is present (symptoms of depression and insomnia), but rather to prevent what the prodrome manifests as threatening but still absent (symptoms of psychosis).

Conversion

Diagnostic distinction between prodromal and first-episode psychosis depends on conversion. Assessing conversion relies on young people reflecting rationally on their suspected irrationality—to qualify, quantify, and temporalize potential symptoms while also describing the degree to which they related to these potential symptoms as "real" phenomena in the world. The idea is that many of us, if not all of us, have experiences, ideas, beliefs that are irrational, but what makes them not psychosis is our ability to doubt them as reason. The demand of rationality is not that we all abandon the irrational. Rather, it is that we know it as such. Virtual reality is just reality if it loses its identity as virtual. That is the danger. Unreason that identifies itself, announces itself as such, is not psychosis.

Determining if someone has experienced an episode of psychosis (i.e., has converted) relies on establishing the individual's level of conviction, or how firmly they hold onto the idea, belief, suspicion, or experience that is suspected to be psychosis. Level of conviction is most often ascertained through psychiatric subjects reporting a percent of certainty (e.g., percent sure) in reference to the experience being interrogated as a symptom (e.g., beliefs, delusions, paranoia, visual or auditory hallucinations). For example:

—I knew they were following me.

—How sure where you?

—80% sure.

Doubt in the experience's veracity, realness, or possibility, represented here by the unspoken 20%, indicates a lack of conviction, which is typical in both the at-risk stage and also for "normal" perceptual experiences such as hearing your name called in a crowded room only to look around and see no one addressing you and deciding you must have misheard something.

Beyond relying on self-report, determining conviction can also rely on reports of observed behavior change. Such corroboration is particularly important when psychiatric subjects are perceived to be unreliable reporters due to compromised insight, denial, or faulty memory. In these instances, the psychiatric apparatus must reach beyond information available to the clinician and rely on relational knowledge and reflection.

This relationality is no surprise. Significant scholarship establishes reality as an intersubjective project. As Sue Estroff explains in her landmark *Making It Crazy*, “most of what we know to be real is what we share with others” (Estroff 1981:217). Estroff demonstrates that becoming “crazy” is a mutually reinforcing condition-identity in which people who are unable or unwilling to produce meanings, realities, and significances that cohere to those produced by others become a product of such failures and refusals. Achieving coherence with others is a matter of establishing not only what one thinks, but what one becomes.

Diagnosing the prodrome is an attempt to identify the earliest indications of emerging incoherence before such becommings. As such, it depends on knowledge that extends beyond clinical observation and knowledge of self in pretty remarkable ways. In one clinical team meeting a clinician presented her intake call with a young man coming into the clinic for an assessment. She moved through his SIPS results, mostly low scores suggesting he had not converted. She told the group he was CHR (clinical high-risk). She then mentioned that the young man sees himself as a talented artist. The attending psychiatrist asked the clinician if the young man was a talented artist. She said she was not sure. She said he seemed as though he could be, but she had not seen his work. The psychiatric assessment of grandiosity here desires to know not only the young man’s self-appraisal of his art but also her subjective assessment of it.

At issue seemed to be deciphering whether the young man has a realistic and attainable (and therefore rational) goal of working as an artist (i.e., is talented), whether he has an unrealistic but age-appropriate dream of becoming an artist (i.e., not talented but believes he is because he is an adolescent), or whether his ambition and self-appraisal is pathologically grandiose and a symptom of psychosis (i.e., not talented but thinks he is as a symptom of psychosis). This conversation, and many others I have observed similar to it, assumed that the belief was either an unrealistic dream, typical of adolescence, or pathological grandiosity without taking seriously, but often addressing, through irony and jest, the possibility of true exceptionality or the absurdity of the entire endeavor.

Psychiatric gnosis, the knowing that vitalizes diagnosis of early psychosis, is then asked to be categorical and visceral. It is not just an assessment of the belief but also that to which the belief corresponds. Examples abound. One young man told his psychiatrist he was going to play for the NHL, and the clinical team asked how good he was at hockey. My point is that knowing what is/is not psychosis requires knowing the psychiatric categories (e.g., delusion, paranoia, hallucination), but also having a particular sense of the lived worlds of these adolescents and those around them.

The clinicians often struggle to assess conviction in intake interviews because more often than not the symptoms have remitted even just slightly, enough to be clinically unobservable—they are/become nothing. And so, diagnosticians generally use retroactive questions: When did you realize you would play in the NBA? How sure were you that you would make a team? How long did you know for sure? In these interactions the demand is exceedingly subtle. Young people are asked to produce rationality (i.e., linear, commensurable, quantifiable descriptions of suspected madness) from within a recollection of an experience suspected to be psychosis. They are asked not to silence or explain madness with rationality—that will be demanded of them later—but for this part of the psychiatric diagnosis, the part where conversion must be ascertained, they are asked to first return to suspected madness and think from within it in order to collaborate with clinicians and their parents in the production of psychiatric truth. In turn, these diagnosticians must assess the potentially delusional quality of adolescent perception, thought and ambition which requires diagnosticians to "know" subjects both psychiatrically (identify signs and symptoms) and also intersubjectively (what a good musician, athlete, artist is). Such knowing is vulnerable to shifts in the evaluation of "talent," particularly where artistic endeavors violate aesthetic preferences of the previous generation (e.g., mumble rap, graffiti) or ethnocentric assumptions. Diagnosing the prodrome, especially the practice of assessing conversion, is fundamentally a relational act that, in turn, impacts the relationships and formation of self it is informed by.

Nothing

In part the *nothing* of prodromal psychosis is the sense that it is not yet and not quite. The category is a prediction, and therefore always resigned to producing an absence (in this case, of fully realized psychosis) rather than representing something manifest. Prodromal psychosis is a set of warning signs that predict illness rather than a set of symptoms that indicate it. In this way, this *nothingness* is part of a larger problem endemic to many early intervention efforts—how to prove prevention.

Limitation in the category's predictive validity means that prodromal psychosis is openly contested as a psychiatric category and is not used in standard psychiatric practice. The effort to include it in DSM-5, was confounded by the fact that despite sustained investment in developing and validating early identification techniques, a majority of young people identified as at-risk do not go on to experience a psychotic episode (Fusar-Poli et al. 2013; Nelson 2014; Yung et al. 2010, 2012).

As it stands, prodromal psychosis is an effort to characterize a stage right before a first episode of psychosis in which young people and families have a suspicion that something is wrong but symptoms are too attenuated and/or brief to meet the criteria for a psychotic disorder. The website of one well-known early psychosis program[14] lists the following experiences as warning signs of psychosis: *you often feel as though: you can't trust anyone. Someone is watching you. As though people or places you know seem different.* Other warning sides include difficulty concentrating, less energy, nervousness or a short temper, and a strong desire to be left alone. It is likely obvious from this description that distinguishing these early warning signs from normal adolescence is a difficult and fraught endeavor.

The term "prodromal" is widely used in medicine to refer to a period of initial symptoms that indicate the start of a fully developed illness. The etymology from Greek of prodrome, *pro-* (forward) and *dromos* (a running), gives an immediate sense of the progressive temporality the term implies. In assessments of a prodrome, prognosis is implied in the very diagnosis, perhaps even comes before it, making it very different from other areas of medicine (Christakis 2001). Over the years, I have often heard prodromal psychosis described by experts in reference to the perhaps universal sensation that foretells a cold coming on—you are not exactly sick, but not exactly well, and you have a sinking suspicion that tomorrow you will feel worse. The prodrome of a cold is an uncertain condition that demands action—vitamin C, zinc, soup, rest—not because of what it is, but because of what it will become without intervention.

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[14] http://feltonearlypsychosis.org/early-psychosis-signs-symptoms/

The issue with prodromes is that sometimes you do get sick, and sometimes you do not. If you do not, something either prevented the manifestation of illness or it might not have been a prodrome at all. This ambiguity is where the use of the term frustrates or fails entirely. If you have that feeling you are getting a cold and you wake up the next morning feeling well, was it not a prodrome? Maybe you were dehydrated. Or was your illness prevented through intervention—the ginger tea perhaps? Because of the experiential uncertainty (e.g., a headache could mean many things), diagnosing a prodrome often relies on assessments beyond patient experience, such as clinical signs, blood tests, or other biomarkers.

This problem of the prognostic validity is especially difficult in prodromal psychosis because there is no available specific biomarker despite significant commitment to discovering one. Concerns around the validity and specificity of diagnosing the "prodromal" stage of psychosis have been used to argue against the clinical use of the term. Many clinicians and researchers maintain its potential utility as a clinical tool (Woods et al. 2010), and others continue to use it as an informal shorthand reference. One scientist perfectly articulated this paradox when they said to me, "We shouldn't really use the term 'prodrome,' except everyone does." The psychiatric category itself is always already circumspect.

In response, new names have been developed to increase precision. The clinics where I conducted fieldwork most often use "clinical high risk" (CHR) in their diagnostic conversations. Ultra-high risk (UHR) is another term with a slightly different meaning. But neither of these terms cohere to a codified diagnosis in the DSM-5. The official diagnosis that most specifically attempts to capture prodromal psychosis in the DSM-5 is *Attenuated psychosis syndrome* (APS):

> This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained) (American Psychiatric Association 2013).

Its inclusion in DSM-5 was highly contentious and continues to be a source of significant debate within psychiatry (Nelson, 2014; Yung et al. 2010, 2012). Concerns over misdiagnosis, stigma, and overuse of antipsychotic medications, particularly with adolescents, continue to result in resistance to the codification and use of the *Attenuated psychosis syndrome* (APS).

In a concession to such concerns, the diagnosis is primarily included in an appendix of DSM-5 dedicated to “conditions of future study.” Locating the diagnosis in this appendix establishes the condition as a discernible diagnostic category with defined criteria, but also restricts its use to research settings by not providing a code for clinical use (administration and billing). The location of the code indicates a salient diagnostic concept but one that needs further investigation in order to be clinically useful. And yet, users of the DSM-5 can also find a fully codified version of the diagnosis under “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder.”

Similar to how symptoms of prodromal psychosis are characterized, the conditional or provisional status of the diagnostic category seems to relate not entirely to *content* (presenting symptoms) but also to *context*, in this case the actual location of the specific APS diagnosis mobilized. Ironically, the version of APS that avails itself to use in the clinic, the one included under “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder,” no longer carries the conditional status attached to the version used for future study. As an unconditioned disorder, the codified version of APS seems even more sure of itself than “Psychosis Not

Otherwise Specified" (Psychosis NOS), a category widely used in the provision of psychiatric services for young people experiencing symptoms of psychosis that are not fully realized.

The contested status of the category furthers the difficulty of clinical diagnosis of psychosis more generally. As I detail in Chapter 6, accurately deciphering the nuances of diagnosis in psychosis with clinical presentation alone is widely acknowledged to be impossible within the limitations of the clinic. For most of the clinicians with whom I spoke, diagnosis is primarily a route to services rather than a precise descriptor of a discrete condition. As such, the goal is "good enough" rather than "perfect," which leads to loads of gaps and also opportunity for play.

APS's utility as a clinical tool rests on its ability to pick up and create a response to ongoing distress. In prodromal psychosis, diagnosis hits a limit as a form of knowing because it is asked to predict the future when it can only speak of the present. One early psychosis researcher explains:

> **Researcher**: The distress piece is based on the literature showing that people who have intermittent psychotic stuff, and they're more distressed by it, are more likely to have a psychotic disorder diagnosis. That's a piece of it. I think we have maxed out what we can get from clinical phenomenology. I do think it has to be some sort of biological measure—multiple measurements probably.
>
> **Melina**: Why do you think there's a ceiling there in terms of clinical phenomenology?
>
> **Researcher**: It tells you what's already happening versus, in some ways, I think the biology can tell you what has not yet become expressed in behavior and experience and thinking.
>
> **Melina**: What do you think clinicians use to predict psychosis?

> **Researcher**: They don’t. Intuition, and they do it poorly.
>
> **Melina**: You think so?
>
> **Researcher**: I know so. […] [There was] this great presentation where [the trainer] had a case description of two different patients and asked everyone which one is going to develop psychosis. And then of course, it’s the other one. And it’s funny because I used to joke—you know despite everything I know about how poor prediction is, it doesn’t stop me from, with my clinical hat on, feeling like I know which ones are going to go in different directions. And I’ve been surprised. So, I think we have to acknowledge that we wish we could predict. So, it’s very tempting to think you know. But you don’t. Especially earlier on. I mean if someone’s really right on the edge, it becomes easier. But if you’re talking, someone’s coming in with 3s, nobody can predict that accurately. Not at that point.

In early psychosis clinics, the status of “psychosis” as symptom is radically in doubt, not only because it can hide from the subject through a loss of insight, but also because it is, more often than not, clinically imperceptible. If psychosis is a mechanism with which we come to identify madness, early psychosis clinics posit the possibility of madness to exist, and from the perspective of psychiatry, hide in the mundane world. In order to qualify as a symptom of a psychotic disorder, psychotic experience must not only reveal itself but also clarify its relationship to the subject and establish that it has an impact on daily functioning. Once it can do that, it qualifies as a symptom. In order for psychosis to perform in this way, it must be asked the right questions. Otherwise, early psychosis can continue to go unnoticed.

Clinical phenomenology, or the practice of taking a feature of a person’s experience and associating it with experience at a population level to support diagnosis, is limited to what one can observe from the present and by the ever inadequate categories provided in the DSM-5. The institutional desire to reduce this prognostic uncertainty vitalizes the ongoing quest for the certainty that a psychosis biomarker would provide. Accordingly, without it, prediction is impossible. And so, clinicians use their intuition, which, according to this researcher, renders poor clinical prediction.

The limitations of clinical phenomenology are not only a critique levied by researchers onto clinicians. The clinicians I spoke with expressed similar concerns around the impossibility of prediction in the clinic. One clinician explained:

> I have seen people that look like they would meet criteria for prodrome, and it doesn't develop into schizophrenia or any other major mental health diagnosis that would have psychosis as an element to it.

One can look prodromal and not be in a prodrome. When I asked how prodromal psychosis is different from psychotic illness, a psychiatrist responded:

> Most kids I see are pretty much interpersonally still intact. They don't have that total oddness about them. Then the other piece is a sort of disorganization. So disorganized speech, disorganized thought, that's a big red flag for me.

Distinguishing prodromal from frank psychosis then relies significantly on the young person's ability to relate—to maintain social relations and to describe such relations to their psychiatrists. Later in the interview I asked how the psychiatrist distinguishes prodromal psychosis from "normal" adolescent experience. The psychiatrist responded, "[they] often have some auditory hallucinations that are not very well circumscribed, so they hear their voice called, or maybe they hear someone talking to them every now and then." Whereas the clinicians can use relatability (and conversion) to distinguish prodromal from frank psychosis at the far end of the continuum, psychosis at the incipient end loses its materiality, its condition of existence. There are hallucinations, but they do not have boundaries—they are not circumscribed. They dissipate into the mundane—*hearing their voice called*—or into the *every now and then*. In this way, they refuse to capture as symptoms.

Even the seasoned clinicians I interviewed described having a difficult time making distinctions at the incipient edge:

> Really we're looking at any marked change in somebody behavior-wise. Somebody that was fairly gregarious that's isolating, hygiene going down, executive functioning skills going down. So maybe not being able to be organized, grades going down. Things that really look like what a lot of us went through as a teenager. So trying to figure out who you are, having a lot of fall outs with friends. Then more specifically looking at things that seem a little like—"huh?"

The prodromal symptom is exceedingly subtle, hard to grasp. Even when noticed, families do not generally attribute such experiences to psychosis (Judge et al. 2008). As with a cobweb, the prodromal symptom acts on the world, but in such a way as it is gone, but also somehow disturbingly still present, when you try to touch it. Diagnosticians of the prodrome are asked to decipher symptoms that are at once highly distressing and barely present, that are *everything and nothing*. Because of these challenges to clinical phenomenology, for a clinician to accurately perceive psychosis at an incipient stage, they need scientific instrumentation.

Interlude: An Instrument

When the researcher above refers to "someone coming in with 3s," they are referring to the Structured Interview for Psychosis-Risk Syndromes (SIPS)[15], the gold standard instrument for

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[15] https://easacommunity.org/PDF/SIPS_5-5_032514[1]%20correct.pdf

deciphering early symptoms of psychosis and identifying their stage (Miller et al. 2003). It is a structured interview guide that diagnoses three prodromal syndromes associated with a high risk for developing schizophrenia in the near future: (1) frank but brief or intermittent psychotic symptoms; (2) attenuated psychotic symptoms; and (3) a functional decline in the presence of genetic risk. The interview takes hours to complete, and interviewers must be trained to administer and reliably score the interview. As such, it is typically not used in clinical settings except as part of an associated research study.

The instrument's stated aims are to rule out past or current psychosis, rule in lifetime history of a psychosis risk syndrome, and determine the current status and severity of each risk syndrome present. It does this through a structured interview format in which the interviewer moves through different types of psychosis symptoms—positive, negative, disorganization, and general—by asking specific questions with structured follow-ups. Questions include:

- Have you had the feeling that something odd is going on or that something is wrong that you can't explain? [Yes, No].
- Have you felt that you are not in control of your own ideas or thoughts? [Yes, No].
- Do you ever feel that people around you are thinking about you in a negative way? [Yes, No].
- Do you feel you have special gifts or talents? [Yes, No].

Answering "yes" to any of these questions does not itself raise concern of psychosis. Obviously, most, if not all, people have had a feeling that something odd was going on that they could not explain. The value of the questions is that they allow the interviewee to assess and challenge their own thinking. One SIPS expert I interviewed attributed the instrument's diagnostic ability to its Socratic question formation, which enables an interrogation of the interviewees' thoughts while maintaining an open position to the underlying premise of these same thoughts. Parsing normal from pathological here is ambiguous. Gaining clarity requires interviewees to remark on their responses in more detailed ways.

Symptoms emerge not in these root questions, but in their qualification. It is not the presence of specific thoughts, beliefs or experiences that enables diagnosis or prediction but rather how they are experienced. When the interviewee answers yes to any given question, the interviewer asks qualifying follow-up questions to assess distress, interference with life, and degree of conviction. These questions are:

- What is this experience like for you?
- Do you ever act on this experience?
- Does having this experience ever cause you to do anything differently?
- How do you account for this experience?
- Do you ever feel that it could just be in your head? Do you think this is real?

It is not the "actuality" of psychosis that makes it a symptom, but the degree of certainty the subject maintains in relation to it and the distress it causes.

The interviewer is then asked to rate the interviewee's responses for each symptom subtype on one of two severity scales that are both ordered 0 to 6, with 0 being absent; 1, questionably present; 2, mild; 3, moderate; 4, moderately severe. At 5 the scales divert with positive symptoms, or symptoms that add phenomena to the person's world, being rated as 5 (severe but not psychotic) and 6 (severe and psychotic), and other types of symptoms (negative, disorganized, general) being rated as 5 (severe) and 6 (extreme). A 6 on the positive symptom scale indicates that the interviewee has had or is having a first episode of psychosis. A score of 5 is the limit of the schizophrenia prodrome.

Everything and Acting Fine

A young woman I call Alice, in her early teens, came to the clinic for a second opinion. A psychiatrist in the community had prescribed antipsychotic medications, and the family was concerned their daughter had been misdiagnosed. Such concerns are a common motivation for families to seek services in specialized early psychosis clinics. The family attributed most of what Alice experiences to severe anxiety and wanted to make sure antipsychotic medication was the right treatment course to pursue. Within the context of a partnering research study, the team decided to administer a SIPS to assess whether Alice was experiencing prodromal or fully realized psychosis. In addition to qualifying Alice for research studies, the determination would help clarify if antipsychotic medications were an appropriate treatment course because low-dose antipsychotic medications are no longer indicated for prodromal psychosis.[16] If Alice's SIPS scores indicated that she had or was having a first episode of psychosis (i.e., a 6 on the positive symptom scale), antipsychotic medications may be indicated. The SIPS results would also determine her eligibility for research studies.

Alice joined us in the office. She smiled generously as we were introduced. I was always anxious at first when observing, and her smile helped. She was wearing short shorts and a black shirt with something written in glitter across the front. Her hair was pulled back into a low ponytail. She was wearing flip flops and had what looked like a professional pedicure, but it had been a while. She seemed a summertime teenager.

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[16] While low-dose antipsychotic medication has historically been a standard treatment option in prodromal psychosis, experts in the field typically endorse "conservative" use only after frank psychotic symptoms emerge (Cannon et al. 2008).

The interviewer, Nancy, started the assessment by asking about any changes over the previous six months. Alice responded, “I’m not very self-aware and my memory is not the best, but not that I noticed.” Nancy inquired about the severity of Alice’s memory issues. Alice said it was not anything “diagnosable,” and that everything was related to anxiety. Nancy and Alice discussed how anxiety impedes memory. Nancy explained, “When we are really anxious, we are primed to run or fight.” The explanation seemed to resonate for Alice. She nodded along in agreement.

Alice’s concern had been that her anxiety makes it hard for her to answer diagnostic questions, to remember. Whereas Alice identified her difficulty remembering details (e.g., when things happened, how she felt) as potentially compromising diagnosis, Nancy incorporated it into the diagnosis itself. Alice’s inability to remember becomes a sign that anxiety is present. In Nancy’s frame, anxiety constricts the space for memory. The mind cannot remember because it is busy with the other, more immediate task of deciding to run or fight. From the perspective of psychiatric diagnosis, Alice effectively accounted for herself and her experience not by being able to accurately reflect on her history, but in being unable to do so. Diagnosis then relies not only on what the patient can recount, but that she forgets.

Nancy then started going through the SIPS interview questions one at a time. At one point she asked Alice, “Is it ever confusing if something is real or imaginary?” Alice responded by telling us about her “OCD [Obsessive/Compulsive Disorder] voice. My paranoid voice.” She attributes it to the medication she takes for depression. Nancy followed up, asking her if it was real or not. Alice responded that it is real. She explained, “OCD sort of puts thoughts in my head that I want to get rid of.” Nancy clarified with Alice that it was not “her” voice. The voice sounded like her, but it would say things she would not say. It is always “inside” her head, entirely familiar but also foreign.

Nancy: Do you feel like people can read your mind?

Alice responded yes, she does. She worries about it a lot. Nancy asked, when does it happen? She replied, when she is with people. Nancy asked, how does she deal with it?

Alice: I scream in my head to see if folks can hear. If I scream and they jump or make a face, I would know.

I was struck with the ingenuity of her strategy. Nancy asked how sure Alice was about people being able to read her mind.

Alice: Pretty sure, but not 100%. Thirty percent is sort of saying, this can’t be a real thing. How could people do that because I can’t do that.

But, Alice conceded that just because she could not do it does not necessarily mean others could not.

Nancy: Do people ever tell you that your beliefs are bizarre?

Alice: No.

They both paused and looked at each other as if they shared a secret. Then, Nancy asked if that was because Alice does not tell people about her beliefs. Alice coyly nodded in affirmation, her smile still fixed. She was putting up a show, and people were buying it.

Alice: Sometimes in social situations I feel like everyone is watching me. Judging me, but not in a positive way.

Nancy: Why do you think people look at you?

Alice: Look at her acne. How fat she is. Her hair.

There was a pause and then she continued to explain that even when people compliment her, she feels it is fake. Nancy left the structured questions for a second, or at least I thought she did, to ask why Alice was smiling:

Nancy: You're smiling, what's that about?

Alice: It's a way to protect myself.

Nancy: It isn't that a part of this feels silly?

I was surprised when Alice responded, "No. It is 100% accurate." I was taken aback. I had taken the smile as an indication that she felt embarrassed about the interview questions, uncomfortable. I thought she felt implicated by the absurdity of the possibility of misperception. But her response revealed that it was something else. It was not the questions that were silly. This clarification changed the way I saw her smile altogether. It became something forced, a protection. Part of a facade. I felt strange about having felt comfort in her effort to protect herself, in her smile.

Nancy recalled Alice reporting that she was often afraid of being shot at school. She asked, Is that still going on? Alice replied, Yes, it is. Referencing the Parkland shooting, Alice described herself as constantly thinking: "Is that door locked? If a gunman came, how would I make sure everyone was okay? Who could I cover?" Nancy normalized Alice's feeling, saying maybe everyone is more aware these days after Parkland. Alice agreed, "I think everyone is."

Given the past ten years, it is not at all surprising that a student in any school in the United States would be anxious by the possibility of a school shooting. "Parkland" references the incident on February 14, 2018, when a gunman entered Marjory Stoneman Douglas High School in Parkland, Florida, and shot and killed 17 people. But there have been so many others. From 2009 to 2019 there were 180 school shootings in the US, resulting in 356 victims and 114 deaths.[17] For a student not to be anxious would be illogical. In fact, preventing youth gun deaths seems to demand such anxiety. Youth are called upon to worry. Most advocates advance the “see something, say something” concept in which young people learn the warning signs of a potential shooter and are asked to vigilantly surveil their environment in an effort to “protect kids and save lives.”[18] Alice enacted this form of protection exquisitely, even wondering selflessly, “Who could I cover?” American violence has made the irrational reasonable. It is no longer “crazy” to imagine, maybe even expect, a teenage student (or a teacher) to use their body to cover another student during a mass shooting. It has become normal, perhaps even our ethical and civic duty, to anticipate such scenarios.

The characterization of Alice’s anxiety of school shootings as normal is striking to me. Nancy framed Alice’s anxiety as likely not pathological because she felt the same as everyone else. As I reflect on this interaction, the conversation resonates in a different way. Perhaps Alice’s anxiety had become normal because everyone else had come to feel the same as Alice. Take, for example, how American violence destabilizes the logic of even our most reasonable acts, such as taking our children to school. As “Parkland Mourns in Time” recounts:

> The sound of Fred Guttenberg’s voice as he speaks from the podium about sending his daughter, Jaime, 14, to school and not remembering whether he had a chance to say “I love you” that day. “She was supposed to be safe,” he said, breaking into tears. “My job is to protect my children, and I sent my kid to school.”[19]

It feels as though Alice’s anxiety found a ready home in the reality of American school violence. Not necessarily that it is not pathological in the same way other manifestations of it are, but

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[17] https://www.cnn.com/interactive/2019/07/us/ten-years-of-school-shootings-trnd/

[18] https://www.sandyhookpromise.org/our-programs/say-something/

[19] https://time.com/parkland-high-school-shooting-vigil/

rather that in this domain, reality (school shootings and US responses) has risen to the level of pathology itself—as if it has become crazy to send a kid to school.

Interestingly, in the US young people have access to early psychosis clinics partially as a result of political responses to this very specific issue of school shootings. When I asked one prominent researcher what influenced the proliferation of early psychosis clinics in the US, they responded:

> You know, it's interesting I'm not sure what's driven it. I'm not sure if it is the influence of ideas outside the US or if it's more that at the same time that there have been these scientific ideas, there has also been a lot of public interest and political interest in treating psychosis or schizophrenia. Now, they are not always sure what that means, but bad stuff, especially if it leads to gun violence on a large scale. Let's be honest. Unfortunately.

The researcher paused for a second as we both let the stakes of their statement sink in. It is a concession neither of us seemed entirely comfortable with.

"Being honest" requires acknowledging that the political support necessary for establishing early psychosis clinics throughout the US is based on an unfortunate, and largely unfounded, association between gun violence and psychosis. The explanation I heard many times throughout my fieldwork was that the National Institute of Mental Health (NIMH) had the data to show that early identification and intervention for psychosis is possible. The Substance Abuse and Mental Health Services Administration (SAMHSA) had the policy infrastructure in place to support the implementation of early intervention across the country, and after the Sandy Hook Elementary School shooting, Congress had the motivation, and pressure from advocacy groups, to invest the much-needed capital into the exceedingly underfunded domain of child and adolescent mental health services. An event of the magnitude of Sandy Hook,[20] where a gunman shot and killed 20 first-grade students and 6 school staff, demanded action. Early intervention gave policy makers an evidenced, feasible, and scalable response, something that could be done. The threat of mass shootings succeeded in mobilizing US resources in a way that evidence supporting the effectiveness and feasibility of early intervention never had on its own. As such, the proliferation of early psychosis clinics in the US is at least partially predicated on the idea of the adolescent mass shooter, leaving the field strangely indebted to a largely false idea that perpetuates stigma.

Many clinicians I spoke with argued that while it may not necessarily be true that early psychosis services will intervene in mass shootings, children are suffering, and extending psychiatric services will help. Even when professionals were highly critical of the connection between psychosis and shooters, they recognized a more dystopian reality. Mass shootings are becoming increasingly common in the US, and early intervention will be critical not necessarily for potential shooters but for all the young people in the wakes of furture shootings. Scholars have demonstrated that causal inferences between mental illness and gun violence on the aggregate level not only unfairly stereotype people living with mental illness, but also inappropriately shift responsibility for gun violence prevention onto psychiatric professionals, mitigating the possibility for meaningful, structural solutions (Metzl and MacLeish 2015). Although the research and clinical experts with whom I spoke often take issue with the connection between psychosis and violence as unfounded and unfortunate, they also recognize that mental health services for children and adolescents have been severely underfunded for

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[20] https://www.history.com/this-day-in-history/gunman-kills-students-and-adults-at-newtown-connecticut-elementary-school

decades. Accepting the “unfortunately” above is a concession to a kind of falsehood, a potentially damaging one, but one that, perhaps, will do more good than harm.

And so, Alice owes this clinical interaction at least partially to a concession that misrepresents her as a potential perpetrator of violence. Yet, her anxiety revolves around being a victim of such violence, and her self-image realizes her as a hero within it. Locating unreason in this morass is difficult indeed.

Nancy asked if Alice ever feels watched. Alice nodded as though it is a given. Of course she is watched. Nancy asked if she behaved differently as a result of being watched. Alice replied, “yes.” Instead of starting with technology, as I assumed she would, she began by describing her experience with the psychiatric encounter itself. “I know that you are watching for physical things.” She told us she was being careful about how fidgety she was. Told us she had been careful not to pick at her fingers too much.

Alice turned to an appointment with another doctor when she knew there had been a camera in the room. She had not shared much with him because of it. Nancy playfully pointed out that she had the camera on her laptop covered. I suddenly became aware of how many cameras there were in the room. I resisted an urge to turn over my phone, which was sitting right side up on the floor. Fixing psychosis to Alice’s perception is impossible. All three of us understand and respond to the potential that we are being watched by our apparatuses.

It is tough to locate psychosis in Alice as an individual. The eminent possibility of mass shootings or being spied on through your computer or phone invites paranoia. We all felt it. It asks us all to feel threatened and demands that we protect ourselves and each other. To act otherwise becomes irrational. Take for example, a recent *Huffington Post* article by Casey Bond, in which the designated cybersecurity expert, Zohar Pinhasi, say of personal electronic devices, "You need to operate under the assumption that someone is always watching what you do." The article suggests, "The next time you want to have a private conversation, it's probably a good idea to leave your smart devices in another room so they can't hear you." The article ends with Theresa Payton, former White House chief of information officer, declaring, "It's only paranoia if it's not true."[21]

Alice's experience and behavior are culturally congruent, or similar to the way others think and act in her social environment. We are all compelled to act as if we are being watched. She feels judged for being fat, for having acne. She feels surveilled by technology. She worries about the real possibility of being shot at school. Alice's fears might qualify as psychosis if they were not "true." Thinking along with Sam Dubal's (2018) work, I see the difficulty of determining the rationality/irrationality of Alice's beliefs not as a limitation of our conceptualizations of psychosis but rather as limitations in conventional notions of reason.

Alice and Nancy circled back to Alice feeling watched. Nancy again asked how sure she was that her life was a TV show.

> **Alice**: 70% Just because there are some good things in my life and why would they put the good things there.
>
> **Nancy**: Anything you do to alter your behavior?
>
> **Alice**: Acted more fine.

Alice felt as though she must act excessively fine in response to being watched, in the context of either a hidden TV show or a psychiatric interview. Her behavior is normal, but she also feels it is false. She told us she "acts more fine" when she is experiencing psychosis. Unreason is masking unreason, an artifice posed with a frozen smile.

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[21] "Is Your Phone Recording Your Conversations? The Answer Might Surprise You." (8/19/19).

Nancy acknowledged in a joking tone, “Note to self: if Alice is acting fine, she is likely not doing great.” Alice laughed along enough to not make Nancy feel as though she felt made fun of, but not enough to suggest that it was untrue. Nancy continued asking more about the TV show.

Nancy: Who would be watching the TV show?

Alice: That is a good question, um, the general public. You.

Nancy: Have you ever looked for the show?

Alice: No, I have not because I think it would be hidden from me.

Nancy: How sure are you now of that?

Alice: Around that? 70/30.

Alice told us that she knew that there are many laws that protect people from being watched. She was not always sure, or entirely sure, but for at least a couple of months she had known that she was on a TV show and that people are watching it for entertainment.

When Nancy asked when it becomes distressing, Alice responded: “I feel like I couldn’t make myself act like it was fine because I wasn’t fine.” At stake here for Alice is not the actuality of whether or not she is being watched, but rather if she can act as though she is not. She knows she is not fine when she cannot act fine for the cameras. For her, the distress comes in her inability to act fine, not from the fact that she does not feel fine. The possibility that Alice ever feels fine started to seem remote.

Nancy continued to probe, asking if Alice ever tried to hide from the cameras at home. Alice replied: “I don’t think there is a place where they [TV producers/cameras] are not there.” Alice’s sense struck me as so distressing I lost myself for a second imagining what it would feel like to be watched all the time. It hit me that I was watching her. I was part of this surveilling apparatus.

When I finally made my way back to the conversation, they were talking about Alice's fear of being sexually assaulted. Alice described it as "just a womanly kind of fear." The three of us all moved on with the conversation, taking it for granted that the self-evidence of that explanation was not itself unreason. Once again, the possibility of actual threats to an American teenage girl cannot easily be dismissed as paranoia and therefore false. Considering the rate at which young women Alice's age are raped or assaulted, it is not an illogical concern.

Nancy asked, "Do you feel like we are going to rape you?" All of a sudden I felt sucked into a conversation I had imagined I was just watching.

Alice: Kinda.

My stomach sank as I was implicated as a perpetrator into her fears. I wanted to reassure her, of course I would never. But, I wondered why should it be such a given that I would not rape her? Taken as premise, the impossibility of my role as rapist leaves no other option but for Alice's perception to be unreasonable. It forces both of us into a scene where I am beyond doubt and she is doubted, most importantly by herself.

After the interview Nancy reflected on the diagnosis. She told me that the previous psychiatrist had likely gotten caught up on the wrong issues. He had focused his diagnosis on an ongoing fear Alice has. Nancy tells me, even though it is highly distressing, the fear is probably not psychosis. When I asked why, she explained that the fear is plausible. And, it does not include a threat. Paranoia would be more unrealistic and include a threatening intent. The fear had felt more like anxiety than paranoia for Alice's parents as well. This sense is why they came in for the second opinion. In this doubt of the diagnosis, Nancy concurred with the family’s sense that something about the previous diagnosis was not quite right.

And yet, Nancy suspected that the psychiatrist may have been wrong about the symptoms, but not the diagnosis, or treatment suggestions. Nancy did not think Alice’s fear was a symptom of psychosis, but she did think that Alice’s understanding of herself as the subject of an ongoing TV show might be. Nancy told me that uncovering the “actual” symptoms of psychosis required asking the right questions—in this case, *do you ever feel as though you are being watched?* Without being asked this question, Alice would likely not remark on the TV show because she takes the TV show for granted. It is just her life, unremarkable. It is this sureness, this firmly held belief that made Nancy think Alice may have converted to psychosis. It is not only the attenuated and fleeting aspects of early psychosis, but also more entrenched symptoms that seem to disappear into their premise.

Efforts to concretize a pre-psychosis phase trouble existent conceptualizations of psychosis as rupture, radical difference, and alterity. Psychiatric concepts such as conversion clarify the moment when certain experiences become pathology, and in so doing reveal how common psychosis is in the mundane world. The *everything* of early psychosis is not only the overwhelming distress that often accompanies early warning signs, but also all the overwhelming distress of the contemporary moment. As we watch the instrument tell us Alice likely has experienced psychosis, we cannot help but notice the legitimacy of her perceptions—her fear of being shot at school, of being watched and judged, of being raped.

Insight into the Plausible

Ellen Corin, an anthropologist, says of early psychosis, “whatever the context, narratives suggest that something rises from within the subject’s experience and destabilizes it, shaking the lived world at its roots” (2004:273). Leaving unknown, and not postulated, what the “something” is, Corin identifies psychosis through the experiences of people who live with and through it. She frames this approach in opposition to a biomedical one, where “natural,” or biological, explanations of psychosis are privileged over “social” or “cultural” ones.

Since the publication of DSM-III, Corin argues, psychiatric subjects have been asked to relate to experiences of psychosis from a position of exteriority in which “patients and their families are asked to adopt an analogous, external stance through sessions of psycho-education in which they are informed of the ‘real’ biomedical nature of the patient’s problems and difficulties and are instructed with how to deal with them” (2004:274-75). Diagnosis, Corin reminds us, is a process of interpretation, never intended to be certain, always partial and provisional. And yet, she warns, this quality can be lost when the perception of a phenomenon is confused with its reality. Most powerfully, Corin argues, “empirical science disregards the fact that for people suffering from it, psychosis remains a boundless experience—one that is beyond anything they can name and explain” (2004:275). Corin’s critique highlights the relational aspect not only of psychotic experience, but also of diagnosis. She does not disabuse biomedical explanations; rather she attends to the problematic way they become the only explanation. She shows how patients and families are asked to establish and maintain an exterior position relative to boundless experience. The demand is folly.

In her “Paranoid Reading and Reparative Reading,” Eve Sedgwick opens up the possibility of imagining the kind of privileging Corin describes above, and in some ways Corin’s critique itself, as paranoid. Sedgwick is careful to distinguish her concept of paranoia from the psychiatric concept of psychosis that stems from Emil Kraepelin and Paul Eugen Bleuler, men who heavily influenced psychiatric understandings of psychosis. She explains, “mechanisms such as paranoia have a clear ontological priority over diagnostic categories such as dementia [praecox]" (2003:129). The concept is prior and beyond "paranoia" in the sense of a psychiatric symptom. It is something we all experience. Sedgwick's generous attention to the hermeneutics of suspicion does not dismiss its truth or its value but rather points to the way it leads to misrecognition through what it does not see, through optics of "minimalist elegance and conceptual economy" (2003:149). As opposed to such paranoid frames, a reparative reading, which she ties and applies to the queer-identified practice of camp, "is additive and accretive. Its fear, a realistic one, is that the culture surrounding it is inadequate or inimical to its nurture; it wants to assemble and confer plenitude on an object that will then have resources to offer to an inchoate self" (2003:149-50). A reparative reading of prodromal psychosis demands resistance against the privileging and disregarding Corin calls attention to above, but also paranoid frames that might inhibit an ability to see instances where "social," "cultural," and relational explanations of psychosis do come to matter in diagnostic practice.

The (im)materiality of psychosis in early clinics renders diagnosis radically uncertain and unstable. Placing a person within the spatial and temporal scene of prodromal psychosis requires a diagnosis that can rule out past or current psychosis and rule in future psychosis. In this way, diagnosis requires an optics of the (im)material, a technique for seeing present symptoms but also what is no longer or not yet there. With early psychosis, clinicians diagnose by cultivating a repertoire of attunements to temporal (e.g., frequency, duration, but also age), affectual (e.g., psychotic feel, distress), and social (e.g., school attendance, texting practices, pot smoking) phenomena. Such attunements at once rely on and doubt various forms of knowing, including knowledge of self and parental and clinical knowledge, while also putting into question psychiatric knowing itself. Deciding when an experience becomes a symptom of psychosis is highly relational and often contested, even by the diagnosticians themselves.

Instruments such as the SIPS diagnose early psychosis syndromes by using what one expert called a Socratic method to engender insight into underlying and often invisible presuppositions and associated distress. By asking the right questions, they reveal what can be hidden by being obvious, fleeting, or attenuated. Young people are asked to remark on unreason from a position inside of it. Alice endorses her anxiety by not being able to remember having had symptoms. She is determined to have likely converted to psychosis because she reports knowing she is the subject of a TV show that exists for no one but her. The instrument succeeds in accurately diagnosing psychosis because it reveals fully manifest symptoms that were hiding in the unremarkable nature of being Alice's everyday life. It uncovered Alice's lack of insight. Insight is a prolific and widely critiqued psychiatric concept. Broadly, it means not having knowledge of one's disease. One clinician was kind of joking when they told me it can also mean, "Don't agree with psychiatrist."

Corin would remind us, the instrument seemed much less able to attend to the 'social' and "cultural" instances of suspected psychosis in Alice's interview. The interview practice seemed unable to distinguish reason from unreason in the face of distressing concern related to school shootings, perceived surveillance, and rape. Turning the burden of insight toward the psychiatric institution itself, I argue that diagnosis of everything and nothing is difficult particularly because psychiatry lacks insight into the plausible, the everything—the manifold ways in which an individual can experience something that is unreason and (not) psychosis. And yet, Sedgwick shows that such a reading risks misrecognition and, if held as *the* explanation, becoming paranoid. If not paranoid, it is at least inadequate. I see my own destabilizing experience of becoming a potential rapist as offering a kind of reparative reading where Alice, and the SIPS instrument, revealed *our* sociocultural world to be inimical to *our* nurture. Diagnosing everything and nothing is then difficult because of not only the limitations of seeing nothing (e.g., predictive validity), but also the parsing of everything. Perhaps the ethical question of early psychosis is not of how to maintain the self either through individual or institutional insight, but rather how to cultivate the resources for inchoate selves.

CHAPTER THREE | Experience at the Edge

> **Edge** (noun): The outside limit of an object, area, or surface; a place of part farthest away from the center of something. (Oxford English Dictionary[22])

The Edge of Teenage Boy

We had all gathered in the conference room after an intake interview. The attending psychiatrist was running a little behind the rest of the team. When he returned to the group, he told us that the family had noticed a change in the young man around high school. He had became resentful and insulting. Stopped helping with the cleaning. Left clothes around. Would not do dishes. Realizing this description was underwhelming those of us in the room, he urged, “most kids will do a dish. This is the edge of teenage boy.” The comment places the young man on the edge of adolescence, an already edgy kind of place. The laziness and angst that contextualize his life exceed the suffering widely associated with this developmental stage, but only by a rhetorical dish.

If there is a single question at the root this study, it is the one posed here. What marks the edge of teenage life and when might this edge become a site for pathology? How can the suffering and transformation that is at the root of contemporary understandings of adolescence be discerned from the suffering and transformation associated with early psychotic experience? How can psychiatric pathology be recognized within a space that is already characterized by storm, stress, torment, and turbulence[23], at least in the West as Margaret Mead (1928) would

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[22] Definitions accessed through: https://www.lexico.com/

[23] I am referencing a large body of literature stemming from Stanley Hall’s (1904) characterization of adolescence as a developmental period of heightened “storm and stress.” A comprehensive review of this literature is beyond the scope of this dissertation and exist elsewhere (e.g., Lesko 2001). Hall adopts this language from the “strum und drang” genre rooted in Johann Wolfgang von Goethe’s (1774/1970) description of a young man who dies by suicide after suffering unrequited love, *The Sorrows of Young Werther.* This conceptual legacy roots contemporary notions of adolescence to an intellectual movement that rejected certain forms of rationalism (e.g., optimism and reason) associated with Enlightenment. For an early review of the psychoanalytic theory of adolescence, see Blos 1962.

remind us—a space of emergence from the madness of childhood and transformation into the rationality of adulthood? And finally, how is life at the edge maintained?

In this chapter, I consider the notion of the edge from the position of early psychosis. In my conversations, the edge emerges as a valuable concept not only in its spatial sense—as a precipice of alterity—but also in terms of other possible ways edge is used as a concept—as a set of practices where boundaries are set and (re)set, a cautious approach, an affective quality that endangers social connections, and as a sharp, exacting, and potentially harmful implement. The edge of experience then is not *an* edge at all. It is an interrelated set of ever-changing, intersubjective negotiations, where the danger of falling is always relative to what protections are made (un)available as well as to what it would mean to not continue along the path.

I first show how in expert descriptions of distinguishing pathological and nonpathological distress, psychosis emerges not only as an extreme of normal experience, but as characteristic of certain forms, such as childhood or transitions from one stage of life to another.[24] Within this framework, adolescence is the developmental phase where a person learns to stop seeing with madness, to filter out visions and noises, to dismiss anxious thoughts as memory. Learning to distinguish what is real from what is not real is part of becoming an adult, a skill acquired during adolescence. It is not expected of children. The psychiatric professionals I spoke with attribute these processes to brain development. It is a technique of negation so practiced as to become no

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[24] Psychosis is widely understood as a brink of alterity where one is in danger of becoming other in relation to one's social world but also to oneself. Janis Jenkins and others advance schizophrenia as the "edge of experience" (e.g., Jenkins and Barrett 2004). She describes this edge as cutting "in ways that are at once ordinary and extraordinary, conventional and inverted, lucid and distorted, making schizophrenia a paradigm case for the broader elucidation of fundamental human processes" (2004:30). Building on work by Georges Canguilhem, Jenkins argues that efforts to differentiate normal from abnormal experience within the context of schizophrenia are not possible epistemologically or empirically. Jenkins reveals schizophrenia, or the edge of experience, not as a psychological or neurological state that forecloses access to the social world, but rather as a condition of existence heavily influenced by culture and agency. Rather than a state of radical difference, for Jenkins, the edge of experience is an extreme of normal experience.

longer noticeable—not a technique of seeing “real” things, but rather of not seeing everything. Such views trouble biomedical logics around early identification that maintain adolescence as the site for psychosis onset, offering an alternative possibility—psychosis may become recognizable in adolescence not only because symptoms of illness emerge at this time, but also because certain ways of relating to experience, typical of childhood, refuse to go away. What might be typical adolescent behavior becomes the very sign of pathology. In this way, identification of early symptoms requires a consideration of psychotic experience from the perspective of both emergence and delay, as something impossibly both incipient and familiar.

Identifying and intervening at the edge relies on practices of noticing changes in how a young person is relating to their experience or to people around them. These practices start before any contact with the clinic, and therefore within the context of family relationships. Concern then corresponds not only to the presence of warning signs (e.g., unusual overly intense new ideas, strange feelings or having no feelings at all), but also to deeply contextualized family histories. In the second half of the chapter, I attend to the ways that marking the edge in these contexts not only cordons off a precipice but also reconfigures subjectivities and relationships. Parents describe ongoing processes of both protecting and relenting space for courage, ambition, conflict, independence, and ethical formation along their children’s path toward adulthood, and young people experiencing unreliable thinking and behavior maintain the desire to be seen as worthy of trust and care. As families proceed, psychiatric intervention looms, promising protection but also inviting harm. The edge of adolescence emerges as a site of protection from risk but also of it.

A Dead Girl or a Tree?

Edge (verb): Provide with a border or edge. (Oxford English Dictionary)

I am interviewing a researcher who specializes in early psychosis. I ask, “How do you think prodromal psychosis is different from normal adolescent experience?”

Researcher: Well, so I guess the question is, is it different in kind or different in degree?

Melina: Right.

Researcher: But, I think the answer is to some degree both. I do believe in the continuum of psychosis. It is definitely true that children, adolescents, have more psychotic-like experiences than do older adults or just adults, but they don’t have them with the same frequency or severity as someone who starts to develop the prodrome.

Melina: So, what it sounds like from what I just understood is that when you’re talking about children, the kind of experiences that they have are not as different between someone who is—

Researcher: That’s right, children not so different. Adolescence, it just starts to get more frequent. There’s a normal distribution. So some people don’t have this at all. Some people have some of these things but it never becomes—it’s infrequent, it’s not bothersome, and it goes away over time. Or, it sticks around their whole lives but doesn’t really cause them problems. But then, when they start becoming more frequent and more severe, more impairing, more distressing, that’s when you get on this path. The same as everyone has sadness. There’s normal sadness, and then there is depression.

Melina: Sure.

Researcher: —you know, or anxiety where everyone gets stressed out and anxious, but when does it start to turn into something else. Everybody has checked the stove twice once in their life, right? Do you check it ten times? Do you have to come back to the

> house afterwards from somewhere else to make sure? Can’t get the thought out of your mind? That’s different. Is that different in kind or degree?

In this description, distinctions between normal and psychotic experience in adolescence differ mostly in degree. Psychosis is a version of normal experience but more severe, more impairing and more distressing. But, the researcher also introduces a temporal difference as well, in the delay of an afterwards. Concerns become symptoms of psychosis not necessarily because they are categorically different than other types of concerns (different in kind) but because they linger. They make demands for too long after any unnerving residual sensation should have resolved. They not only threaten return, as one would expect with something characteristically episodic, but symptoms of psychosis refuse the kind of dismissal that makes a subsequent possible.

> **Researcher**: So, I mean, everything is a continuum, all of these things. You can have a severe personality issue that is fun and quirky when it’s mild, and extremely problematic when it’s severe.
>
> **Melina**: Can you give me one example of something that in childhood would be, you know, normal and then—
>
> **Researcher**: Oh yeah, so David [his son] says to me, you know, there’s nothing like having kids to help you—He tells me that he sees a dead girl. You know, that freaks him out.
>
> **Melina**: He’s nine?
>
> **Researcher**: This was probably when he was seven or eight.
>
> **Melina**: Got it.

> **Researcher**: You know, and I'm like, we've got to stop letting you watch those movies, you know? And so, I ask him about it, and it scares him. It does. But, it's not often. And I'm not worried about it unless it's still happening when he's 13, to a certain degree.

If a hallucination is the perception of something that is not present, as any dictionary will tell us, the dead girl fits the bill. Even once you add the criteria that a hallucination, in order to qualify as psychosis, should cause distress—it still resonates. It is not so much that this experience does not qualify as psychosis, but that such experiences are normal in childhood—or at least "psychosis-like" experiences. Not just that it is normal to experience psychosis in childhood, but rather that childhood perception and experience is in some way "psychotic." Psychosis, from this perspective, is something we all grow out of. Seeing reality is not given, it is learned, or at least developed. And, the ability to imperceptibly distinguish between what is real and what is not is supposed to emerge during adolescence.

> **Melina**: Yeah and then at 13, he should be able to—do you think it's that he has a different experience, or do you think he can reality-check better at that point?
>
> **Researcher**: That is a whole fascinating cognitive development in childhood issue that I don't really know, that I'm not familiar with. That is sort of interesting to me, but it's not really my area. […] when I think of, you know, he doesn't want to go into the bathroom to brush his teeth by himself because the tree outside the window scares him. Because it looks like a person is out there or something, and no matter how many times I open the window and show him it's the tree, if the window is down which has you know—
>
> **Melina**: Like a silhouette?
>
> **Researcher**: Yeah and it's also not clear glass. So, it's—
>
> **Melina**: Foggy?

> **Researcher**: How does a nine-year-old brain make sense of visual images differently from a thirteen-year-old brain? I don't know, that's not my area. I'm sure someone knows that. I don't. But, I do know by 13, I think the perception is different as well as the—or the cognitive reality-checking ability to see something, get a little freaked out but go, okay I know that's just the tree. So, I think it's both.
>
> **Melina**: Yeah, not just interpretation. It's not just that your brain learns how to dismiss things. It's something at the perceptual level you think.
>
> **Researcher**: I think so. I do. I do.

In this explanation, experiencing a shared reality is constituted not by accurately perceiving the material world, a silhouette of a tree as a silhouette of a tree, but rather through a limiting of possible perceptions. Psychosis then can be seen as a problem of filtering, seeing too much "reality." For this researcher, this skill of filtering develops in adolescence. The researcher refuses my invitation to think through interpretation alone. It is not good enough to know that it is a tree, to be able to remind oneself, "that's just the tree." What characterizes "normal" adolescent perception is actually no longer perceiving the person in the silhouette. In this scenario, the 13-year-old brain should not only know differently but see differently than the 9-year-old one. Here, psychosis is discerned not in hallucination, a false vision, but rather *in what an adolescent is unable to not see*—what a child could still see. For now, it is okay to see the person, even after a demonstration that it is just the reflection of a tree. After all, the glass is foggy. It is only a silhouette. He is a child. But at 13, the researcher would begin to worry.

Probably Little Kids Hallucinate a Lot

It was midafternoon and our conversation was shifting. I admitted to the attending psychiatrist that I was confused about why a person could not convert to psychosis over and over again. It seemed to me, in fact still seems, that the way psychotic symptoms often remit after a psychotic break might mean that the concept of conversion would need to capture a fluid, multidirectional process rather than a linear and final one with a threshold.

The psychiatrist agreed with parts of my assertion. “Some [symptoms] are chronic, but most of them you see in waves,” he explains. He called the ones that come in waves “episodic.” He offered voices and paranoia as examples. The more-chronic symptoms, such as affect blunting or disorganization, take longer to remit, do not wax and wane as much, and sometimes never completely go away. He told me—

> The DSM has the built-in assumption that you are going to have schizophrenia for life, even though that is not well-supported by the evidence. I mean, sure a lot of people will continue to have psychotic symptoms for life. But, it is interesting. It doesn’t do that with other diagnoses. It doesn’t assume you are going to have it for life… There didn’t used to be a DSM code for "in remission," which I always thought was strange. So, only residual—as if somehow you are just expecting—it is always going to be there to some degree.

I wondered aloud how this notion of residual operates within a recovery-oriented framework. I asked, is recovery possible after the threshold of conversion if psychosis is made forever through diagnosis?

> **Psychiatrist**: I think the narrative that does a lot of harm is that—and this is where I do think the power of the schizophrenia diagnosis, we might be a little too cavalier with. Hopefully not us, but maybe we are—if the system assumes that schizophrenia is lifelong and the system assumes that antipsychotics are a specific treatment, the inertia of the

> system will be for everybody who has ever been diagnosed with schizophrenia to stay on antipsychotics for decades.

The doctor takes issue with how two narratives of questionable validity, that schizophrenia is lifelong and that antipsychotics are specific, produce a logic sustaining medication use in diagnosed patients. Stories have real effects.

We tracked back to one of the clinician's patients, a man in his early forties. The patient had been coming to the clinic for years after he was arrested while experiencing a psychotic episode. The psychiatrist did not give many details but told me his symptoms had manifested in a particularly unfortunate way, resulting in a traumatic experience for multiple people involved. The doctor explained that the resonance of this damage, along with resulting legal implications, left the man and his family terrified that *it* might happen again. This fear made the family hesitant to any of the psychiatrist's attempts to lower the dose of the man's antipsychotic medication. For them, "if this happens again, it is a horrible outcome." But, the doctor pointed out, "for a lot of our folks it's like, if this happens again, it will be bad, but it won't be the end of the world for the voices to return." His point was that the prescription of and adherence to antipsychotic medication is heavily influenced by a sense of inevitable return of symptoms—symptoms that resonate as family narratives, beyond the individual.

One of the problems, the psychiatrist told me, is the way medication trials use rebound of symptoms as a proxy for return of disease or even as a proxy for loss of brain cells. This explanation, advanced here as spurious, is one I have heard many times in my research—that episodes of psychotic symptoms inflict damage on the physiology of the brain, making recovery more and more difficult over time. I commented to this effect. He responded,

> I think the first episode message, which is true, is that anybody who gets treatment within six months of serious effects does better than anybody who waits more than six months. The easiest proxy for that is antipsychotic prescription because that is the easiest thing to define whether someone entered treatment or not.
>
> Actually, it would be much harder to track them down across systems and private practitioners—did they go to a group? It's a little hard to control for everything. I think even if you control for severity—the super severe, paranoid, and odd people, they are not going to seek treatment unless they are forced to. We see this all the time. They have been paranoid for two years and finally their parents say, "You can't live here." And so, that is true, and I think that message is important. There is something about being actively psychotic for long periods of time that makes psychosis harder to treat. But, I would say that is probably true of almost anything. That doesn't surprise me.

In this dialogue, not seeking early psychiatric services is not directly attributed to the standard culprits, which generally include stigma and lack of access. Those are assuredly there, but in this depiction his point was that experiencing more severe symptoms over a longer period of time itself makes access to services less likely. The health system works least well for those who most need it, not just in psychiatry; this is true of almost anything. What is perhaps most surprising is that this was not surprising at all. He continued:

> Sometimes I frame it this way to the trainees—paranoia is in a sense new learning. And so, the longer you are engaged in a learning paradigm that is reinforcing, the more that is going to become embedded as the way the world is. Right, and so, of course, if you are paranoid and if you engage in a pattern that reinforces your paranoia, the phobia pattern that most of our folks engage in—they see something. They interpret it in a particular

> way. They act on it in a particular way. They freak everyone out, and they interpret that as everyone else against them. And so, it becomes a self-reinforcing habit. Of course, if that goes on for two years, they are not going to change their mind. You are just going to walk in there and say, "Oh, you are psychotic, and I am going to give you an antipsychotic. And, you are going to change your mind." No. That is not how belief works.

Paranoia here is not simply imposed as a symptom of disorder but self-reinforcing and relational, practiced. The psychiatrists shifted back to the notion that episodes of psychosis harm brain cells and the hypothesis that these insults result in brain shrink:

> Think about everything that is captured into brain shrink. I mean what causes brains to shrink? The most supported thing is lack of stimulation. So, you could actually make the argument that you get a population of people who restrict their activities such that they actually don't get a lot of active social interaction, but you can't really prove or disprove that. It is true that being actively psychotic for long periods of time is bad. Again, so, however you stop that or slow that, that is probably important at any point in the course. It is probably just most important early on. The brain shrinkage data is very problematic. It is very hard to make the argument that psychosis is toxic, which I think is the argument that most people make.

He continued by troubling the idea that psychosis specifically shrinks the brain and points to evidence, from animal studies, to argue that antipsychotic medications do. We discussed the scientific difficulty of teasing apart overlapping populations, and he wondered aloud why brain shrink is not more commonly attributed to medication rather than disorder. Perhaps an effect of training, he mused.

I took the opportunity to ask about pruning, a neurological process often implicated in causation hypotheses of early psychosis. Synaptic pruning is a part of brain development that occurs in adolescence. I have heard it described many times as a process wherein the brain trims away superfluous synaptic connections in an effort to achieve more effective processing. I ask how this brain shrink is similar or different to pruning, which I qualify as a *normal, healthy process.* He corrected me:

> **Psychiatrist**: Uh, it is a normal process. It is not clear. It is a good example. I mean back to the point that there is no optimal brain function, the more you zoom into the data, the more it brings up questions. Different populations have different temporal patterns of pruning. Is there good pruning? [laughter]

His point was that my description assumes a single normal process as healthy when there is little evidence to support such a view. I easily relented to the problematics of my claim and laughed along with him at the irony of an optimal brain function. I asked sarcastically,

> **Melina**: is there a good time for pruning?
>
> **Psychiatrist**: Exactly, I don't know. Clearly it is mostly happening in childhood. And by the time you are in your twenties, it is mostly over. So, that is true. But it varies by population. It varies by SES [socioeconomic status] and things like that. It may have more to do with the brain's adaptive function to stress than it has to do with schizophrenia pathology per se. So, you could just make the argument that you are picking up a population that has poor stress tolerance. And then that population is at risk of schizophrenia, but it is not a specific effect for schizophrenia. I don't know. I go back and forth. There is no way to prove or disprove that.

Pruning continues to be a puzzle of adolescence—related, but only tangentially, to the onset of psychosis. I asked why he thinks psychosis manifests in adolescence.

> **Psychiatrist**: I think it is probably because that is when these systems are all coalescing into their sort of final state. So, if you look at animal research, most of learning when you are a baby is entirely sensate. So, what that means is that—this is what makes trauma so horrible I think—in a sense you just implicitly take the way the world *is* to be the way the world *will be*. It makes sense. Gravity is gravity. So, it makes sense to learn gravity. You know, hard objects are hard objects. In a social world it actually sets a whole set of things in motion that you call transference. This is how people are. This is how caregivers are. And so, gradually that type of learning stops, and in fact we think you kind of can't even get that back. You can't sort of unlearn those kinds of things. And what starts more is schema-based reward and punishment. And so you develop a model of the world and you fit your behavior based upon abstract understanding of what's better, what's going to be helpful to you or not. That's how it is with most other learning. And so, behaviorism starts to kick in. Most people respond to behaviorism pretty robustly.

He continued explaining that the process is not likely explicit. People are not always operating opportunistically, but there is something different about the way adults recognize the function in addition to physical properties of the world. He gives the example of a chair—to a baby it is a thing with a sensorial presence in the world, but to an adult it is mostly a thing for sitting. He explained,

> People are very unlikely to change musical preferences or political preferences after the age of 25, right? [laughter] Whatever that making sense of the world process is. And it is probably because at some point, the opportunity, the new learning from being sensate,

> starts to become, starts to reach diminishing returns. And so, it actually becomes very inefficient to learn the world that way after a point.

I asked if he thinks this transition in learning styles creates an opportunity for psychosis to manifest. He responded:

> That clearly happens in late childhood, early adolescence. That is where most belief formation happens. It gets a little bit harder when you are talking about hallucinations. What I am talking about is more an argument for cognition and belief formation. Hallucinations are weird because you see them across the developmental spectrum. You do see them more in adolescence, but it is not like they are restricted. Whereas clinical schizophrenia is largely restricted to adolescence. 90% or something. Which is not true of hallucinations. It is not that 90% of hallucinations started when you were 16. A lot of them start when you are a kid.

I clarified by asking:

> **Melina**: I thought it was more that those experiences are often really common in childhood, and then they start being called hallucinations in adolescence.
>
> **Psychiatrist:** I think that is true. That is probably true. Probably little kids hallucinate a lot.

Even though I am the one who offered the general idea, the straightforwardness of his claim startled me. I had maintained somehow a distinction between the experience of seeing or imagining things in childhood and hallucinating. His explanation refuses such a distinction. "Probably little kids hallucinate a lot." The experience is not categorically different in childhood and adolescence—it is the same, or at least similar enough to both be called "hallucination." He has not presented childhood experience as pretend or make believe, distinguishable from the "real" pathological visual and auditory experiences that characterize some psychotic symptoms.

Along with the researcher above, the psychiatrist's frame inspires me to think about psychosis not necessarily as something that comes on, something with an early onset, but also perhaps as something that is supposed to be grown out of—not something that develops into a problem, but something that becomes a problem because it resonates too long. Young people must learn to distinguish "real" from fantasy because it is in part what characterizes the transformation to adulthood. It marks the edge between these two foundational developmental stages. Children can see with madness, but becoming an adult means learning not to. And, failing at this developmental task means maybe becoming caught up in powerful psychiatric stories that, unchecked, can lead to assumed chronicity and prolonged medication.

Interlude

My daughter and I read together at night. When she was six, I was in the early stages of planning this research—she is eleven now. At the time, she pulled my childhood copy of *Charlotte's Web* (White 1952) off a bookshelf and suggested we read it. When we opened the book we saw that as a child, I had scrawled on the cover page, "belons to Melina! giv it dake!!" [*sic*]. We wrote her name in the book with a date (5/15), no demands and no exclamation points this time. Now the book is ours.

One night we came upon a passage where Mrs. Arable decides to consult with the family physician about Fern spending so much time speaking with animals in the Zuckerman barn. Her decision is framed by the following conversation with Fern:

> "Charlotte [a spider] is the best storyteller I ever heard" said Fern, poking her dish towel into a cereal bowl. "Fern," said her mother sternly, "you must not invent things. You

> know spiders don't tell stories. Spiders can't talk." "Charlotte can," replied Fern. "She doesn't talk very loud, but she talks." "What kind of story did she tell?" asked Mrs. Arable. "Well," began Fern, "she told us about a cousin of hers who caught a fish in her web. Don't you think that's fascinating?" "Fern, dear, how would a fish get in a spider's web?" said Mrs. Arable. "You know it couldn't happen. You're making this up."

Of course, there *are* spiders that catch fish in their webs. Fern's mother is worried and decides to consult their family doctor, Dr. Dorian.

> "It's about Fern," she explained. "Fern spends entirely too much time in the Zuckerman's barn. It doesn't seem normal. She sits on a milk stool in the corner of the barn cellar, near the pigpen, and watches animals, hour after hour. She just sits and listens." Dr. Dorian leaned back and closed his eyes. "How enchanting!" he said. "It must be real nice and quiet down there."
>
> […]
>
> "Fern says the animals talk to each other. Dr. Dorian, do you believe animals talk?" "I never heard one say anything," he replied. "But that proves nothing. It is quite possible that an animal has spoken civilly to me and that I didn't catch the remark because I wasn't paying attention. Children pay better attention than grownups. If Fern says that the animals in Zuckerman's barn talk, I'm quite ready to believe her."
>
> […]
>
> "Well, I feel better about Fern," said Mrs. Arable. "You don't think I need to worry about her?" "Does she look well?" asked the doctor. "Oh yes." "Appetite good?" "Oh, yes, she's always hungry." "Sleep well at night?" "Oh, yes." "Then don't worry," said the doctor (White 1952:105-12).

It occurred to me as we read the passage that this fictional account had likely been my introduction to the type of diagnostic processes that I was now studying. The story would be my daughter's as well. I wondered, what would we learn from it?

The passage establishes childhood as a medically sanctioned space in which it is possible and even enchanting to talk with animals. It explains that children hear the stories animals tell because they pay better attention than adults. The dialogue between Dr. Dorian and Mrs. Arabel is a tale about the unknowability of nature—the miracle of the web and the perceptual capacity of children that is lost to adulthood. The book acknowledges limits in what can be understood, but only to the extent that the experiences, behaviors, and objects that refuse being known can be rationalized as unreason. The conversation establishes the excesses of childhood as normal and gendered, but also fascinating and, unfortunately for the doctor but comfortingly for the mother, short-lived. They are conditions of childhood—something lost in service of participating in the social, or perhaps biological, order of development. In adolescence, Fern will (necessarily) learn to pay less attention to what animals have to say.

This story, and so many others similar to it, teach readers that relating to "reality" is not given, but developed. They carve out a space for unreason to be contained rationally in childhood so long as the experience or behavior is charming. Sacrificing access to this enchanting mysterium is a requirement of adulthood, a task to be done regardless of what is lost—in Fern's case, many loving friendships.

This much of the lesson seemed clear to me, but I could not shake the sense that I had learned something else in the (re)reading. The moment was uncanny, not just in the sense that my handwriting connected my daughter and I to my childhood, but also in a brief sensation where she and I were able to meet as children. The edges became blurred. In that moment, I forgot to worry about Fern.

(Re)reading this allegory of childhood whimsy gave me a glimpse of how processes of rationalization, such as those demanded of the adolescent, are never complete. As I expand in Chapter 4, the valence of figurative description does not rely on accurate representation of facts. Unlike literal description—for example, scientific—it does not only contain but also opens. The figurative can expand by suspending the reader's need to decide what is real and what is not. In the scene where my daughter and I met as children, Charlotte can tell stories.

You Have to Be Honest

The adolescents I spoke with were within the process of embodying the sociocultural frameworks of their worlds (i.e., learning what not to see) and struggling to describe that experience, particularly the "failures," in a way that made sense to others. Typically, this struggling is what premeditates a call to the clinic. In question is a young person's ability to experience the world rationally in terms of both their maturity and their potential mental illness. In this context, psychiatry has a difficult time determining the difference between signs of early psychosis and features of "normal" adolescence (Fusar-Poli et al. 2013; Yung et al. 2007). Adolescents are not expected to be rational all the way, or all the time, but their status as no longer children means that they can no longer be excused from participating in the rational world. Since the edge of adolescence defines the threshold after which individuals will be expected to see rationally, it is a site where truth is (re)negotiated. Such ongoing negotiations have implications not only for what is true (can paranoia be true), but also when truth becomes necessary (who deserves to be told the truth), what truth is (can it contain a lie) and who/what can be seen as honest or worthy of trust.

I interviewed a resident after a full day of her seeing patients. I began our conversation by asking about how psychiatry trainees learn to manage the stress families bring into clinical encounters. She replied, “I would say zero actual training. Certainly not in adult training. I don’t think we do that.” She explained that it was difficult to work with families who have the sense that “it is not okay for [their child] to be schizophrenic for one more day.” Medications and therapy do not work on such a timeline, she explained. She told me the disjuncture between how long it takes for symptoms to respond to treatment and how quickly parents want them to respond leads to parents searching the Internet desperately for faster approaches offered through questionable sources. The result, she said, is the family constantly adjusting medications, which is not “how they work.” Patience in her representation is not only a virtue but also a therapeutic. Being able to wait for improvement, to delay action, is a technique of parental care.

The resident framed families as vulnerable to misinformation on the Internet. She worried that companies sell the promise of recovery or cure in the form of supplements, brain scans, and special liquids meant to help taper psychotropic medications. She struggled to understand how such information can be taken as “more true” than clinical expertise, and offered, “so, it is just really sad.”

We continued talking about when she becomes concerned about the family environment itself. In addition to the medication adherence issues she mentioned, she told me clinicians also become concerned when parents seem to be restricting a child’s access to social interactions, such as when they withdraw their children from school. During clinical team meetings, I had heard multiple conversations about parents locking their adolescent children in rooms during dinner parties, refusing to allow them to go on trips with friends or to leave for college. Such scenarios were often framed as protective but inadvertently harmful, a cause for concern. Parents are expected to hold the edge, maintain the space for their children's inclusion in the social order in the midst of experience that threatens to push them outside of it.

Our conversation returned to medication adherence. She told me there are different styles in the clinic for setting boundaries around expectations that patients and families will adhere to prescribed medication regimens. I asked what orientation she plans to take on. She responded:

> **Resident**: I think I have learned a lot in terms of kids in particular. Because, with adults you can make a recommendation for them to take a medication, and if they don't want to take it, that is on them. For blood pressure. Whatever it is. You could have a stroke if you don't take this, but you are the boss of you. You can go do heroin if you want. That is on you. But, with kids, it is different, because if their parent says they have to take medication, they kind of do. And, if we tell them they need a medication, or we will call CPS [Child Protective Services] or whatever it is, then, they kind of do have to do it.

The point is so simple it took me a second to grasp. *They kind of do have to do it*. The adolescent child and the parent must negotiate this complex space of shared responsibility for psychiatric medication. Her comment highlights the layers of authority involved in a "choice" these young people make every day about whether or not to take medication.

I urged her to continue by asking if the parent is responsible in that scene. She responded, yes. But it is not always so straightforward. It gets tricky, she explained, when parents lie to their kids about the dose of medication they are taking or when the parents hide meds in applesauce. I had heard this example before, at another clinic—the applesauce trick. It jumped out at me. I considered for a second how the ethics of a technique of parenting, delivering disguised medication, transforms from being overtly good with a small child (e.g., the bubble-gumflavored antibiotics of my childhood) to ethically repugnant for an adult. But, what of the adolescent?

> **Resident**: So, the advice that I have gotten is, you don't need to proactively tell the kid [the accurate dose], but if the kid asks, then you have to be honest about what they are getting. But, I think that is really hard because when I think about pediatrics, you have a three-year-old who needs amoxicillin for an ear infection. They are screaming bloody murder. They don't want to take it, but you shove it down their throat. You know that it is good for them. And, we have to strap kids down to get vaccines with four people in the room. And, you do it against their will. So then, this [lying about the dose] doesn't seem that bad. But, at what age do you decide that the kid should really be aware of what medication they are taking?

The ethics are not as clear as they would be with a child. With adolescents, it is not merely the need for a rational surrogate decision-maker. We cannot rest assured on knowing that it is good for them. She continued, "It's really hard to think about." I responded, "And, I mean, adolescent medicine came about as a response to pediatricians feeling that adolescents needed to have certain abilities to control their own medication[25]"—

> **Resident**: Right. Absolutely. And then what do you do when it is a psychotic adolescent? When you are wondering, do you really have capacity to refuse this medication? Are you not taking it because you have some delusional belief that your parents are poisoning you when, they kind of are because they are sneaking medication into your food. But, they are doing it so that your delusions will go away. And you [the psychiatrist] think they [the

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[25] See Prescott 1988

> adolescent] might kill themselves because of their delusional beliefs or get themselves into some super dangerous situation. So, yeah I want them to take Seroquel. But, yeah.

The difficulty here, at least one of them, is that “a psychotic adolescent” can be both delusional and right—be imagining that they are being poisoned when they “kind of are.” In this simulated scenario, medication becomes poison as it is concealed in food. Or is it that poison becomes medication when it is “good for you”? Either way, the trainee cannot find stability in psychotic symptoms as false reality alone. Paranoia is not only a question of if an adolescent is “actually” being poisoned, but also how old they are, by whom they are being poisoned and for what reason. Psychosis does not preclude truth. In fact, it may reveal it. Sometimes, one must be paranoid to see what is happening.

Trust Me with Myself

Thomas’s symptoms started at the end of middle school when he became fascinated with the occult. He had always been religious, but he told me this instance felt different. While he was practicing rituals, he began to see and hear things. Thomas explains, “I consider myself like a Faustian type of character. I was just so consumed by this stuff that I neglected real life, you know?”

He eventually decided that he could switch between different realities. He thought he had created the universe. The voices he heard at the time would mostly just talk to each other, but eventually they got mean and started telling Thomas to kill himself. This worsening of his symptoms came after he sought out treatment. As he described the scenario, it occurred to me that they had a sense he was trying to make them go away. I asked him what he thought was going on at the time.

> **Thomas**: I had many theories. A couple times I thought I was receiving other people's thoughts, like our thoughts were blending together. […] A couple times I thought it was the voice of demons or something. I don't know. I feel like it was always in the back of my mind, maybe this is a medical issue. [laughter]
>
> **Melina**: The whole time?
>
> **Thomas**: I felt deep down I kind of suspected that because my uncle has schizophrenia, so I kind of, I don't know, felt like I kind of should have known.

I asked Thomas what the clinicians told him about his experiences.

> **Thomas**: They say that I have schizoaffective disorder, which is like if schizophrenia and bipolar disorder had a baby. [laughter]

His operationalization of the diagnostic concept seemed especially apt for capturing the expansiveness and absurdity of what he endures.

Thomas's brother was the first to notice something changing in Thomas, but Thomas's thinking quickly came to the attention of his friends as well.

> **Thomas**: I told my friends, yeah you guys are all figments of my imagination, and I created the universe. I have to jump to another universe and you guys are all going to die, because when I jump to another universe, you're going to be replaced by copies of you. So, I just told them all this stuff, and then they were so freaked out.

His friends became very concerned and eventually one of them connected with Thomas's brother and together they told his mom. By that time, he was moving from middle to high school. As with many of the other young people with whom I spoke, Thomas considered the stress of that transition as part of the problem. He told me that he was becoming increasingly introverted just when everything was getting really social. He felt as though he could not express any emotion. He said one friend stuck with him but told me he does not know why.

Eventually, Thomas started experiencing catatonia, times when he could barely move. It was "like being in wax," he explained. Recalling his gratitude when a nurse pushed him into a chair after he became stuck standing, he told me, "It's not like being paralyzed. It's like you physically, you mentally can't. It's not like your body won't move. It's like your mind doesn't know how to move—it doesn't know how to tell your body to move. It's weird."

In the beginning, Thomas told me, he had a lot of trouble taking his medications.

Thomas: The first hospitalization was for a suicide attempt after I went off my meds. You know, for a long time I was medication noncompliant. I just didn't understand why I had to take meds. And, I just didn't like them.

Melina: What didn't you like about them?

Thomas: I felt like they kind of suppressed me creatively and spiritually. I don't know. So, I went off my meds, and then one thing led to another.

He reflected that sometimes he felt as though "I don't get psychosis because I go off my meds. I go off my meds because I'm in psychosis." His nuanced consideration troubles formulaic notions of medication compliance. He knew medication helps alleviate some symptoms, and yet also recognized that it does not specifically prevent or treat psychosis. Being "in psychosis" itself is a challenge to his medication use.

I asked him if he felt as though his condition is treatable. Thomas responded, "Sometimes not. [laughter] No it doesn't feel treatable. Sometimes it feels like I'm just taking a bunch of sugar pills." But, in other parts of the interview he attributed his medication to helping him sustain friendships, preventing him from dying by suicide, and supporting him in realizing a future without psychotic episodes. His relationship with the medication is not at all confused or flippant, not the result of denial. It is soundly ambivalent.

Thomas began telling me about a past psychotic episode. It started when he disclosed that he had thought about killing himself to a clinician, who decided to hospitalize him as a result. Thomas was pissed. He described the man as having been overzealous. Thomas explained,

> I felt like I shouldn't have even been hospitalized because I didn't even say I was going to kill myself. I was just being honest. I thought about killing myself in this past week.

I asked him if there was a way for him to be honest about having suicidal thoughts without getting hospitalized. He said,

> **Thomas**: I mean it's kind of like playing a game. You've got to be specific enough that they can help you but not specific enough that you get involuntarily hospitalized you know? [laughter]
>
> **Melina**: How do you do that? What are the rules to that game?
>
> **Thomas**: Just don't say, "I have a plan." Don't say that, that's the key word. [laughter]

He has learned what not to say. While hospitalized, he was put on new medication and released. After being released, he was back in the hospital 72 hours later. Thomas described those 72 hours.

> **Thomas**: I just kind of became that crazy person on the street yelling, and I was naked. I had underwear on, yeah. I ran down the street. It was the middle of the night, and I was yelling at people about aliens and stuff.

Thomas had gotten in a fight and had blood running down from his nose onto his shirt. The person who punched him had been trying to keep Thomas from one of things that triggers his psychosis. All of a sudden, Thomas apologized to me saying, "Sorry, this is a long—I have so much to tell." After some reassurance, he continued telling me that when they found him in this condition, his relatives called the police. While running from the police, he found some glass from a car window on the street.

> **Thomas**: I scraped myself up with it and the police were like "Drop it!" And so, I freaked out and I ran away from them and they tackled me. I totally could have gotten away because they were really slow. But, I stopped. I was like, you know this has to end. This has to end. We can't do this. I always had that insight.
>
> **Melina**: What were you trying to do when you scratched yourself?
>
> **Thomas**: I was trying to cut the UFO out of my blood. I felt there were tiny UFOs inside my bloodstream, but it felt really good to cut them out. It was kind of scary because it felt really good. So, this was when I was diagnosed as schizoaffective and not just schizophrenic because this was a manic episode. I had been awake for many, many days and I was, yeah, I was just, it was really bad and—

His voice trailed off. I return to his comment about always having had insight.

> **Thomas**: I had a glimmer of, like a flash. It was a confusing moment. I was so confused and then I just had this like voice say, not a hallucinatory voice, but just this like idea say, *you need to end this, this has to stop*.

Thomas listened to this voice and allowed the cops to catch him. He was returned to the hospital.

> **Thomas**: Yeah and in the hospital, ER rooms are kind of like sensory deprivation because there's no—you're not allowed to leave as a psych patient, you can barely go to the bathroom. They keep the door open to the bathroom, and it's a white room. There's no natural light. So, you don't know what time of day it is. There's no clock, and so it was really just kind of confusing and really delirious. I was hallucinating. People are

> coming in out of the walls, writing on the walls. I was just completely—It was just messed up.
>
> Then the nurse comes in and she says, "Thomas you can take your medication the easy way or the hard way." I was like "fuck off!" And then five nurses come in, five male nurses—big male nurses—they pin me down and pull off my pants and inject into my right thigh something which I later found out was Haldol because I was like, "what was that?" And she said, "Haldol." For a second, I tried to get back to whatever I was doing, and then I was like, wait a minute. Everything kind of just came together. It was like magic sanity juice, magic sanity juice. I was instantly so sane. And, I was like "what did I just do?"

After sleeping almost constantly for 48 hours, Thomas was getting ready to leave the hospital. He told me, Haldol sucks and it was wearing off. He refused more. I asked why.

> **Thomas**: Because I didn't want to take my medication. I hate medication. [laughter] And then I started to get manic again. And I needed to write, I felt this compulsion to write, because you know I write poetry. I just need to write especially in times of stress. And so, they wouldn't let me have a pen, and I grabbed the pen from the nurse behind the counter and she was like "Code green! Code green!" Then this big guy comes out of nowhere and tackled me. [laughter] But nothing ever happened to that. They just locked me in the quiet room.
>
> **Melina**: Did they give you anything to write with?
>
> **Thomas**: No. What I would do is I would steal crayons from art group and then go write with that. [laughter] […] I understand why they do it because—I wasn't going to hurt

> myself with the pen. I knew that. I wasn't going to do that, but they don't know for sure that I'm not going to do that. So, I understand, but it sucks, and I wanted to have the pen.

Curious about the non-hallucinatory voice that had told Thomas to stop running, I asked him how he differentiates between psychosis and the other kinds of extraordinary experiences we had talked about.

> **Thomas**: So, generally the way I tell the difference between something like a visionary, spiritual experience or a visionary psychotic experience is I examine, does this experience contribute to my life in some way? Reveal something about the nature of God? The nature of myself? The nature of the people around me? Does it positively impact me? You know I ask those questions. I also ask, does it cause harm in any way? Is it helpful to think like this? Does this negatively impact me?

Experiences that have value, ones that advance his understandings, do not qualify as psychosis for Thomas. Again, psychosis is not a particular kind of experience. An experience becomes psychosis, at least partially, in its relationship to the subject.

I ask Thomas how psychosis has impacted his relationships.

> **Thomas:** It's probably, it made things a little strange. My mom is always worried about me, and I don't want her to be.

Unable to imagine an alternative motherly orientation, I ask:

> **Melina**: What would you want her to be—What would you want her to feel instead of worry?
>
> **Thomas**: I don't want her to not care about me, but I just want her to trust me with myself more.

With a few simple words, Thomas expressed what I think is one of the most profoundly difficult demands of psychosis, to care and trust at the same time, especially in a scene where truth is radically destabilized.

Very Dangerous Space

> **Edge** (verb): move gradually, carefully, or furtively in a particular direction. (Oxford English Dictionary)

Angela Garcia ends her *Pastoral Clinic* (2010) in conversation with a medical provider. The person, responding to the vivid depiction of heroin use and the relations between loved ones and landscapes in which it is sustained, declares the ethnographic material inapplicable to medicine and policy. History and loss such as those experienced in the aftermath generational dispossession are impossible to incorporate into intervention. Garcia, unable to respond at the time, reflects in the final sentences in her manuscript, saying:

> While it may be true that *she* and even I cannot conceive of a plan of care that could incorporate all the history, all the losses, this is precisely what families try to do for one another every day. They conceive of ways to care for one another in a context where their very relations, and the very struggle to maintain the everyday, are at stake. Of course, they often fail, and tragically so. But they keep trying to the very end (Garcia 2010:203).

Garcia's reflection hints at the potential of familial care but also warns of its dangers. With such forms of everyday care, it is not only the psychiatric subject who is at risk, but also the very relations that make care possible. Thomas's provocation, that he wants his mother to care about him but trust him with himself more, demands an alternative to intervention. Similarly to the psychiatric trainee quoted above, what Thomas seems to be asking for is a caring that does not intervene, a presence or being with that can accommodate suffering and risk—a therapeutics of delay. While preemptive intervention may be the hope for cure in psychiatric care (Insel 2007), familial care may orient to a different call and a different temporality. Preemption is organized around an immediate threat, it demands immediate intervention. Familial care, on the other hand, must go the distance. It has to accommodate failures, setbacks, and conflicting truths. Familial care must be capable of not only intervention, but also waiting. Maintaining the trustworthiness of a child staggered by early psychosis might mean putting at risk one's own certainty. It may threaten ethical commitments and familial dreams, even the very child and relations it strives to protect.

I originally met Xavi's mother, Luz, briefly during her son's intake months before our interview. She does not remember me having been there. During the feedback session at the intake, the psychiatrist asked Luz how her son had been doing. I remember how she turned to gaze at her son saying, "Some of the cuddling has come back." I remember the wash of warmth.

Luz starts our conversation by telling me about their family. They had moved around a lot and traveled as well when Xavi was young. She describes their life as modest but comfortable. Their home is small, but full of music, art and books.

I ask her about Xavi's college applications. He had been applying when I met him. She tells me he had been admitted to an extraordinary university. She says, it is beyond what they thought possible. I ask if she is excited. She says, yes. She says, of course there are concerns, that it will be too demanding, too rigid, too stressful, but she has seen a shift recently, where the depression has lifted, and that makes her think it will be okay.

When we shift to talking about what brought her family to the early psychosis clinic, I ask Luz if it had occurred to her originally that Xavi was experiencing psychosis. "Not at all," she explains. Anxiety. Depression. Maybe stress. She explains, "I thought, well, that's part of this age. That [the possibility of psychosis] completely escaped me. I had no sense of that." The therapist identified it right away. He referred Xavi to a psychiatrist.

> **Luz**: [The psychiatrist] was super direct … "He needs medication and this is the medication that starts tomorrow." And we're like, "what do you mean?" Of course, I was shifting jobs. It was difficult. Maybe that's impacting him. So we tried to come up with all the excuses why he didn't need the medication. And then she said, "best case scenario is that this is just depression, but I'm seeing a risk of psychosis which can lead to schizophrenia." She was super direct in front of the three of us and we were completely shocked. So that was hard to process.

I ask how they ended up processing it. She tells me they did not talk about it, not in the car on the way home at least. She says they were really cautious about who they talked to about it.

They ended up telling a few family members, who encouraged quick psychiatric treatment. She also let the school counselor know about her son's diagnosis. Luz felt that it was a risk to disclose the information, but it really helped in the end. From that point, the counselor managed everything school-related. The counselor let his teachers know about necessary accommodations. The counselor made space for Xavi in her office, to come when his "mind was scattered and he just couldn't do anything." I had a sense as Xavi's mother described this space, that the counselor had made room for her too. Not in the office, but a space for Luz to be in her own life in a different way, if even just for a while. A space where she did not have to disclose her son's mental health status again and again.

> **Luz**: When we went to the clinic, everything was so much easier because everybody was so much softer about the language… After the first assessment, the full assessment, she described there are five factors that they use to diagnose if he is at risk of psychosis and

where he scored positive was that unusual thoughts, now you have to remind me what are the five things that you probably know.

Melina: Yeah it's grandiosity and—

Luz: Grandiosity, I had to ask a little bit about that because his self-esteem was very low. But then when he related to his peers, he felt so on top of everybody else, his peers or the clinicians. It was hard to understand for me. As he is very interested in philosophy and explorations, we kind of encourage those unusual thoughts in a way and the school will encourage those, "if you want to explore a different path go ahead." So, it took a lot of conversation with [therapist] to understand what that really meant.

Luz struggles to understand how her son could be both grandiose and insecure. She recognizes his sense that he is superior, but also sees another side.

Melina: Were you convinced that he is at risk, or are you still skeptical?

Luz: So, the way [the clinician] explained, it's not about his interests in a different perspective but the intensity with which he engages in that material, in the amount of material that he's processing on that subject.

She goes on to explain that in hindsight, she can see where he was "coming over the edge." Interactions between them now appear strange. She recollects debates they used to have about social theory.

Luz: Xavi was having a blast discussing free will because he was in this whole thing that free will doesn't exist. And I thought, "how fascinating." He grew up in this environment where we're questioning everything, and so I thought "how interesting." But thinking back, after I learned what was going on—I would have conversations with him until 3 o'clock in the morning. He was trying to convince me about the nonexistence of free will.

> I have to say, there were times where I was pretty exhausted. On the other hand, I thought, “what a great opportunity to talk with him.” But he was getting very upset.
>
> **Melina**: Okay and that wouldn’t be—if it was just a discussion you wouldn’t assume that he would have the kind of response you were seeing.
>
> **Luz**: Well, I was thinking he’s really passionate at that moment. Then thinking back, I can connect the dots and make sense of—he was coming over the edge. But, I couldn’t see it when I was having these conversations with him. I wouldn’t realize that I was feeding that potential psychosis.

I feel both sad and relieved as I ask a question I think I already know the answer to.

> **Melina**: Do you and your son still talk about philosophy? Can you still talk about free will or has that totally stopped?
>
> **Luz**: That stopped. But, occasionally there would be subjects that come up. I’m a lot more careful and I have talked to his therapist a little bit. She said it’s good to have conversations, but to ensure that there is clear reasoning. That there is a connection between A, B, and C, and that’s a good exercise for our conversations. It’s good to have these conversations, but to keep those conversations grounded. So, I have tried, and I think I do have some resources and skills to manage some of those conversations.

Of course, grounding these types of conversations is difficult. The therapist suggested figuring out the steps, focusing on more concrete tasks, specific tangible situations. No room for free will. Luz seems relieved to have the constraints. Some of the conversations had been hard on her too. Not just because they were exhausting, but also because of the content. His positions in certain debates trigger her emotionally. But this conflict she attributes to normal adolescent behavior:

> **Luz**: I think there's some natural normal pushback. So, "this is what I'm hearing from my mom, I'm going to push that back." So, I didn't want to feed that kind of pushback. I kind of withdrew my engagement a little bit because it was triggering some of my emotional spots.

He had pushed against frameworks she maintained ethical connections to, such as her critiques of racism. In response, she pursues a strategy of withdrawal in the context of grounding these risky conversations. She is protecting not only her son, but herself too.

> **Luz**: So, it is difficult and now that you're saying, you're making me think kind of more intentionally about that. That some of my communication with Xavi has been disrupted because I am scared of delving into those spaces and feeding something that doesn't work for him. I think to some extent, he is as well. He's sensing some of my fear, and he doesn't step into that.

She is worried about poisoning her son, not with food but with debate. She is worried it will damage their relationship, but also that it will hurt Xavi. Ultimately, they must stop, and he seems to know it too.

> As our interview was wrapping up. I ask a final question.
>
> **Melina**: Do you have a sense of whether you think that your son will experience psychosis in the future?
>
> **Luz**: I don't know. I don't know. I hope he doesn't. I think if he does, I hope he has the kind of social institutional support to manage that. I can see him interested in exploring the edges.
>
> **Melina**: Interested in exploring the edges?
>
> **Luz**: Of a thought, of an object, of a sound. And so, he walks in a very dangerous space.

Even though the only diagnosis Xavi carries is depression, his curiosity at the edges becomes dangerous in light of psychosis risk. Perhaps it always was dangerous. If the role psychiatry gives itself is, as Foucault and others have demonstrated, to liberate us from madness, her role here is different. The clinic's task is to make her son understood through diagnosis and functional through treatment. She is grateful they do this task well. Most of the people I spoke with expressed similar gratitude even in the midst of significant concerns around these very practices. Luz has a different job—to protect her son's footing on the other side of the edge. To keep psychosis *and* its rationalization from eclipsing the beauty of what is their real world. A world filled with debate, aspiration, sounds, and objects. A very dangerous space where she is a fulcrum of Xavi's risk and his ambition.

Iatrogenic Sacrifice … An Easy Thing to Do

> **Edge** (noun): The sharpened side of the blade of a cutting implement or weapon. (Oxford English Dictionary)

Some months after my conversation with Xavi's mother I tell one of the psychiatrists about this issue of things in life, important things like debate, becoming risky for families in the midst of early psychosis. By then, it had come up in multiple interviews. The psychiatrist claims at least part of the effect as iatrogenesis, a harm caused by medical treatment:

> **Psychiatrist**: I mean yes, I would say, it is a common source of iatrogenic harm. Which is that we give people the impression that there are behaviors that are symptoms, and there are behaviors that are not symptoms. But, we do a ridiculous thing that, just because you are seeing me, I give you my expert opinion on what behaviors could be a symptom. Which is not a ridiculous, not a stupid thing to do. But, I am telling you things that in the general population, in 99.9% of people who exhibit those exact same behaviors, will be

fine. And wouldn’t even think. There would be no second-guessing associated with that at all. You would just say, yeah, that was inappropriate. Or yeah, everyone got sick of listening to you argue. But, nobody would turn it into a symptom.

[…] Just to give you an example of something that jumps into my mind, we had a family meeting recently with a young woman who is doing a lot better. It has been several years, but she is doing a lot better. Part of reducing the medication has had an interesting effect for her. Because the medication is a sedative, once you get to the very lower doses, your thoughts do speed up because you are not sedated. That is a common experience, people tell me. But, “thoughts speed up” is so ingrained in our culture as racing thoughts. Which is funny because racing thoughts—the point prevalence of racing thoughts is enormous. It is kind of funny to say that it is a manic symptom. It does go along with other things. But, to say that it, by itself, is a symptom, is very problematic.

Melina: So, it is unlikely that anybody has ever not had that experience, right?

Psychiatrist: Right. I would make the argument that on any given day, most people at some period do. Which is not true of hallucinations, right? Brief misconceptions, maybe. But, not fully formed hallucinations. Those are relatively rare. And so, it was just interesting to hear her arguments with her parents about what was a symptom or not because she is having a much more robust internal world—like she used to. And, part of having a robust internal world means—again, this is where you have to put it in normal language. It means, having memories and thoughts that are inherently internal but are emotional and meaningful to you. So, you get preoccupied with your thoughts. You smile at your own thoughts. You laugh at a funny thing you remember. But, what the family sees is someone who is laughing to herself. But now, it is a symptom, because she has

> schizophrenia, and people who have schizophrenia often laugh to themselves because they hear voices. Which is true. That is true. They often do that. But, it is just a good example of how the behavior gets turned into a symptom even though, the vast majority of the time, if you were just taking a camera around and you saw that behavior, you wouldn't think twice. You will see people briefly laugh to themselves on the bus all the time.

The psychiatrist's comments reiterate the quandary I trace throughout this manuscript. Diagnosing symptoms of psychosis requires considerations of context, relationality, and biography. Psychotic symptoms, at least at this stage, do not manifest in isolation of other information. I am skeptical that the loss is a product of psychiatric diagnosis alone. In the explanations shared with me, diagnosis of the sort we are discussing (e.g., the kind that happens outside the clinic, in buses, or with your parents) seem to operate beyond, perhaps even before, the clinic. I ask:

> **Melina**: And, do you really think of that as a product of the family having received psychiatric diagnosis—
>
> **Psychiatrist**: It's not the only thing. I just think it would be an iatrogenic risk for the doctor to say, this is a return of your symptoms. Which I think would be an easy thing to do. The momentum would be in your favor. This could be an early relapse. That could be true. […] But, it is just interesting to me that her subjective experience was exactly the subjective experience if you asked you or me on the bus why did we just laugh. We would say, "oh I was thinking about this movie I just watched last night that I really enjoyed. There was this really funny part with this x, y and z." Which is something she has not had very much of before, for whatever reason, for years. So, in a sense, it is a

> good thing to have that back. That is part of your sense of self—to have an internal kind of sensory world.
>
> **Melina**: So then, your hope for the parents is that they might release a little bit of the anxiety around this exact behavior, that this exact behavior equals an exact return. Instead, they might be able to gain, a skill or whatever, an ability to say, "hey, what did you just laugh at?"
>
> **Psychiatrist**: Yeah. And, not be afraid of it. Not claim that it is a problem. It is a good example of somebody where it could be part of a problem. It is just that by itself, it is not particularly problematic. Right? It was a very interesting conversation because she had been dysfunctional for so long that the family had just gotten used to her, the treated-with-clozapine version of her. Which was, stable. Much better than it was before treatment where she was confused, and agitated, and disorganized. But, it was not expressive or emotive.

The diagnostic "momentum" guides everyone toward the notion that what she is experiencing, something that everyone experiences, is, for her, a return of symptoms. It gains its force through psychiatric diagnosis, but also visceral returns for the family of what had been, what had happened when she had laughed aloud to herself before. In the end, the momentum sucks up and contains not only the symptom, but also the laughter.

CHAPTER FOUR | Not Authoring Madness

In this chapter I introduce one young man's consideration of psychosis as metaphor, a descriptor applied to an object or action to which it is not literally applicable. Similar to Katherine's notion of psychosis as empathy, his concept opens up the possibility for psychosis to facilitate rather than foreclose shared understanding. Psychosis as metaphor extends what psychosis can tell us beyond its literal manifestation as symptom in a way that may preserve the possibility of a psychotic subject. And yet, throughout the diagnostic interviews I observed, I noticed a hardening of the distinction between literal and figurative descriptions of potentially psychotic experience. I take one such intake interview, with a young woman I call Lucy, and demonstrate how metaphors are clarified and literal description is demanded. Percentages are used to replace complex and dynamic phenomena. In this way, diagnosis intervenes on treatment plans but also on narrative, refining not only the stories people will tell about their experience but also how they come to be defined by the experience itself. Extending from Foucault's *Madness and Civilization,* I argue that such diagnostic exchanges leave stories of madness not only unheard but also unspeakable. As one young woman explains, giving voice to the non-being of mad thoughts and ideas, experience sets the stage for their manifestation as threatening entities. As a conclusion, I build on Stefania Pandolfo's concept of the Cervantes Stage to raise a concern that, within the space of early psychosis, figurative description is refused at the very moment it may be most necessary.

Psychosis as Metaphor

Evan is a young man who has been identified as being clinically high risk (CHR) for psychosis. He and I are talking about the experiences that brought him to the early psychosis clinic. He tells me there was no question that he had been "mentally unhealthy." At one point he felt so stagnant, "wrought with suppression and restrictions," that he threw a mini-fridge out of a window of a tall building. He calls it a metaphor. I ask what it was a metaphor for.

> **Evan**: Action. Just any sort of action. It was so bad at that point where I couldn't get myself together to, just move forward. So, I realized that you can do things if you work yourself up enough. It could have been me, you know? I could have been that mini-fridge with that same mental processing. I'm glad it was the mini-fridge and not me.

I ask when his parents started to worry about him. Evan says, earlier. He tells me he would shut down, panic.

> **Evan**: I wouldn't talk to my parents, and I wasn't able to speak correctly. I would jumble my words or more than jumble my words, just sort of stutter. I wasn't able to keep it together.
>
> **Melina**: Did you think that you were making sense when you were talking to them in those moments?
>
> **Evan**: No, I knew I wasn't making sense. It was just really hard for me to speak and communicate. Yeah, it was both a culmination of being shy and uncomfortable, and it was just really hard to muster up the strength to talk with them about it. So much so that if I were frustrated or angry, instead of trying to communicate my emotions, I would just seize up entirely.
>
> **Melina**: Okay into one of these—
>
> **Evan**: Into a catatonic state sort of.
>
> **Melina**: Do you remember being in those catatonic states?
>
> **Evan**: Yeah. I remember just feeling really angry but almost feeling, you know, feeling super distant at the same time. Feeling miles away, but the anger is so close. […] I would

> just close up entirely and just wouldn’t want to be touched or anything and just really, really distant. At the same time, I would be tripping myself out on my own thoughts. I’d spend a lot of time in my own head, and a lot of that was attributed to getting high alone and just wandering about—just not having anyone.

Alone. Stuck. Unable to communicate. Inside these catatonic states, the only thing Evan feels close to is anger. Everything and everyone else feels far away. He wants to be far away, but it is no good to be alone, to not have anyone. He has to force himself to move, act. Throwing the appliance showed him he could move. But, it could have been him. It is almost him, as though he threw the mini-fridge instead of throwing himself. Or perhaps he threw it as a part of himself, the part that was refusing to animate.

The event came to the attention of friends and family and they came. He acknowledges the risk, especially to others. He worries that he could have killed someone. He laments that the apartment handyman had to clean up the mess. The threat to the subject in Evan’s story is stagnancy and isolation. Psychosis both threatens and saves Evan’s life. It helps him communicate a paralyzing, isolating anger, but only insofar as the relationship remains metaphorical. *He could have been the mini-fridge.*

Tracing back to when he started to recover, he tells me:

> **Evan**: I was mentally unhealthy but was still sort of learning how to function. I was doing some landscaping but ultra-neurotic landscaping.
>
> **Melina**: What does ultra-neurotic landscaping look like?
>
> **Evan**: Just having major glorious plans for this backyard that never happened. Weeding the entire back lawn, which was a good thing. But just weeding the entire back lawn by hand and clearing out—there were some wasps in the laundry room, clearing out the

wasps by hand. Which was a good personal victory for me I think, but also really fucking weird. Really over the top and you know could be good, but at the time it was definitely metaphorical.

Melina: For?

Evan: For myself and getting all the wasps out of my own head I guess. Clearing all the wasps out of this little laundry room, so I just went in there with a flashlight and—

Melina: Did they get you?

Evan: No, I got them.

Melina: Did it help?

Evan: It definitely helped, because I worked through some fears. I just got to know what I'm doing, and fucking do it. And I did it. And you know, it made me feel good. Just the fact that I was able to alright shit, I did it. It was good. But also, ridiculous.

Again, Evan acts on mental torment by acting on material objects in the world—this time, wasps. He again describes the process as metaphorical. He finds a kind of catharsis in doing something ridiculous, irrational, something "really fucking weird." Obviously, the psychosis as metaphor that Evan offers is not entirely cathartic. It is dangerous, odd, and scary. After all, the wasps could have gotten him (my concern) or the mini-fridge could have been him. Evan's psychosis as metaphor is not a denial of any literal manifestation of psychosis, but perhaps it is an alternative. The depiction of psychosis that Evan offers highlights the stakes of maintaining the possibilities of psychosis as metaphorical representation. As metaphors, clearing the wasps and throwing the fridge become external operatives in his perception; they maintain space between the description and what it describes. A literal account of Evan's perception runs the risk of removing this space.

Diagnosis and the Demand for Literal Description

In the following vignette, I detail an intake interview in which a young woman, Lucy, negotiates experiences that do not make sense. She attributed them all to “her mind,” claiming them as her own, hers alone. Experiences that could not find explanation in the “real” world found a home in her (mis)perception. In this section, I show how by founding diagnostic truth in literal description, there is a silencing or refusal of figurative expression. Diagnostic interviews, such as the one reported below, rely on ascertaining an individual’s conviction in thoughts, beliefs, voices, and visions that are suspected to be psychosis. As such, young people are asked to describe in detail the experiences that brought them to the clinic. Figurative expression is devalued even though the figurative is a foundational, perhaps the only, way knowledge of madness can be approximated.

All in My Mind

Lucy’s intake interview began abruptly and casually. The interview was initiated by a medical student, which is typical in academic clinics. The student started the interview with a question an adult without children would ask a kid at a dinner party, something similar to, how’s school? Lucy answered with what you would expect a young person at a dinner party to say, “a lot of homework.” They chitchatted for a bit. Interviewing was new to the medical student, and they both seemed to know it.

The student eventually zeroed in and asked for Lucy’s understanding of how she got to the clinic. She puttered through a confused response to a confused question.

> **Medical student** [clarifying]: What did your therapist think you needed to talk to us about?
>
> **Lucy:** The voices, I assume.

Her tone was playful but sharp. She would not own the confusion. She told us that three months ago she started hearing voices, saying, “I thought it was coming from in the room so I didn’t realize it was a voice at first.” She thought that it was the voice of another person speaking in her classroom, but something seemed off about the voice.

Lucy: It didn’t feel right. I’m not sure if that makes sense. I couldn’t hear what they were saying—does that make sense?

Medical student: They were muffled?

Lucy: Yeah muffled. […]

Medical student: have you ever heard voices others didn’t?

Lucy: I don't remember, I mean—I never asked people about that.

Her response answered his question but posed a new one. What would it be like to ask a person about that? While obvious from a psychiatric perspective, it had not seemed relevant or possible to Lucy to verify her perceptual experience in comparison to others. Her unspoken question hung heavy. Indeed, we were asking her questions about that.

The medical student followed up, asking if anything similar had ever happened. Lucy mentioned the bugs. They crawl on her now and again. It had started with the bugs. The student asked her how that makes her feel.

Lucy: Like I needed to take a shower.

He continued asking questions about how she makes sense of the sensation of bugs crawling on her when others do not perceive them. Lucy told us it did not really bother her when it started.

Lucy: When you are in third grade, you just think everyone is seeing things.

As with the psychologist’s son seeing a dead girl in the tree (Chapter 3), the understanding of her experience as extraordinary must be learned. It is not given. As a child, she assumed everyone experienced things as she did. Or, perhaps it had not even occurred to her to compare her experience with others at all.

She refused the medical student's invitation to frame the bugs as intrinsically distressing, pathological. As a child, seeing the bugs did not really bother Lucy. As an adolescent, they seemed to concern her more, at least enough for her to bring them up in a psychiatric interview. They made her feel dirty, like she needs to take a shower. The simile is immediately available—as actual bugs would. The bugs only become a hallucinated sensation in hindsight and from the position of learned rationality that considers them alongside bugs other people experience. It is growing up that imposes the recognition that her experience is out of the ordinary, and it is from the position of this learned rationality that the space of the simile must be imposed—these experiences are real as experienced, but they are not real bugs.

The resident took over the interview from the medical student, saying, "Let's go back to what brought you in today." I assumed the student had missed something. Lucy patiently recounted her experiences in high school with school counselors discussing some thoughts she had of hurting herself. The resident asked her more about how she felt during that time. Lucy dismissively responded, "I don't think I had a plan. My best friend was not talking to me … things were out of my grasp." The resident clarified, "literally out—." Interrupting her, Lucy said dismissively: "No, metaphorically."

It was slippery. In a psychosis clinic, things being "out of my grasp" has literal and metaphorical possibilities and implications. Weakness, trembling, stiffness are all potential symptoms as well as possible medication side effects that must be psychiatrically parsed. But in this case, possible psychosis perverted a common use of a common expression. It rendered it literal. It is the resident’s question that then became odd as Lucy was forced to abandon her metaphor. She qualified it literally, “I wasn’t ready for high school.”

When Lucy tried to use figurative language to explain how such experiences affect her, “things were out of my grasp,” she was asked to respond literally. She had to label her metaphor as such, draining it of its power and resonance, its truth. Once the description was rendered false in a literal sense, it was translated, dismissed, and not pursued. Throughout the interview, her descriptions were further and further refined, sacrificing the vastness and specificity of her original expressions.

She contextualized her difficulty with school as a result of worry. Lucy mentioned starting medications at that time. The psychiatrist and resident both jumped in to clarify the timeline. Lucy obliged but did not clarify much. Conversation transitioned back to what she had been worried about.

Lucy: That they would see through me, that I wasn’t a normal kid.

Resident: Do you think other kids really saw you that way?

Lucy: I don't think anyone even noticed that I was in class.

She was afraid her peers would see that she was abnormal, but it ended up that they were seeing all the way through her, not to an underlying oddness but rather insofar as she felt completely unnoticed, unseen. The resident asked more questions about what Lucy was afraid of. What was worrying her? She told us that at the time she was so scared that she could not sit down and think about what she was scared of. The next year was better. Therapy had helped. For the second time, she recalled starting on medications.

Psychiatrist: Do you by chance remember the name [of the medications]?

Lucy: I was just so overwhelmed with the diagnosis—I can’t remember. I’m sorry.

Young people in the clinic often apologize for what they do not know or cannot describe. There is clearly an unstated, and often unrealized, expectation for self-knowing and articulation. Most of the time forgiveness is readily given, but just as often the failure comes up again as the clinicians work to produce a diagnosis after the interview. Not knowing can itself be taken as a symptom. In this clinic, an adolescent should be able to track and remark upon the medications they take. Adolescence then is marked by ability to both filter out stimuli and manage what is left.

Lucy told us that she was not sure why, but something shifted at the end of that year and she started feeling unsafe.

Lucy: I'm not sure how to describe it, I just felt scared all the time.

Resident: Now?

Lucy: It was all in my mind.

Resident: How long did it take you to realize it was coming from your mind?

Lucy said, "two months," with a little grin. Voices were talking about her all the time. Trying to clarify the voices for us, Lucy explained: "It felt like it was one main person but other people involved. Not fun."

After the interviews, the clinical team met to discuss the diagnosis and make a plan. The attending psychiatrist shared with the team, "I wasn't picking up on anything like conviction." He referenced her response that she was 50% sure that the voices were "real." The "problem" he focused on was that Lucy was unable to report accurately about her medications. Lucy's mother was taking responsibility, and that did not sit well with the psychiatrist. His expectation was that Lucy would more or less independently manage her own medication or at least be capable of describing them. Interestingly, in another conversation, a therapist from the same clinic had used managing medication as an example of how young people with early psychosis are thrust into lives that are too old, demand too much responsibility, close too many doors for their adolescent lives. And so, medication management is a task they should do, but one that is not age appropriate. It is necessary, but also a forfeiture of youth.

The therapist who interviewed Lucy's mother agreed that Lucy lacked conviction, saying, "she was receptive to reality testing." Being receptive to reality testing means Lucy was able to objectively evaluate her perception as not cohering to reality. It is not misperception that indicates psychosis, but an inability to know it as such. We all hear and see things that are not "there." Recounting a story we had heard in the interview, the therapist not only reflected on Lucy's ability to recognize her perceptions as misperceptions, she also highlighted that Lucy's mom had described Lucy feeling guilty about having been wrong about what she perceived. She offered this guilt as evidence of her receptivity to reality testing. The psychiatrist acknowledged the meaningfulness of this example and noted aloud that she was "readily able to reinterpret." I wondered if it mattered that the reinterpretation had felt so bad.

The clinicians broke for the team meeting. After about ten minutes, the psychiatrist brought Lucy and her mom back into the room to hear the results of the assessment. He began by introducing *the prodrome,* describing it as a scientific advancement over the past 10-15 years that attends to the "early manifestations of psychosis." He said it gets called many different names, including clinical high risk and psychosis risk syndrome. Distinguishing the prodrome from a "full psychotic episode," he explained that many people hear voices, and that hearing voices is actually not a very reliable sign of psychotic illness. "Voices are not very predictive," he told the women. The psychiatrist went on to explain that transition to full psychosis is marked not by the presence of experiences such as voices, but rather in "lost insight about them not necessarily being real.” Diagnosis, he said, comes when *we* can “convince ourselves that you have reached that point.” *That point* is conversion. In this diagnostic process, the clinician is not only required to notice signs of illness but must also determine the degree to which they are convinced of a patient having been convinced that what she had experienced, thought, or believed was “real.” Conversion is noticed through double conviction, that of the patient and the diagnostician.

The psychiatrist continued to lay out his diagnosis but took the opportunity to double back, asking Lucy once more, “So how certain you were … you said 50%, remember?” Lucy nodded in affirmation. While I had been in the other room with the clinician interviewing mom, Lucy must have indicated that she had been 50% sure that the voices were real at the time she was hearing them. Interviewees are generally asked to assign a “percent sure” value to how real their experiences suspected as psychosis had been, had felt. At issue is not whether the experience is or is not real. She hears the voices, but what matters to the diagnosis is whether the realness is pathological (sure) or normal (doubted). The psychiatrist, nodding after getting the confirmation he needed, continued his explanation, telling the mother and daughter that the distinction between psychotic experiences and conversion to psychosis is not widely recognized by community doctors.

He went on to explain what “we” know. First, once a person has a full episode of psychosis, earlier treatment leads to better outcomes. Second, of people showing signs of prodrome, only about 20-30% convert to what he referred to as “full-blown” psychosis. The “we” here are early psychosis experts, a group of psychiatric specialists distinguished from general psychiatrists and other mental health providers, including psychologists, social workers, and counselors working in the community. The message was that Lucy was getting a particularly nuanced diagnosis, one she might not expect outside this scene of specialization. And yet, what makes the diagnosis specialized is not necessarily that the experts are better able to identify symptoms of psychotic illness. Rather, specialized expertise here is knowing when hearing voices is not yet psychosis. Specialized expertise offers the ability to recognize that symptoms largely associated with psychotic illness (e.g., hearing voices, hallucinations, paranoia) are, in fact, part of “normal” experience. What Lucy gains by accessing a specialty clinic is learning that she does not yet have psychosis even though she is experiencing what would likely be recognized as psychotic symptoms. The prodrome becomes a way for psychiatry to hedge their bets, a strategy that demands intervention but also leaves open the possibility for psychotic and unpsychotic futures.

The psychiatrist then offered the family a SIPS—the gold-standard scientific instrument for assessing prodromal psychosis detailed in Chapter 2. He described it as “a computerized algorithm to quantify risk.” To get the SIPS, Lucy would need to enroll in a research study on early psychosis. He said the results could “help you with what you say to docs in the future.” Framed this way, the instrument promises double recognition—the possibility that psychosis symptoms can be identified before they are fully realized and that these symptoms could be more effectively brought to the attention of medicine as a result of instrumentation. The test would help Lucy with her psychiatric biography.

At this point I noticed Lucy’s mother gently touch her daughter’s arm to bring Lucy back into the conversation. She had not been in it for a while, eyes cast down to her lap, not sad, just otherwise engaged. Lucy offered a polite smile in acknowledgment that she had not been paying attention, and then looked relieved when she realized that no one was waiting on a response from her. The psychiatrist continued to talk about the SIPS: it “can tell us this is getting better, this is getting worse, so you don't have to worry.” As he finished, Lucy and her mother gathered up their things. I noticed that mom did not look less worried. Lucy looked tired. They told the team that they would let them know about the research study.

Lucy's status as prodromal was based on a clinical determination that she had not converted to psychosis. Her lack of conversion is determined by how uncertain she was in characterizing the voices and how readily she came to the realization that they were "in her mind." She recognized her perceptions as misperceptions and even felt badly about having held them. As she described the voices, she said she knew they did not make sense as voices. They were muffled. They didn't "feel right." She thought maybe they were people talking in another room, but she knew that did not really make sense.

The question of whether or not the voices are "real" is not a question of malingering or simulation. No one doubts that Lucy heard them. It is an assessment not of whether she experiences psychosis, but rather how she relates to it. They are "real" insofar as they are experience and potential symptoms. The multiple returns to her interpretation of her experiences as "real" is an interrogation not of the quality or impact of her experience, but rather of the degree to which she interprets what she experiences as part of the outside world. Lucy has symptoms generally associated with psychotic illness. She was having visual hallucinations. She was hearing voices. She maintained delusions, albeit only briefly. And, the symptoms were distressing. She worried so much that it became hard for her to interact. They were "not fun." She was "scared all the time." But, the clinicians determine that she was in a prodrome stage of psychosis, not because she did not hallucinate, but rather because she continued to doubt the actuality of her experience.

Lucy was spared a psychosis diagnosis precisely because she claimed the voices, bugs, fears, and ideas as her own, of her world, not the world. But taking such ownership seemed to take a toll. Lucy's voices are not real as reality or symptom. Her understanding of them as "not real" helped her maintain her sovereignty of self; she has not experienced an episode of psychosis. And yet, the experiences remained. They distracted, tormented, and excluded her. They made her socially invisible. They foreclosed life chances. She could continue in school.

Lucy tells me later that she is glad to not have psychosis, glad to be just at-risk, her interpretation of the prodrome. Such is the subjectivity of not-yet psychosis, an ambivalent position on the periphery of psychiatry where maintaining a close relationship to fleeting and attenuated psychotic experiences, seeing them as of your own world, is seen as negating the onset of "full-blown" psychosis. And giving them over entirely to the world marks conversion to psychotic illness.

Beyond the specifics of pre-psychosis, the practices wherein uncertain diagnoses are stabilized in psychiatry have long been critiqued by anthropology and from within psychiatry itself. Less well addressed are risks associated with disabusing or refusing to authorize an experience as a symptom. It is widely assumed that people do not want to hear that they have a psychotic disorder. One psychiatrist told me that as a result of massive misinformation around the condition, parents often experience a schizophrenia diagnosis of their children as "worse than cancer." And interviews categorically confirm that young people and family members are generally relieved to know they are in an at-risk phase of psychosis. And yet, interviews also consistently show that this relief is tempered by the ongoing presence of not-yet psychosis, experiences that are often highly distressing but refused what Sue Estroff et al. (1991) call the shelter of a disease designation. As shown above, potential symptoms of psychotic illness are disqualified as such when a person maintains doubt in their experience. But, maintaining such doubt is itself a punishing, and by all accounts exhausting, endeavor. If conversion to psychosis is determined by the point at which a person stops doubting their experience, it seems important to better understand not only how to mark that threshold but also how doubting feels.

If Lucy learns to doubt her experience from a position within it, who is doing the doubting? And, who is under doubt? There is a burden to the demand that reason makes on our attitude toward unreason. If preventing psychosis means asking young people to stay in a position of doubt vis-a-vis their perceptions of the world, we need to know what we are asking of them. In our efforts to protect them, we are asking young people to describe their experiences, but limiting their expression—requiring them to speak without offering the possibility of really being heard.

The Silencing of Madness

Michel Foucault offered an explanation for the silencing of madness (Foucault 1965). He argued that the relationship between reason and unreason becomes increasingly distanced until finally in the nineteenth century it is cut entirely, rendering dialogue between the two impossible. The removing of chains by Philippe Pinel in 1793 signals the humanization of the mad. But liberation comes with a price; to be free, the madman must accept himself as sick or be able to become a productive citizen. From either position, madness will not be heard.

Foucault explains that the absence of the use of constraint in the nineteenth-century asylum “is not unreason liberated, but madness long since mastered” (Foucault 1965:252). This work situates the emergence of mental illness in a political field, highlighting the process of separating, confining, and finally silencing madness as critical to contemporary conceptualizations of reason and rational thought. By revealing what he calls an archaeology of silence, Foucault refuses any easy notions of simple medicalization. Instead, he shows that beyond segmenting, confining, and finally silencing madness through medicalization, the process also creates, reaffirms, and polices the terrain of reason. There is no reason without madness. As relational concepts, their meanings are maintained through their opposition.

Foucault offers a historical account of madness beginning in the Middle Ages, where it existed as a link to a transcendental world, but among daily life. This reality, he explains, is now largely unimaginable and reflected exclusively through art. It was a time where demons walked among the living. Folly, a sign of the devil, was treated religiously, with the discernment of spirits; it was otherness, but an otherness that one could relate to. He argues that madness is born from folly during the Renaissance. Here, the ship of fools marks the banishment of madness to a particular place while maintaining its possibility. The threatening other is still an outside other, but one that is possible for everyone, and only distinctly different (slightly more mad) than lauded forms of imagination seen as lenses to the Truth (word of God, power of the animal). In the Classical Age all those deemed mad (the other) were rounded up within city walls and imprisoned, marking the moment when madness could not be openly tolerated, not even in an elsewhere.

While characterizing madness in some ways betrays Foucault's notion of it, he offers some qualities, "With error, madness shares non-truth, and arbitrariness in affirmation or negation; from the dream, madness borrows the flow of images and the colorful presence of hallucinations" (1965:106). What madness lacks in positive character as error, it fills in with dream, leaving something that is neither merely the concept of non-truth nor the sensual reality of images—it is a false presence. It evades the capture of literal description. After the Enlightenment, reason places madness in the unconscious and characterizes it as "always absent, in a perpetual retreat where it is inaccessible, without phenomenal or positive character and yet it is present and perfectly visible in the singular evidence of the madman" (1965:107). Since madness is nothingness, it can only speak for itself through reason (language, body, soul) as unreason. Transformed in this way, through embodiment or speech into unreason, it is rationalized, and what remains uncaptured escapes back into nothingness—filtered out through diagnosis.

Foucault continues by explaining that the indicated intervention of the newly formed subject of moral treatment, the mentally ill person, is forced silence—a refusal to speak with unreason. Referring to one of the first individuals unchained by Pinel, Foucault recounts how, by insisting that no one speak to the man, Pinel cultivates a therapeutics that replaces outrage with indifference, observation with inattention. This treatment of silence marks the final severing of possible dialogue between reason and unreason. Foucault explains, "the language of delirium can be answered only by an absence of language, for delirium is not a fragment of dialogue with reason, it is not language at all; it refers, in an ultimately silent awareness, only to transgression" (1965:262).

For Foucault, it is this transition from language to transgression that accounts for the confessional nature of Sigmund Freud's later attempts to reaccess unreason through psychoanalysis. Critical to this moment of therapeutic silencing is the role of *homo medicus* to authorize the confinement of the mad man which, Foucault explains, is founded on legal and moral rather than scientific authority. These conditions of authority firmly establish the asylum as a moral endeavor, ushering in a demand for recovery and by reference the absolute authority of the doctor as both family and law.

Additionally, confinement of madness comes to take on another dimension of morality, the concern with work, productivity, and the problem of idleness. Asylums, once used to hold the poor, the idle, and the vagabonds, become a place where idleness can be put to work. Foucault explains:

> It [confinement] was no longer merely a question of confining those out of work, but of giving work to those who had been confined and thus making them contribute to the prosperity of all. The alternation is clear: cheap manpower in periods of full employment and high salaries; and in periods of unemployment, re-absorption of the idle and social protection against agitation and uprisings (1965:51).

But the intervention is not simply a matter of economics. Labor, Foucault explains, had undergone a “moral enchantment” where it becomes penance for Adam’s original sin of idleness and a chance for redemption. Employment is not merely a didactic relationship between work and gain, but rather a three-party relationship where labor begets gain through the favor of God. Hence, idleness is not only economically shortsighted but also sinful. Confinement emerges within this simultaneously economic and moral demand for labor, and the *mad* are distinguished “by their inability to work and to follow the rhythms of collective life” (Foucault 1965:58). It is in this scene where labor and confinement meet where Foucault argues that madness is once again transformed. He explains:

> It was in this other world, encircled by the sacred powers of labor, that madness would assume the status we now attribute to it ... it is no longer because the madman comes from the world of the irrational and bears its stigmata; rather it is because he crosses the frontiers of bourgeois order of his own accord, and alienates himself outside the sacred limits of its ethic (1965:58).

The new subject is excentric to social order and also implicated by being so. Her alienation is of her own accord. Reason remains intact even amidst its inadequacy insofar as fault can be located not in the subject’s irrationality, but in her insistence on remaining outside. Henceforth madness is not only silenced, but also severed from its relation to the irrational and forever bound to reason, morality, and “their monotonous nights.” Doomed to boredom and speechless, madness retreats to the unconscious, where it remains inaccessible but affecting. From there, it exceeds understanding, or even presence. Living with it becomes *the* ethical task.

In this chapter, I have attempted to trace how young people learn to take on this task, to speak for the nothingness of madness without the possibility of it ever being heard. The following vignette describes one young woman’s remarkable strategy for deciding which symptoms to speak and which to silence. In the end, it is the way thoughts that abhor her actualize as they are voiced, or typed, that make them unmentionable.

The Dinner Party, the Couch, and the Unspeakable

Sarah made quite an impression on me. The office had felt slow and sleepy in the afternoon sun, but Sarah changed all that when she entered the office. The only thing small about her was her stature. Her hair was fashion dyed reddish pink. Her voice was bold. Her personality filled the room.

Sarah had allowed me to observe her therapy session. She started right in with her therapist, telling her about how she has been feeling, before she had fully entered the office. Their rapport was readily apparent. The therapist had to interrupt Sarah to remind her why I was there. “Oh yeah, it’s fine,” Sarah said. Sarah just acted as though I had always been there with them in the therapy. I appreciated it even though I feel a little lost as a result.

Sarah said she was confused about her diagnosis. Is it really bipolar? She told us about a new psychiatrist in another clinic who had read her file. Sarah joked rhetorically, “how long will that take?” Two things became obvious in her jest. Sarah had a good sense of humor and a long history with psychiatry.

Sarah was being treated at this clinic for being at Clinical High Risk (CHR) for psychosis. She was at the tail end of her teenage years, which means her long relationship with psychiatry must have started at a pretty young age. For Sarah, as with many others who seek out services at early psychosis clinics, early psychosis does not mean that she is new to psychiatry or mental illness. While she had not converted to psychosis, she had significant lived experience with psychiatric diagnoses, treatment, and mental illness. In fact, being at-risk for psychosis is more often than not compounded by significant histories of other diagnosable mental health conditions, such as depression, anxiety, and bipolar disorder. Often, only the psychosis is new.

That day, the therapeutic approach was Cognitive Behavioral Therapy for Psychosis (CBTP). It is widely acknowledged as a core component of high-quality early psychosis treatment programs. It is a brief therapeutic modality, with a robust evidence base, that helps people identify and cope with problematic thinking.

After a quick check-in, she and her therapist started identifying issues to discuss, to think through together. They agree on precursors to intrusive thoughts. Intrusive thoughts are unwanted and often unpleasant and are very common for young people in early psychosis clinics. Sarah and her therapist reviewed what they had covered before—these thoughts typically come on when she is tired and feeling lonely, especially in the dark, or when she is really stressed. And, they reminded each other, being overcaffeinated does not help. The problem, Sarah reflected, is that “it’s more of an emotional thing rather than a brain thing. So, it is hard to think my way out of.” The distinction struck me right away. I wondered if it was a push back against the cognitive approach of this therapy—the premise that you can help yourself feel better by thinking differently.

For Sarah, not all intrusive thoughts were the same. She described her system for ranking them one to three, each level incrementally more severe. Our conversation started in the middle. Twos are less upsetting thoughts. Sarah explained that with twos "I can ascertain if it's true or not, but it isn't easy to find the answer." She offered as an example the possibility that there could be a nuclear attack tomorrow. She explained, "There is some inclusion of logic and the real world, but I can't disprove it." It could be true, but likely it is not, and either way, she would know for sure tomorrow. Her therapist tracked back to their check-in and joked that a nuclear attack would put a damper on Sarah's forthcoming summer vacation.

Sarah explained that with ones, there is not enough evidence to scare her. They lack specificity. She gave an example, "thinking bad things will happen." She told us they are thoughts other people can understand, relate to. She quipped, "It's the dinner party versus the couch." She drew the line not by the kind of thought, but by who the thought can be shared with.

Threes, she explained, definitively were unspeakable. The issue with threes was that "there is very little you can do to legitimate the freakiness." The therapist rephrased, "The thought is so weird, I can't tell anyone about it." Right, Sarah nodded. At first she refused to give examples. Ultimately she relented and offers generally, "ill thoughts about loved ones." She told us they are unquantifiable in the sense that they cannot be understood as more or less likely. You cannot research them. The therapist reflected, "You can't create any certainty around it." On an emotional scale, Sarah told us threes are a 10 out of 10. They torment her.

The therapist moved to action: what can be done with threes? Sarah said that lately she had been working on a theory that everyone has creepy thoughts. The therapist and I both nod in affirmation. But, she told us, knowing everyone has creepy thoughts still does not make her feel comfortable sharing threes. She filled the silence created by the therapist with an example, a thought of violence toward someone she loves.

Sarah continued, “I guess normal people don’t have thoughts like that.” She corrected normal to neuro-typical, but left the rest of her hypothesis as it was. I wanted to tell her I am pretty sure normal people do have thoughts *like* that. She explained that with threes, “it feels like a different universe with different rules. Can’t be real. Can’t be fake.” Because they are not fully realized, they cannot be refuted. They just haunt her, always just outside of consideration.

“So, what can she do when she has these thoughts?” the therapist asked Sarah. “Talk to someone, I guess,” Sarah responded. But, that is the problem with threes. It is not so much that they are upsetting because they are true. She told us they are most upsetting when they become “real,” and they become more “real” in the telling. She said, “sometimes it helps to talk to a therapist, but in some ways it makes it more real.” She turned again to Googling, “Typing it in makes it worse because it makes it real, but having the information helps.”

Threes are so hard because for Sarah they actualize as threat as soon as they are shared. They pose a threat simply by existing, and once they are spoken or typed, they exist not only for her, but in the world she shares with those around her. Until then, she can relate to them privately, as something prior to thought.

Sarah’s strategy for “threes” holds their location in the domain of the imagination as Vincent Crapanzano offers it. In his *Imaginative Horizons* (2004), Vincent Crapanzano addresses the terrain of the imaginative through “the hinterland, and its correlatives: the *audelà* and the *ailleurs*, the beyond and the elsewhere” (2004:15). Referring to Yves Bonnefoy, a French poet and art critic, Crapanzano establishes nonbeing as an essential characteristic of the imagination. He explains:

> The beyond is like shadows—the *ombres* to which Bonnefoy frequently refers: it cannot be contained. It slips away—to appear again just when we have thought, in relief or in despair, that we have finally done away with it. Bonnefoy insists that the *arrière-pays* is inaccessible, nonexistent—the way any object of the imagination (as Jean-Paul Sartre [1940] argued in his phenomenological studies of the imagination) is absent, nonexistent, a negation, nonbeing (2004:17).

Crapanzano presents the hinterland as terrifying in its unrelenting inaccessibility, not necessarily because of what such a domain means itself but what it makes of our impressions of reality, "the artifice of factuality, of our empiricism, our realism, to which we blind ourselves—often through absurdist methodologist of truth and naively positivist philosophies" (2004:17). But, he does not want to succumb to this terror. He asks

> whether there is any reason why we should be terrified by the hinterland, by the imaginative possibility it offers and denies, by (the impossibility of) crossing over. Can we not take pleasure in its irreality, in its possibility, the play it facilitates? Are we culturally and historically bonded to fear and anxiety before imaginative possibility? Before the absence—the nonbeing—that we attribute to the imaginary? Are we victims of a puritanical epistemology of presence? Or are these fears, this anguish, an essential component of the human condition? I do not know. But I can imagine and do indeed know the pleasure that that possibility furnishes, the release, the escape it affords (2004:17).

In this way, “threes” are not figments, things that she would form beliefs around—that are true or false—but rather as something prior. Unspoken or untyped, they remain something toward which she does not have to form an attitude, she does not have to consider as having actualized. They still terrify. They move her—affect her. But, they are not of her. They are not even real.

The problem is that “help” is mediated through the very processes wherein these thoughts become “real.” Threes are further concretized not in their truth but in communication, as they are spoken or typed. Sarah’s thoughts become threats in the telling, not in their actualization as potential harm, but rather in what actually thinking them means for Sarah. And so, she keeps them to herself, remains silent. She endures them on her own, negating any possibility for normalization. She cannot express the thoughts that terrify her without them becoming literal—without them being taken seriously, most critically by her. Being at risk for psychosis seems to mean that Sarah cannot even allow herself a figurative expression of malice.

Cervantes Stage

In her *Knot of the Soul*: *Madness, Psychoanalysis, Islam* (2018), Stefania Pandolfo introduces a different stage of psychosis, the Cervantes Stage. The concept is given over to her by a young man she calls Reda in the course of a psychiatric intake interview in an emergency room in Morocco. Pandolfo describes the Cervantes Stage as:

> that other place, *the Stage,* where Reda retreats (*kanharrab*), and from which he fights back (*kanharrab),* in the rough moments of his illness as during the ER interview. The Stage to which he bestows the status of a theory, in which he is both a character and the director, and which is the site—rhetorical, existential, physical—of surrender to the Other and his desire for self (2018:117).

Pandolfo calls it a stage in the sense of a place of performance, a site where existence is not given but rather established creatively in dialogue. The Cervantes Stage is a sanctuary, but also a site of conflict. It is a somewhere else, the unconscious, a space where a young man seeks recognition through madness rather than in spite of it. Pandolfo continues:

> The Cervantes Stage, as a topological elsewhere, is an effect of withdrawal, of breaking ties with "home" in all its forms: the family, the hometown, vernacular Arabic (the mother tongue), the space of the everyday, social relations and traditions. It is the result of radical disaffiliation of which Reda is at once the victim, the character, and the author. […] But the distancing is more than just a withdrawal. It is a departure, a journey, the metamorphosis of the self in a theater of imaginary forms, where the possibility of self-realization gambles with the risk of nonreturnable" (2018:119).

As with psychiatry's prodrome, the Cervantes Stage is a topological[26] scene destined for transformation. Similar to a train station, it is itself a place, but it is somewhere you go to, to go somewhere else. It is not an elsewhere where one remains. It is a site of transformation where a single person's position relative to herself shifts, sometimes in perverse ways, rendering dynamic subject relations often imagined to be constant. In this scene, Reda is living a life of which he is a coauthor. The Cervantes Stage is a site where he gambles with the possibility of madness, not where he is put at risk of it. But, of course, there are risks in gambing as well.

Pandolfo warns of the temptation to understand this stage through the logics of psychiatry:

> To phrase the question in terms closer to the clinical concerns of psychiatry, it would be wrong to reduce Reda's procedure to the deployment of a delusion, or to the commonly

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[26] Characterized by connections, continuities and convergences

> observed quest of patients at the onset of psychosis, trying to make sense of and "rationalize" their experiences of growing strangeness in terms of a fantasy, which is then systematized into a delusion. That reduction would miss the dimension of struggle in Reda's experience, obliterating the sense in which his search is meaningful, and his experience of otherness less unfamiliar than one may be willing to acknowledge (2018:119).

Understood as a prodrome, the ambivalence of the Cervantes Stage is explained away. It becomes only retreat, loses the *fight back.* Through reductive clinical logics, Reda's madness cannot offer the promise of self-realization. It is either/or. This logic not only obscures the *work* of occupying this scene but also reifies a false sense that the scene of radical disaffiliation is his alone, abnormal, and unfamiliar.

The Cervantes Stage is another place, but, unlike the prodrome, is not one reserved for the not-yet psychotic. It is not a scene of preemption and rather offers the possibility for commensurability. Pandolfo explains:

> The Cervantes Stage becomes then the site of a possible mediation, a passageway between delusion and creation, where the rejected terms of cultural identification, the remains of an inaccessible tradition, are reencountered, and can be symbolically transformed. For a moment the threatening otherness of the persecutory interpretation (the poisonous communal meal), becomes for Reda a literary experience. As he puts it, "one must keep the presence at a distance" (2018:120).

As author, or even perhaps as a reader, Reda can create the distance necessary to maintain an interlude between himself and madness, a risky dialogue that promises rather than prevents transformation(s).

I offer Pandolfo's Cervantes Stage not as a stage of illness, but rather a scene of transformation, where the subject reaches to the imaginary in the process of self-formation but must resist relenting to it entirely. It is also a site of struggle, between a young person and their tradition, home, and culture. Envisioning the prodrome through the Cervantes Stage reveals it to be a site of tireless effort where young people work toward self-formation by maintaining personal but not fixed relationships to what they see, hear, believe, and think. For example when Lucy maintains an intimacy with "her" voices by keeping them "all in her mind." *They are her voices but not her voice.*

Contemporary notions of the psychosis prodrome are also a type of passageway, but not in the sense of mediation. Rather, it is a geography of experience and affect that foretells psychological suffering, loss of self, and loss of commensurability. It is a passageway that opens up to psychosis. The implied goal is to stay put.

In Chapter 6 I highlight one clinician commenting on the diagnostic practice of a colleague. She told me, **"**He can go places and not get stuck in saying this is the knowledge. This is the truth. Hung up on that at the expense of someone's story." What are the possibilities for refusing a distinction between truth and story? Stories are not only about someone. Rather, they are a practice of authorship—not only description but also creation. The expense of silencing madness may not just be a story unheard, but also a life, or at least a biography, unauthored. The relationship between experience and narration extends beyond explanation but is also tangled up in it. We are in part what we narrate. As we learn from Sarah, there is no easy solution to be found in clinical confession. To speak with madness is a gamble and, from the position of being at-risk for psychosis, one with high stakes.

Perhaps, it is not a choice between either story or life. When Reda's psychiatrist asks him what the Cervantes Stage is, he responds, "In any case, this is what I call it. It means to make use of imaginary characters at certain times, to speak with the windmills" (2018:116). For Reda, making use of imaginary characters does not mean necessarily succumbing to madness. It means maintaining the gap, the interval within which mediation, or dialogue, remains possible. It does not attempt to preempt transformation, but rather to protect it, even with all its risk. Reda's response raises the question, what kind of biography could be written or told, what kind of lives lived, if young people experiencing early psychosis could speak with the windmills? Such narration is not a panacea, as Pandolfo would be sure to remind us. This intervention would not even necessarily dream of cure, or even a life free of psychosis. And, the threat of non-return is ever present.

If we look to the prodrome not as an early stage in a disease model but rather as an interstitial space, as Reda and Pandolfo offer it, a gap wherein discourse with madness remains possible, figurative expression becomes essential to the task of both expression and self-actualization. And yet, within the context of diagnosis and intervention, such as the processes recounted above, description operates according to its literal inferences, even so far as to concretize a thought as literal or "real." There is little room for figurative expression, and with Sarah's threes, no possibility. The stakes are too high for misperception, misinterpretation, and actualized harm. Psychiatry needs to know if there are tremors; if there is actual abuse; if someone's thoughts make them dangerous. And yet, there are stakes in silencing or refusing the irreality as well.

Remember My Name

I started clinical observations about a month after my mother died. She had dementia. At the time, I was not ready to start fieldwork. I had thought about notifying the clinics and delaying my start date for research but decided to go ahead and begin. One evening, as I returned home from a meeting with the clinic, I was feeling particularly blue. Stuck in traffic, I thumbed through my phone looking for some pain/comfort—a release. I found what I was looking for and played the only voicemail from her I still have on my phone. Her voice, this instance, saturated with confusion, always feels different than a photo.

> Hi sweetheart. I'm going to be over working on some stuff, but I just wanted to call and tell you that I am so happy that you are doing the things you are doing. Getting the kinds of things… I am really excited about finding Matilda also because it sounds from what I am looking at and seeing that she is there with you guys. I love you and just call me whenever you have something you want to say. I love you so much. Bye-bye…

It almost made sense. Matilda is my daughter, her lastborn grandchild. Matilda was the first of our immediate family to start to slip from my mother's memory. In her final months, my mom fought to know Matilda not through memory, which she had lost, but by always wanting to know where she was, what she was doing. At some point during the final 26 seconds of rustling noises recorded on the message as she attempted to hang up the phone, "Gypsy" by Fleetwood Mac came on my car radio. The catharsis I had sought but not found in the voicemail came quickly. It was her favorite song. The tears welled as I was filled with gratitude that she had spoken to me this way—through the radio. But, it was the Bay Area, and they play "Gypsy" all the time.

I recounted this story to an early psychosis clinical team, and one of the clinicians turned to me and said, "exactly, it's about who gets to be mad." I am not suggesting that knowing my mother spoke to me with the radio that day is the same as psychosis. Rather, I share the experience to suggest the possibility of not having to ask one way or another. The demand that phenomena be either real or non-real constricts what can be considered, filters what is in view. Young people go unheard, unseen. They suffer alone. They are forgotten.

William is one of a handful of people who goes to the clinic to get antipsychotic medication via a clinician-administered shot. He carries a diagnosis for a fully realized psychotic disorder but continues to access services through the clinic. When I asked why he uses an injectable, he said he preferred it that way, “I wouldn’t want to be psycho-analyzed.” After his monthly visit we chatted about things we had in common—college, not playing Frisbee golf or dungeons and dragons. I asked him if anything had happened since the last time we met. He replied, no. He said that he thought he had had a hallucination but his psychiatrist said it wasn’t one. He had heard a song and thought it was singing right to him, addressing him directly. I asked him if it had been upsetting. He said, not really. I asked what it said. He paused for a second and explained that it had said something like that it hadn’t given up on him. “It was nice.”

Melina: How does it feel that your psychiatrist doesn’t think it was a hallucination?

William: Disappointing, I guess.

He continued, if it had been a hallucination, it would have been “more real, instead of something I’m imagining.” I asked him if he knew why his psychiatrist didn’t think it was a hallucination and he said because it didn’t last long enough.

Melina: Do you think he is right?

William: It doesn’t feel the way they used to. So, I guess so.

We chatted for a while and then I mentioned I was worried about him getting a parking ticket. He seemed grateful, but also as if he was used to conversations being ended abruptly. I mentioned I would be contacting him soon for an actual interview. He looked rightfully confused about what all that talking had just been and graciously agreed to meeting again.

William's disappointment poses a kind of paradox. At once, I recognize the psychiatrist's move as an effort toward normalization, an intervention on the patient's interpretation of an experience as pathological or abnormal. Within the context of the early psychosis clinic, such acts of de-pathologization can precipitate lowering the dose of antipsychotics. They can shift treatment considerations away from crisis management to stabilization, even toward recovery. The refusal to authorize the symptom is a refusal of schizophrenia's chronicity and the overdetermining way, once cast as diagnosis, psychosis seems to explain everything. It is care.

And yet, this time the intervention did not seem to have had the intended effect, or did not simply have the intended effect. It had produced rather than alleviated distress, a disappointment. The experience was too brief to qualify as a symptom. Psychiatric rationalization could not save William from the possibility that his experience is not real. Instead, the psychiatrist's refusal to authorize the experience as a hallucination offers the radically unsettling possibility that one can experience something that is neither a symptom of psychosis nor a product of reality—an entirely different kind of madness.

The source of William's distress was difficult at first to see. It was not a loss of reality to madness. Being addressed was not itself distressing. Neither was it a loss of madness to psychiatric rationalization. Having it declared a hallucination would have been fine. The disappointment seems to stem not from the way the symptom secures madness as not real, but rather from how it secures his "real" as not-mad. The song's address itself had been nice, but made "less real"—it lost its valence as an entity. It became neither a reinforcing presence nor a symptom of psychosis, just a figment of his imagination. Fiction. For William, there is no possibility for the song’s address outside of madness. The song cannot speak directly to him. Without being a hallucination, the source of the address becomes nothing. And one cannot be addressed by nothing. William does not get to be mad without becomming mad.

William and I met up again a few weeks later for our interview. I knew from our previous conversations that he had experienced debilitating paranoia. I carried that knowledge into the informed consent process. I anticipated paranoia. I knew I needed to be especially sensitive in my explanation of data security procedures. I assumed he would be concerned. Carefully, I detailed all the ways he would be distanced from his data. By code. By firewall. By password. Finally, I talked about pseudonyms and he glanced up to make eye contact with me and said, “But you will remember my name, won’t you?” My heart sank as I reassured him I would even as I struggled to remember what it was and found, just for a second, only his code. I have chosen to use pseudonyms to protect the people who have participated in my study, as I have been trained to do and as I promised I would. But I do so while feeling uneasy about my being complicit in William feeling forgotten, or in the least forgettable.

It strikes me that, as with the other processes of filtering I have discussed such as adolescence in Chapter 3, or constraining narration in this chapter, my attempt of preempting a reasonable threat filtered so much information out of what I was seeing that there was barely anything left at all. I had protected him to the point of near annihilation, and he caught me. I had replaced his name with a code when what he wanted was to be recognized, remembered.

CHAPTER FIVE | Psychosis Timelines: Chronologies as magic

In *Extraordinary Conditions* (2015), Janis Jenkins pursues what she calls a cultural approach in her reflection on serious mental illness. This approach holds that both reality and mental illness are culturally constituted, and that reality is always in question for those who are afflicted by serious mental illness and their families. Many decades of anthropology inform this view, advocating for a consideration of the sociocultural conditions of the experience, diagnosis, and treatment of mental illness. Such work draws from a long history of engagement with "culture-bound syndromes" and transcultural psychiatry. As anthropologists have turned their lens back to US psychiatry, these same inquires inform the work.

In this chapter, I look closely at a particular technique central to US psychiatric practice, the clinical timeline, using a similar approach. I carefully consider how timelines are fashioned, how they are used, when they become problematic, and what they do. I then look to the non-linear experiences and presentations of time that people on the incipient edges of psychosis described to me to open up the possibility that the timeline—a technique compromised by its reductive tendencies—could become expansive enough to accommodate radical difference. This chapter is about clinical timelines, but more than that, it is an attempt to better understand how people process experience in and though the institutions of psychiatry, family, and time. It asks how we might learn from timelines to apprehend experience in another way.

Within psychiatry, deciphering early signs and symptoms of psychosis depends on subtle distinctions of symptom severity, chronicity, and duration. As such, diagnosticians must learn from people seeking treatment not only what they have been experiencing but also (and most importantly) when, how often, and for how long. Such centralization of timing in diagnosis makes various demands on the diagnostic interview and also creates moments of confusion, frustration, resistance, and levity. Consider the following quick examples:

Intake interview with a young man in his early twenties who has come to the clinic, as he explained it, hearing voices, feeling depressed, and taking lots of drugs:

> **Clinician**: Help me keep track of time.
>
> **Youth**: It's a bit blurry. I don't remember the timelines.
>
> **Clinician**: Were you kicked out of the house before or after college?
>
> **Youth**: After college, but also before. I only do cocaine when I have money.

Intake with youth answering a question about early symptoms:

> **Youth**: I would have this sensation that bugs were crawling on me. Bugs crawling on my hands and legs.
>
> **Clinician**: Which happened first, the anxiety or the bugs?
>
> **Youth**: Who knows. It certainly didn't help the panic attack.

Moments of disjuncture such as these, where the past cannot be easily set into a linear chronology, are often attributed to insufficient interviewing or to patients or families being inadequate historians. I argue that these moments are reflections of the dynamic and relational temporal dimension of experience and memory. They challenge assumptions of time as linear, rational, and always either progressive or regressive. In the examples above, both a before and an after are refused, and instead time is organized around a panic attack or when there is money to buy cocaine.

One day an attending psychiatrist posed a question to me as we were walking to an intake interview. He explained the tension between not overtreating people who have yet to develop a full psychotic disorder but also not extending the time someone's symptoms go untreated. He asked, “How do you find that magical day?” He explained that the early intervention framework is compelling. Mitigating the damage of psychosis by limiting the days people are “in it” makes good sense. But reducing the duration of untreated psychosis (DUP) in practice requires something he does not know how to identify—magic.

I take this rhetorical question seriously to explore how and why clinicians work with youth and their families to cultivate and stabilize psychosis timelines that are reliably chronological and unidirectional in the midst of oral histories that often refuse such telling. In the first section I describe how timelines are used to reveal symptoms of psychosis. I then build on what science and technology studies have robustly shown to argue that timelines are not discovered but fashioned through complex coordination between individuals as they consider various forms of information and reconcile that information with authoritative structures in psychiatry. In the next section, I demonstrate that while timelines are widely used in the clinic, their veracity is at once taken for granted and always in question. I then share a story about a young woman I call Emily, who offers a description of early psychosis that helped me understand timelines as meaningful beyond clinical diagnosis and treatment. Her story inspires a less unidirectional timeline, one that can accommodate transgression of time’s progressive “nature.” In the final section, I show how timelines invite causal thinking and recount a young man’s theory of causation to highlight how it relies on relational rather than chronological orientation.

In conclusion, I argue that by thinking about timelines as magical, we can imagine how they work to establish a foundation for commensurability, for the experience of psychosis to become tenuously and partially a shared experience. I argue against a notion that the timeline is somehow less rational or less valid as magic. Instead, I draw on anthropological work to suggest that the rationality of the psychosis timeline, or at least some of it, is contained not in its reproduction of truth (accurate recounting of events in time) but in the degree to which the timeline works magically to found collective truth in the midst of the radical difference psychosis threatens.

The (im)possible magical day DUP starts

Much has changed since I began working in the field of early psychosis research just over 10 years ago. When I began this work I was overwhelmed by what I did not know. At the time, preventing psychosis seemed possible, if not probable, and inherently moral. Even with the litany of ethical issues posed (e.g., psychiatrization of childhood, long-term risks of antipsychotic medication), or perhaps because of them, the collaborative multisite initiative I worked on was fueled by a sense of doing good by preventing serious treatment-resistant psychiatric disorders. The idea was that our study would demonstrate that young people who needed treatment (i.e., symptoms would continue or worsen without intervention) could be distinguished from those who did not (i.e., symptoms would clear up even without intervention). We also sought to demonstrate that a combination of mental health interventions, including medication management, psychoeducation, multi-family group therapy, individual therapy, and occupational/educational supports, could prevent people from moving beyond at-risk stage to experiencing an episode of psychosis. Study findings supported the interventions’ efficacy for improving symptoms and various other outcomes, including work and school participation and global functioning among “youth at risk for, or experiencing very early psychosis” (McFarlane et al. 2010, 2015). Critiques of the study highlight its lack of a control group and suggest claims of treatment efficacy may be premature (Heinssen and Insel 2015).

In the US, such findings have been used in concert with international studies as evidence to propel a wave of federal funding for early identification and intervention program implementation through the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as efficacy studies through the National Institutes of Health (NIH). When I returned to early psychosis five years after the study ended, the field's hopeful and determined commitment to the possibility of preventing psychosis had been humbled a bit. Claims of predictability are now couched in explanations that only 20-30% of people identified as at-risk for psychosis go on to develop a psychotic disorder. This qualification is often then bolstered by a reference to the fact that risk in common medical conditions such as heart disease has similar predictive values. Additionally, it has been difficult to demonstrate specific and effective treatment within a heterogeneous group of interventions and with the difficulties that remain in determining prognosis (Preti and Cella 2010).

One of the enduring and widely accepted concepts in early psychosis emerging from the past decade of psychiatric research is the Duration of Untreated Psychosis (DUP). This concept traces the amount of time (typically in months) that a person has experienced psychosis at an above threshold valence of psychosis without accessing psychiatric treatment. Studies tracing DUP have found a connection between the length of DUP and the severity and persistence of psychotic disorders (Marshall et al. 2005). The longer a person's DUP, the worse their symptoms are likely to become and the longer it takes them to get back to baseline or recovery. DUP is used to motivate the proliferation of psychiatric care in early psychosis, imposing a pressing call to identify individuals as close to the day they move from being at elevated risk for developing psychosis to experiencing an episode of psychosis—the day when the DUP clock starts ticking. This call, in turn, demands a response in the form of treatment, but it also poses a problem, perhaps an impossible one, to psychiatry and the families it serves. As the psychiatrist phrased it, “How do you find that magical day?”

When I asked the attending if finding that magical day was the job of psychiatry or the family, he quickly and confidently replied that it would be unreasonable to expect a family to identify the subtle and slow changes of the risk period. Referring to Andre the Giant, the famous wrestler and beloved Fezzik from *The Princess Bride*, he explained that the disease that had caused his bone overgrowth is so slow that it remains imperceptible to those who see the person every day. He told me, diagnosis of this condition often relies on asking the person for his or her driver’s license, the change only obvious in comparison to the face of a younger self. It is similar with psychosis, he said. And yet, with psychosis a driver’s license photo will not do; it will not suffice to provide a legible representation of an otherwise imperceptible change. The question then becomes, what will suffice?

In their anthropological critique of the DUP concept, Tranulis et al. (2009) call attention to the problematic way that DUP assumes people will recognize emerging psychotic symptoms as such. The problem for these authors lies in how the DUP concept poses an unquestioned connection between insight, an ability to recognize a morbid change in oneself, and help-seeking. Tranulis and his team rely on Gananath Obeyesekere’s *work of culture* to offer an alternative view of one woman’s extended DUP. The *work of culture* refers to the process wherein affinity is produced through a transformation of unconscious motivations and experience into publicly meaningful symbolic representation (Obyesekere 1990).

They argue that rather than a delay in treatment, DUP could be thought of as a time for the cultivation of a safe space between individuals and their confidants in which psychotic experiences could be narrated and shared without being understood as inherently pathological.

They show how temporal space can then be thought of as productive and not as a product of denial as it is so often framed. They argue for a reconsideration of psychiatric insight by retelling a woman named Kuna's clinical timeline, illustrating that the duration between when she first actually experiences psychotic symptoms and when she recognizes them as such and seeks out treatment cannot be conceptualized simply as delay. The idea is that what is done in the duration between when Kuna first experiences symptoms of psychosis and when she seeks treatment is crucial to her understanding and narrating her experiences as psychosis.

Tranulis and colleagues call attention to the way self-knowledge is attained through practiced narration and in relation to a loved one—a husband in this particular case. Kuna first reveals her experiences in conversation with him, and he understands them as stories. Later, she discusses these same experiences with a friend, and then a psychiatrist. Through these conversations, her experiences reveal themselves to the couple as more than stories, as symptoms, as something that might need treatment. Essentially, she gains insight into her symptoms over time and in conversation *with others*.

What interests me about this case is how the critique of DUP itself depends on a clinical timeline. Throughout the article, the authors (re)narrate her earliest psychotic experiences as dating back "at least" to her immigrating to the US in 2000. The authors see the timeline as grounding.

> Expressing statements related to one's illness is contextual; it is grounded in a timeline, incorporating accounts of past events, shifting sociocultural contexts, subjective experiences and future plans. Thus, it is important to note that the subject's articulation of her psychotic experiences needs to be viewed as part of a temporal development (Tranulis et al. 2010: 613).

Later they remark that in some interviews she talks about early psychotic experiences in India, while in other interviews refuses them, an open acknowledgment of the timeline's questionable facticity or instability. And yet, the timeline, as it is presented in the article, brings the pathology into being for the reader. The authors use the timeline to distinguish stories from symptoms, allowing readers to see exactly what it is that she has come to understand. I argue that in early psychosis, the timeline works like the driver's license photo to reveal the symptom.

Getting the Temporal Story

The possibility of rendering a discernible pre-psychotic phase demands a particular kind of timeline that is detailed and accurate. Getting the timeline was an explicit goal of every intake interview I observed. Sometimes it seemed easy. For experienced clinicians working with psychiatrically savvy respondents, the dates would stack up neatly and in order. Other times it seemed nearly impossible, and I would want for the interviewer to stop trying. Most of the time it required input from multiple people, including the person being evaluated for services, a parent or caregiver, at least one psychiatrist, a therapist, and various existing documentation. While not always explicit, the effort to establish a timeline is also in conversation with the DSM-5. The timeline is not just revealed. It must be crafted in collaboration with these multiple actors, often with significant back and forth between them.

As many science and technology scholars have shown with other scientific objects, the timeline is fashioned through modes of "coordination" (Mol 2002), assembled within networks of existing relationships (Latour 2005). As a product of coordination, the timeline gains coherence as hierarchies are established between subjective accounts of psychosis by patients, objectifying observations provided by concerned parents, and authoritatively objective observations of the diagnostic apparatus represented by the diagnostician. What results is a dynamic where the clinical team has the authority to ask the questions that will constitute the timeline, and responses from patients and their family are constantly weighed and reconciled.

I cannot recall an intake interview in which getting the timeline did not require clarifying questions from multiple members of the treatment team and corrective responses. The correctives come in many forms. Children look to their parents for the right answer, and parents oblige. Clinicians clarify when information does not match up. Parents interrupt with corrections and their children push back or concede, sometimes generously and sometimes with a heavy roll of the eyes. Occasionally, parents listen to their children's account or a clinician's retelling, visibly working hard to resist the urge to clarify, waiting until the time was right or deciding to pick their battles.

I noticed two types of intake interviews in these clinics. The first is an intake interview with patients and families who are relatively new to psychiatry. Typically, these families are referred to the clinic by a community therapist or psychiatrist for a specialized assessment of symptoms of psychosis. The second type of intake interview was with patients and families who are receiving a second opinion or who are "stepping down" from having been in a psychiatric hospital or participating in a part-time hospitalization program. The processes in the two types of interview do not look much different in practice, but there is something different about hearing a family new(er) to psychiatry talk about their experiences. Likely true across medicine, families who have been in the system a while seem to tell a different kind of story or tell their story in a different way. Their narratives are often prefaced by significant documentation of psychiatric assessments, diagnoses, and treatment and are peppered with psychiatric terms. For example, instead of saying his child was talking fast, a father would say she had "pressured speech," or a young person would describe a speed-up in thinking as "racing thoughts." When these terms are used in descriptions of presenting issues they can be obscuring or misleading diagnostically. Diagnosticians constantly would ask, “What do you mean by …?” for clarification. One psychiatrist remarked to me after assessing a young woman new to psychiatric assessment that she had offered a “perfect description of early psychosis” because she had not yet been taught by psychiatry how describe it.

Determining the frequency and duration of potentially psychotic symptoms was often difficult with the timelines that were obtained. The trouble was never for lack of trying, both by the interviewers and interviewees. There is just so much to tell, so much to hear. Even in instances where reliable data is readily available, identifying if and when the “magical day” has occurred when someone moves from being at risk to experiencing an episode of psychosis rarely if ever seems straightforward. The “symptom” and “duration” do not exist within a temporal narrative, waiting to be uncovered. They are fashioned through a process of coordination between the DSM-5, the individuals taking part in the conversation, and the institutions they represent (e.g., family, psychiatry, school). In this way, the timeline is a generative and iterative act, not merely an act of discovery. Therefore, timelines are vulnerable to all kinds of divergence.

Timelines are widely mobilized in early psychosis clinics. They reveal symptoms, ascertaining how long symptoms last and how frequently they are experienced. Essentially, they are used to determine whether someone has had psychotic symptoms often enough or for long enough to qualify as having *converted* to having a psychotic disorder. Once conversion is established, timelines inform the DUP, which can be used to indicate prognosis. They are also used to call attention to imperceptible improvements and to reinforce progress and hope for patients and their treatment teams. They can also provide points of reference for establishing cause and effect, and help individuals identify “triggers” for their symptoms and distress. Timelines are established, revised, and relied upon throughout various stages of assessment and treatment. Still, their veracity is often in question. In the next section, I explore why.

Bad Historians and Other Problems of Veracity in Psychosis Timelines

The importance of clinical timelines is not unique to the early psychosis clinic. In fact, Foucault places *chronology* at the foundation of the clinic’s classificatory structure, essential to the way disease(s) come to be understood as reliable medical facts. History, gained through clinical timelines, offers not a story of the conditions under which disease came to be known, but rather a demonstration of what it was all along. Foucault explains, “It is no longer a question of giving that *by which* the disease can be recognized, but of restoring, at the level of words, a history that covers its total being” (1973:95). The manifest truth of disease comes to be at a site of temporal conflation between what is noticed and what the physician describes. He explains:

> The order of truth does only one thing with that of language, because both restore time to its necessary and statable [*sic*], that is, *discursive,* form. The *history* of diseases, to which Sauvages gave an obscurely spatial meaning, now assumes its chronological dimension. The *course* of time occupies in the structure of this new knowledge the role in classificatory medicine of the flat space of the nosological picture. The opposition between nature and time, between what is manifested and what announces, has disappeared; the distinction between the essence of the disease, its symptoms and its signs, has also disappeared; and the play and distance by which it betrayed itself, but at a distance and in uncertainty, have also disappeared … the disease escaped from this rotating structure of the visible that rendered it invisible and the invisible that rendered it

> visible, and dissipated itself in the visible multiplicity of symptoms that signified its meaning without remainder (1973:96).

Disease in the clinic becomes whole and subsumes the signs and symptoms that characterize it, without remainder. In the clinic, as disease is totalized across time, timelines serve this interest and become a scientific object that totalizes.

In some ways, early psychosis works similarly to what Foucault describes. Regardless of the stage (risk, early, chronic), once psychosis is named as such, the naming contains the possibility of all earlier and later stages. Diagnosis collapses timelines into events that have a solidity and permanence to them. And yet, in other ways, early psychosis clinics are overtly attempting to reintroduce a bit of space between the essence of disease and its signs and symptoms. If the very truth of a disease rests on the temporal proximity between what disease is and what it is called in the clinic, reintroducing temporal space between symptoms, signs, and the diseases they characterize likely also reintroduces some of the play and betrayal that trouble the label’s veracity. In this section, I attempt to show a few particular sites where this play becomes an issue.

I arrive at Sandra’s office to learn more from her about the intake process. She takes all incoming calls, making decisions about who should come in for an intake, who might be good for various studies, and who might need to be referred elsewhere. As such, she is also the person who places people on the waitlist, a highly contentious space heavy with morally laden claims around who belongs in the clinic. The power inherent in this responsibility is readily visible as a burden. Sandra minimized the load, saying mostly it is screening for insurance. The clinic only takes people with insurance, so many people are turned away before an initial appointment. After that, the other major reason callers are directed elsewhere is if the person experiencing symptoms has been too sick for too long. Sandra called these young people “not well again.” She explained that parents often look up the program in hopes of finding more effective care in a specialized academic clinic because of the more elevated expertise such an institution implies.

I ask if she has an algorithm or tool that she uses to ask consistent questions. There is one for the research studies, she says, while pulling it up on her screen. The fact that the clinics I observed were connected to research studies introduces a certain set of possibilities in relation to admission to the clinic that are different than in typical clinical settings. We glance at it together on her screen, too quickly for me to read it. Sandra continues, saying, information comes in from all kinds of places—schools, community therapists and psychiatrists, hospitals, but mostly parents.

Sandra: If someone is having full psychosis, I’m almost always talking to the parent.

Melina: Why?

Sandra: Because they are the concerned person.

The idea here, and an underlying logic throughout the field, is that people who are in “full-blown” psychosis are often not aware of, or particularly distressed by, experiences understood by others as symptoms. They may be bothered by the thoughts themselves (e.g., they are being followed), but without the premise of these experiences as mental illness, they do not resonate as psychiatric symptoms.

I ask if all the history is helpful, and she says yes, “assuming it is an accurate timeline.” I inquire, why is the timeline so important? She explains how the timeline distinguishes between the various diagnoses most typically associated with psychosis. For example, attenuated risk syndrome, the newest iteration of pre-psychosis and the provisional DSM-5 category, is defined as not full conviction for more than 1 hour a day, 4 days per week. If psychotic symptoms last longer or are more frequent, she tells me, you start thinking about schizophreniform—unspecified psychosis if symptoms remit within 6 months, and if they do not, schizophrenia. She carefully added that gathering an “accurate timeline” is so important because the DSM-5 timelines correspond to when the individual started experiencing symptoms, not when the symptoms become known to a clinician. Tying symptoms to clinical observation would not make any sense, she explained. You would be pushing the onset months into the illness. I notice that to the degree that early psychosis extends the discernibility of signs and symptoms beyond a clinically recognized episode, necessary information for diagnosis becomes uniquely accessible through the person or family and their memories. Prodromal psychosis pushes the prospects for clinical diagnosis into times and social spaces temporally prior to those in which actual clinical encounters take place.

Sandra warns me of the inadequacy of her initial distinction between attenuated psychosis, schizophreniform, and schizophrenia. She tells me that this quick pattern works as an explanation of some of her considerations at intake, but the nuanced and myriad ways that timelines are critical in stabilizing psychiatric diagnosis of psychosis per the DSM-5 are much more complicated.

Returning to my original question about the importance of the timeline, Sandra adds that timelines are not just important for diagnosis but also throughout the person’s treatment. From the stress-vulnerability model perspective, which was widely mobilized in this clinic, establishing a timeline can become a valuable tool for the patient as well. With timelines in place, a patient can watch over and maintain their mental health status. A timeline can reveal a vulnerability by establishing a chronologically ordered relationship to a trigger. Sandra explains that when the patient takes this process seriously, this knowledge can help people avoid triggers, and, by inference, more symptoms or distress. The conversation establishes timelines as so important clinically that they can essentially be taken for granted, at least for someone who knows the DSM or who does therapy. And yet, Sandra adds as almost an afterthought, patients are often unwilling or unable to account for their psychosis chronologically.

I learned over time that clinicians sometimes refer to patients as being “bad historians” because they either cannot or will not provide clear, chronological, and, if not true, plausible accounts of their past experience. A person can be a bad historian for all kinds of reasons. Too many drugs. Too withholding. Too immature. Too psychotic. “Bad historians” do not pay enough attention, cannot remember, or if they do remember, refuse to tell you. While the term is overtly judgmental, it always seemed as though anyone could be, and likely has been, a bad historian. Being a bad historian is always a possibility.

Still, the DSM-5 offers clear temporal thresholds that were clinically relevant to the team, and timelines could be made to matter in therapy as well as in the self-assessment of a therapist’s own successes with a patient. It was easy to see how timelines were important to clinicians. And yet, it was not always clear to me what aspects of the timeline specifically made them so valuable. Sometimes, as when the timeline is used to stabilize a DSM-5 diagnosis or distinguish between attenuated risk syndrome and psychotic disorder, the timeline seemed valuable insofar as it can be taken as accurate. Even though the categories themselves, and the DSM-5 more generally, are widely acknowledged as problematic, the demand they make for accuracy is not ignored. It is indeed possible and necessary to know when symptoms started, how long they lasted, and how frequently they showed up. Other times, the timeline seemed to be doing another kind of work: an assessment of how successful a person could be organizing their communication in ways that were readily intelligible. The value of this type of timeline seemed less founded in the chronological accuracy of the account (i.e., correct dates) and more about the respondent's ability to put a timeline together that made sense to someone else.

One resident explained that a person's ability to formulate a temporal story is an important component of diagnosis and prognosis. In our interview I asked what the resident pays the most attention to during an initial diagnostic assessment. She explained:

> How easily they are able to tell their story is a good sign… How able are they to ground themselves in dates and times and tell a linear, logical story. They don't always know what medications they were on and when, but they can tell me "Oh, I was having a hard time in high school and then this happened and then this happened and then this happened." Versus somebody who can't do it in one go and requires a lot of pulling and clarifying.

Timelines, then, can cut both ways. Accurate timelines establish diagnosis, but timelining can lead to diagnosis even when it is inaccurate. Here the diagnosis is less concerned with whether the young person's symptoms started in high school or middle school and more with the intelligibility of the temporal story. In this use, the inability to construct an intelligible timeline is an indication of pathology, a sign of a thought disorder. In these instances, it does not always seem to matter to the psychiatrists that they are accurate. Rather, what seems to matter diagnostically is whether or not the young person can order events coherently. *This happened and then that happened*. When a person cannot do this temporal ordering, their prognosis worsens.

Being a bad historian is rarely taken as a permanent trait. Instead, history-telling is a skill that can and should be intervened upon. Recall the team discussion when, after deciding Lucy (Chapter 4), a junior in high school, was experiencing early symptoms but had not experienced a full psychotic episode, the lead psychiatrist asserted that the most productive intervention could be helping her learn how to tell her story to other clinicians. He was flummoxed by what he felt was an age-inappropriate inability to describe her daily medication regimen. When asked what medications she takes, she suggested they ask her mom. The intervention became to teach her how to tell her story psychiatrically, a practice we already learned ironically runs the risk of compromising the description itself.

Sandra’s explanations show how modeling or teaching someone how to tell a chronological story can itself be a valued intervention for people who cannot or do not narrate their histories well. Not only can it help identify onset of symptoms or triggers, it can also help to reinforce progress in a field where successes are so small that they easily go unnoticed. Timelines can make less-discernible treatment gains visible for both the patient and the clinician. As such, psychosis timelines serve diagnosis, but also clinicians, by establishing or reinforcing a sense of efficacy. In our conversation, Sandra explained that with early psychosis, “progress is so slow that I need to have something to mark my skills.” In this way, the timeline matters precisely when it is particularly difficult for an individual to track or narrate his or her own experiences linearly through time. Timelines then are an important practice of noticing what is hard to notice.

The idea of the bad historian permeated many clinic conversations and seemed to always be available in reference to what we all know about teenagers or what we all know about psychosis. I was not always clear which. There are many other reasons why someone may struggle to tell their story. In addition to a lack of skill in narration, the clinicians also have to consider a litany of other factors that may account for the problem—immaturity, shyness, being withholding (keeping information from others), drugs, psychosis itself. The persistent possibility of the bad historian means that the clinical utility of the timeline is rivaled only by the timeline's inherent potential to be wrong.

Younger Self

Even if the timeline is so much work to craft and its veracity is almost always in question, it remains a fundamental aspect of service delivery in these clinics. The timeline is uniquely valuable as a psychiatric tool relevant to the new demands that a staged disease model introduces. Timelines work to stabilize diagnoses, enable self-surveillance, signal pathology, but they also can seem almost irrelevant or impossible for the young people and families who were being asked to produce them to provide. Time and again I watched as diligent interviewers attempted to ascertain true and accurate timelines by clarifying dates, circling back to triangulate incongruous accounts, apologizing for the need to ask again—did that happened freshman or senior year? Fall of 2018? Was that before or after the car accident? The response was often: "yeah." "I think so." "Sounds right." "My mom will know." "Sorry."

As my fieldwork went on, I grew increasingly suspicious of the possibility of an accurate psychosis timeline. They never seemed to be adequate for all that patients and families shared. Emily showed me how chronology can become relevant not only for diagnosing psychosis but also to the experience of psychosis. Her reflection on her experiences with time during an initial episode of psychosis, which I detail below, opens up the possibility of psychosis timelines that can accommodate attempts to stay in normative time as well as experiences of transgressing it.

During the interview, Emily shows me the journal she had started writing when her coworker suggested she might be simply overwhelmed. "Just write stuff down," her friend had said, "that might help." She had taken the suggestion in earnest and began documenting her thoughts. One or two words at a time written in two vertical lists from the top of the page to bottom. First right then left. Page after page. I scan the words as she continues to tell her story about that day. Half-listening, half-reading, I notice the way her handwriting turns from print to scrawl, the ink shifting from the tone of a casual hand to the intense darkness that comes from pressing hard and writing fast. “Scared to death” jumps off the page, one line written in purple in a sea of black.

The journal strikes me as a scientific accounting. She includes dates on each page. The same date repeated again and again. Systematically referencing the same day over and over. About halfway through she starts documenting time as well: 11:52PM… 12:02PM… 12:16…. Six and a half pages of notes documenting 1 hour and 24 minutes of a young woman observing, or at least keeping track of, her own process of disorientation.

She offers the notebook to me during the interview as an illustration of “how all this was.” We were talking about the day she had been hospitalized. The day that now marks her first episode of psychosis. I am not sure how to ask about the entry, worried about taking her back to how she felt in that moment but at the same time profoundly interested. I see that she had grasped at chronological time—held on to it desperately as everything became more and more confusing. A timeline is clearly vitally important here. This psychosis timeline is different than those fashioned in the clinic. Emily’s timeline is foundational but not taken for granted. It takes work to hold on to. Time itself is unstable. It is tracked in moments, not days. Recorded, not recollected.

As we continue to look through the journal together, I ask her what she was thinking or feeling as she looked at the entry. After a deep breath she responds:

> It just brings back how quickly things got distorted. When I first got to work, I was just feeling—. I was tired and I was worried about the fight with my boyfriend. I went for a

> walk with one of my coworkers and she suggested just listening to some music and writing things down. And all that seemed normal and then I started. As I was writing, especially as I was writing, I just got super paranoid. And started thinking that people were watching me. And yeah.

She trails off as she becomes distracted by the notebook. In hindsight, her timed entries in the journal mark the speed at which she became increasingly confused and afraid.

I can almost feel her heart racing, or is it mine? I decide to shift to another topic, give her a chance to decide not to return to the space contained so carefully in another time.

I remember that she brought the notebook to her intake interview and offered it to the clinical team as an account of her experience then as well. The clinicians glanced through it and returned it to her without including a copy in her chart. In my field notes I recorded the attending psychiatrist remarking on the notebook as the team summarized their account of the intake appointment. He uses Emily's relationship to the notebook to support his optimistic prognosis: "She reads her journal with a sense of 'who was that person?' not, 'I found the truth.'" She has re-established doubt in her experience. In this interpretation, Emily's good prognosis depends at least partially on her relating to the written account of her experiences from a place of temporal and subjective distance. She is neither the same person nor in the same time. Reflecting on the interview and my sense of our mutually racing heartbeats, I wonder about the effort required for Emily to read her notebook in this way. What must she do to maintain this distance? What are the risks and possibilities of encroachment?

The way Emily offers her timeline to me qualifies the timeline, her psychosis timeline, as valuable but fraught. The notebook illustrates but is also implicated in the development of her psychosis. She clearly sees it as an explanation of it all.

After the hospitalization, Emily's sense of time was altered. I ask her what it was like when she returned from the hospital. She recounts how her large family rallied and visited sequentially, one sibling, then the next. She returned to the house she shared with a sibling. Emily tells me that she was really confused about why her mom was in the house when she came home. She remembers wondering: "Is something wrong—what is going on? Is something going on with mom and dad? Why is mom here? I just didn't understand why she would be in the space. It just didn't make sense to me."

I ask, had it not been apparent that her mom was there to care for her? She casually responds, "Yeah. Yeah." But it wasn't just that. She thought that she had slipped into an alternate world. "For a while I thought that you could kind of jump around in, that life was some kind of weird timeline and that you can jump around on that timeline." She had been afraid to go to sleep because she feared she would be zoomed forward, past her own death.

Melina: Do you still have thoughts like that?

Emily: Not really. No. It freaks me out a little bit sometimes when I have thoughts, what if I did see some sort of alternate reality? What if that is what happens to people when this thing happens and we just don't really understand? So, I find that line of thinking interesting, and also when I start to think that way, it's like "ew," I don't like that—pull back and let's get a more solid grasp on things [grabs onto table]… But, I wonder about other people's experiences. I don't know, how people experience the world—people who claim they see ghosts and things. You probably didn't see a ghost but what was going on in your brain? Maybe it was something like what happened to me.

As we continue to talk, Emily situates what she calls scary thoughts in relation to real things in the world, such as systems of oppression. They are not fantastical. She describes them as warped.

Not new or transcendent but rooted and of this world. The ordinariness of the scary thoughts means there is risk everywhere, even in her own curiosity:

> **Emily**: Trying to think about alternate ways of thinking is interesting but also scary because I don't want to go too far off the deep end like I did before. But also…

I acknowledge how hard it must have been.

> **Emily**: It was scary. I was terrified.
>
> **Melina**: What do you think was most terrifying?
>
> **Emily**: Um, I think it was just not understanding what was going on. For some reason I was just getting really scared by a lot of things … Something I thought of, going back to you asking how I was as a kid, is that I feel like I really kind of regressed in a way when I went through the episode and when I was in the mental hospital because I got really shy there. I feel as though I acted more like my younger self.

She continues by explaining that she became very, very shy and intimidated in the hospital. She had worked hard to build confidence as an adult, to become more outgoing. I asked her if she was just feeling like her younger self or if she thought she was acting like her younger self too.

> **Emily**: I think a little bit. Yeah. And I feel like I have been trying to climb my way out of that. This kind of smashed me down back to a baseline almost that I had to build back up from, if that makes sense.

It did to me, and I told her so.

On the ride home, I thought of Foucault's discussion of Tuke's Retreat, a historical emblem for the moral care for madness in the West. The entire structure of the Retreat, Foucault argues, is designed to infantilize the people it treats. The condition for people with mental illness to be set free was that they take on the status of a minor. Foucault explains that for Tuke, “Madness is childhood. Everything at the Retreat is organized so that the insane are transformed into minors” (1961:252). This process worked as a double alienation of both juridical status and liberty through the constitution of an asylum modeled on the family.

Foucault describes a depersonalized adult transformed discursively into a child. The transformation, while a return of sorts, is still progressive. The Retreat returned you as a minor to a family, but not your family. Emily taught me that she did not experience being hospitalized for psychosis as being treated as a child. The event was not only, or even primarily, a disempowerment, but a transgression of a developmental timeline. In my understanding of the infantilization of people with mental illness, I had not accounted for the intimacy and familiarity of the transformation, not into a new child, but a younger self.

Emily’s careful attention to time, both at the edges of her episode and as she reflected back on it, illustrates how time is foundational to our experience of the world and how time can become otherwise in psychosis. By recounting her travels in time, she offers a glimpse of what happens on the margins of human experience. Her sense of time was formed in relation to others, to her notebook and her friend who recommended she write it; to her mom, who should not have been there, and her siblings who care for her. But it is not just them helping her to stay in time by holding or (re)forming a sense of time that is shared in common. Timelines are crafted through relationships, and they impact them. She also shows how the time she experiences in psychosis and in the hospital reorients her status in ambivalent ways. It opens up the possibility of a return to a younger self. She is cared for as a child and a sister, but also returned to a way of being in the world that is less outgoing, less self-assured. She must redo the work of self-actualization that she attributes to growing up. Emily invites me to imagine what clinical timelines could accommodate if their time was less confined to being either progressive or regressive, their teleology more out of order. Is anything other than pathology possible in the context of a nonlinear temporal narrative?

“I lost my girlfriend. I lost my mind” – Collectivity and Causation

At some point during my fieldwork I began to notice how rare it was that diagnostic or prognostic clarity would come from chronologically ordered distinctions of cause and effect. One cause never seemed to rule out another. Rather, they often just seemed to pile on, one atop the next, confounding considerations in the development of a psychosis onset story and the prognosis it would foretell. One attending psychiatrist was always frustrated yet empathetic when parents asked for the cause of their child’s distress. As he would reflect back, he would usually shake his head, look to the ground, and just say something similar to, “it’s the wrong question.”

Anthropologists have been asking the same question for decades. They have consistently argued for a consideration of social causation in psychosis, highlighting the devastating impact of double-binds (Bateson et al. 1956), pathological families (Henry 1973; Weinstein 2013), “broken cultures” (Scheper-Hughes 1979), and “social defeat” (Luhrmann 2007). These concepts, some of them taken up in ethically problematic ways, offer an alternative to the brain disorder model that dominates contemporary US psychiatry.

I see the centrality of the chronologically oriented timeline in clinical diagnosis and treatment as inviting causal thinking. In what follows, I take an example of how a well-known psychiatric technique to decipher oddness from psychosis establishes symptoms, assumed to result from a brain disease, as the cause of social marginalization. I then demonstrate how the timeline helps accomplish this coherence. I counter this causal coherence with one young man’s understanding that loneliness caused his psychosis as an alternative relationship between marginalization and symptoms. His description of symptom onset refuses chronological ordering, which productively destabilizes the possibility of linear causal inferences altogether. His telling offers instead a schizophrenogenic notion that is neither entirely brain-based nor entirely social and resoundly relational.

One of the attending psychiatrists I observed often reminded the team that psychosis and oddness are distinguishable precisely because psychosis marginalizes and oddness has at least the potential to affiliate. I quickly recognized the notion as an effort to prevent medicalization of non-pathological odd beliefs or behaviors. The following conversation clarifies the technique and demonstrates how the notion that symptoms cause marginalization stems from and also reinforces a consideration of psychosis as entirely singular.

In an informal conversation after an intake interview, the attending and I linger, working on our laptops. I often squatted in the room after meetings. The psychiatrist tells me that someone who looks as if they have schizophrenia here might be a shaman somewhere else. I indulge him. We have moved to my turf, and to be honest it feels more comfortable here for me too. Of course, I had heard of this culturally relativist approach, but he continues to say that his mentor also taught him that in these same communities there were also ways to identify people with schizophrenia. I took him to mean that while the experience of psychosis was culturally relative, any specific cultural group will have ways to determine who is and is not sick. As he closes his laptop he ends the conversation saying, “there is no collaboration on the in-patient unit.” His comment reinforces a widely held assumption that psychotic experience is fundamentally idiosyncratic—there is no possibility for commensurability across psychotic views.

From the psychiatric frame that pervaded the clinics where I worked, *communitas*, or even more fundamentally, communion, is refused in psychosis or, rather, by psychosis. The experience of psychosis is entirely singular, pathologically so. The psychiatrist's training allows him to see that it is possible to think with unreason and not be psychotic, so long as other people think similarly and along with you. Unlike the madman, the shaman is joined in their beliefs and ideas. I take his point to be that people who can be shamans are by definition not psychotic regardless of how "unreasoned" their beliefs or behaviors may be from an outsider's perspective, precisely because they continue to interact and resonate with others. And yet, as I showed earlier, insight and diagnosis both require relationality. Experience comes into being as psychosis in the context of relationships with others. As such, could it not also be marginalization that precludes insight, or social inclusion that prevents psychosis, or at least the recognition of it as such?

Timelines that identify the start of symptoms and then subsequent loss of friendships or other kinds of attachments (to sports, school, music, hobbies) seem to shore up the idea that symptoms of psychosis marginalize. They isolate people. But, fairly often, patients and their families offered alternative orders of things, temporally and socially. A broken heart, the loss of a beloved grandparent, too many of the wrong kind of drug, and of course, mistakes in parenting, particularly mothering, were all posed as potential causes of psychosis in the early stages. The timeline, imposed as a linear account of what comes before and after, reinforces an instinct to think causally because it orders certain events as temporally prior to others. In this way, the demand for chronological coherence obscures the relational dynamics that influence diagnosis and insight. I argue that it is this forensic approach to timelines that may distort experience in its own way, leading inevitably toward questions of causation which are impossible to answer and historically fraught.

David, a young man I interviewed, offers the possibility of a more dynamic theory of what caused his first episode of psychosis. Our interview is at his parents' home, a condo in a gated community that has more than one fountain. He is aspiring to move out. I ask him what he thought causes psychosis, and he does not miss a beat in his reply: "loneliness."

The first time that I met with David I told him about my study and asked him if he might be willing to participate by either allowing me to observe some of his visits or maybe doing an interview sometime in the future. He decided to just start participating right then. He needed a wall to charge his phone anyway, he said—he could talk for a bit. He was going out in the city with his friends tonight and needed some juice.

He told me about his job. He said he loves it because he can be friendly. It does not bother him when people are mean. He was about to get benefits. Move out of his parents' house, but it would take a bit longer. He told me he was finally too old to be on his parents' insurance and would have to leave the clinic.

He said that in the beginning things just kept getting worse. He was paranoid because of the stigma. When it all started he felt as though he was "Throwing my life away. Never would belong. Never be happy."

He described having been hospitalized. Assaulted twice as a patient. "They injected me with some shit." He learned from the experience how bad it can get, and that he should take his meds. His revelation was colorful but not exactly enthusiastic or transformative. "Yeah, fuck it. I'll take it." He wished his first psychiatrist had told him what could happen if he did not take his meds because he might have taken them sooner. He said that when he was in the hospital he would have visual hallucinations, "People's eyes would look like snake eyes with slits." He checked in with me to make sure I was following, "you know how they open up and down?"

He said that while he was in the hospital he felt as though he would never get out. When his dad came to visit, “the way he looked at me was so terrifying for me. My mom looked crazy to me. I lost my girlfriend—I lost my mind.” The timeline disoriented me in the telling. Was it that he lost his girlfriend and his mind, his girlfriend and then his mind, or his mind and then his girlfriend? Does it matter?

My goal in telling this story is to help find an escape to the question of causation that demands timelines and relationality work in tandem and in a seamless coherence. What David offers in his refusal of a neat, ordered, and linear timeline establishing cause and effect is the possibility of a kind of relational causation, where no event needs to be stabilized as prior. The way his dad looked at him, what he saw when he looked at his mother, how a love and a mind were lost. David offers these moments together as an account of his experience, fearing that he was trapped in a psychiatric hospital. Placed in chronological order, they might offer a very different account more amenable to a causal narrative. Such as, he lost his girlfriend because he had lost his mind. Or even the reverse, so widely available, that he lost his mind after having been scorned by a woman.

It is hard to imagine suspending a desire to understand what is causing someone’s distress. It might be the wrong question, but I cannot imagine myself not looking for cause(s) in this way. Most people are accustomed to thinking causally and linearly. What would it mean to suspend a forensic frame and instead think of relationships between love and perception, symptoms of psychosis and loneliness, snakes and mothers?

Psychosis as Vernacular and Finding Another Place with Magic

As I began to think about how psychosis timelines work to know early psychosis, distinguish it from “normal” oddness or decipher one condition from another, I become stuck in a dilemma between how central the timeline is as an object of psychiatric knowledge and how conciliatory everyone seems to be about its potential to be false. My first instinct, looking to Reinhart Koselleck (2004) and his analysis of historical time, is to think of the impossibility of the psychosis timeline as rooted in the inadequacy of modern time to account for experience. Perhaps the demand of psychiatric diagnosis in the form of a chronology cannot accommodate experience. For Koselleck, experience is understood as past-present, a totality where “many layers of earlier times are simultaneously present.” It cannot be “chronologically calibrated … since at any one time it is composed of what can be recalled by one’s memory and by the knowledge of others’ lives” (Koselleck 2004:260). As such, experience is contextual, relational, and totalized, leaving the making of psychosis timelines problematic practically and epistemologically, if not altogether ontologically.

Within this frame, it is easy to understand how a mother could date her child’s first time hearing voices as last year when it was in fact “two, oh, no, wait, three years ago. Sorry.” This mistake needs no apology if we adhere to Koselleck and the temporal dimension he ascribes to experience. “Chronologically, all experience leaps over time; experience does not create continuity in the sense of an additive preparation of the past” (2004:260). Voices were timed in relation to bullying, sex, medications, and treatment, but diagnosis in the early psychosis clinic needs to know when so it can know what is likely to come next. Referring to less specific, but I argue related, notions of diagnosis and prognosis, Koselleck explains:

> The probability of a forecasted future is, to begin with, derived from the given conditions of the past, whether scientifically isolated or not. The diagnosis has precedence and is made on the basis of the data of experience. Seen in this way, the space of experience, open toward the future, draws the horizon of expectation out of itself. Experiences release

> and direct prognosis (2004:262).

Experience releases and directs but does not determine, since the very essence of prognosis is an expectation of something new. Koselleck describes an increasing space between experience and expectation resulting from the Enlightenment's end to the Christian doctrine of the Final Days.

With Final Days looming just ahead, the horizon was less vast and quite a bit gloomier. Within the restricted horizon of sacred time, the past and the future remain more closely tied to one another. Secular time is stretched as taffy might be, pulling but not severing the future's relationship to the past. This distancing requires, or at least makes relevant, various technologies of forecasting, statistical and otherwise, in the name of planning. As the apocalypse transitions from transcendent to mundane, it must be anticipated and planned for. Doom becomes capable of producing both fear (toward that which we are unprepared) and hope (toward that which we have planned for). As this transition continues, religious prophecy increasingly loses dominion to the rational prognosis of science and technology. Experience cedes ground to these other forms of knowing until we arrive at the moment of pure speculation in late capitalism. Koselleck offers this spiral to make sense of the rupture that modernity brings. What frustrates my use of Koselleck, however, is how difficult it is for me to clearly categorize the psychosis timeline as rational. If a timeline is clearly inaccurate, how could it continue to operate in a process of rational prognosis? Perhaps we reach a limit of acceleration into a future once it has been severed from the past so entirely (i.e., noticing things before they exist) that we have arrived at something like scientific prophecy.

Emily revealed a possibility of time-stamped data that would enable her to keep separate but also bring about psychotic experience from the past to the present and future. The journal calls attention to how the timeline operates in a way not entirely rational, or perhaps beyond rationality. Its truth seems to reside somewhere beyond the timeline. As clinicians seek to hone in on *the magical day*—the timing that confirms anticipated psychosis or its onset—I wondered, what can we understand about the psychosis timeline if we consider it as magic?

Marcel Mauss (1972) presents magic as collective but private. Magic attains its rationality through social worlds, but operates in isolation and secrecy. Unlike religion, magic's practices are hidden, illicit. He describes magical ideas such as *Mana*, the force of magic, as having "no *raison d'être* outside of society, that they are absurd as far as pure reason is concerned and that they derive purely and simply from the functioning of collective life" (1972:121). Magic functions as an aphorism. It contains its own truth:

> This term is force or power. The idea of magical efficacy is ever present and plays far from an accessory part, since it enjoys the same role which the copula plays in a grammatical clause. It is this which presents the magical idea, gives it being, reality, truth, makes it so powerful (1972:122).

Through tradition, magic enjoys an effectiveness that is *sui generis*. Magic is scientific insofar as it has clear laws, and these laws enable experimentation and rational forms of causation through contiguity, similarity, and opposition (1972:64). These laws lay the groundwork for meaningful (communal) representation and translation.

> Magical practices are not entirely without sense. They correspond to representations which are often very rich, and which constitute the third element of magic. As we have seen, all ritual is a kind of language; it therefore translates ideas (1972:60).

He situates the possibility of magic's efficacy at the site of the collective:

> There is no need to follow up this idea of primary causes since we have already said that magical beliefs are dominated by a universal belief in magic which goes beyond the

> fields of individual psychology. It is this belief which allows people to objectivize their subjective ideas and generalize individual illusions (1972:124).

It is a shared premise that matters. Did heartbreak bring about psychosis or psychosis, heartbreak? When did the voices start? The chronological order may matter less in its specificity and accuracy than in the idea that once we sort it out, the patient will make sense (to us). In this view, the timeline provides a mutually-believed-in object with laws—that time can be tracked, that some things happen before other things, that experience can be remembered. The psychosis timeline functions magically when its efficacy, or its ability to produce truth and transformation, is taken for granted. As such, and even in the midst of substantial difficulty in getting a temporal story, it is continually and communally pursued.

Of course, the laws beg transgression, and any gains are likely to be ambivalent. The cost of legibility can be significant. I noticed interviewees' comments being dismissed as conversations were taken back yet again to another date clarification. Often, people who could not produce intelligible timelines become bad historians or are deemed to lack insight. The process of triangulating data for the timeline creates strange equivalencies across various forms of experience and information. A school counselor's report becomes equivalent somehow to a mother's attempt to fit a lifetime into a digestible response, email, or phone call. Also, although I am arguing for a different kind of value, the concern around the possibility for lack of veracity or clarity of the timeline is palpable. An inaccurate timeline can result in a less precise diagnosis or formulation, a person taking antipsychotic medications too soon or too late. And, it is not just the clinicians who are concerned. Parents are often troubled by their impression that they or their children are providing less than accurate chronologies.

Imagine that the psychosis timeline works rationally insofar as it functions magically. Does magic give us the capacity to think about time and knowledge together, to capture how, in the clinic, they seem to be interrelated? Patients describing psychosis have been "in it" but can only know psychosis as psychosis from outside of it (with insight). Accurate diagnosis then requires a person or people who can retrospectively produce an intelligible, chronologically ordered account of an experience that may not actually reflect the experience of time that was lived. I argue that the psychosis timeline attempts to capture, but often falls short of capturing, the facts as they were known. In this process, it requires extensive coordination, observation, and narration. The value I could not easily identify in the timeline's ability to produce dependable psychiatric truth is eclipsed in its ability to produce a foundation for intelligibility, a mode of communication that renders singular experience, or at least pieces of it, legible to others.

Viewed as operating along the lines of magic, the psychosis timeline's effect may not be contingent on its accuracy but more on a shared understanding of it as an approximation of truth. Technologies often operate in this way, by creating a coherent narrative that can produce certainty even if they erase and efface other important empirical facts and details. In this way, psychosis timelines can operate beyond their role as a diagnostic technology. They are not only valued for their accuracy. The timelines can double as a site for communication between experience and clinical logics, providing a kind of ephemeral, contested and private space for collective experience even as such commensurability is often foreclosed.

My effort here is inspired by James Boon (1999) as he lays Mark Twain's strategic colloquiality alongside Marcel Mauss's theories of magic, demonstrating that such "incestuous unions" can attend to contradictions and conflicts in ways that comparative analysis cannot. Boon starts with the preface of *Huckleberry Finn* in which Mark Twain explains his use of multiple dialects so as to avoid the reader supposing “that all these characters were trying to talk alike and not succeeding” (1999:143). Not a failure, but a not-accidental difference. Perhaps it is not that experience cannot be spoken in the same temporality as psychiatric knowledge. Maybe instead, what is most valuable about it would be lost if it did. As madness has always been a kind of “alien heteroglossia at home” (Boon 1999:163), how can we capitalize on the psychosis timeline’s magical qualities? What kind of clinical timeline could be conjured that would be capable of accommodating rather than replacing the vernacular of psychotic experience with official psychiatric language? As it is, the clinical timeline demands chronology and is thereby constrained dimensionally, flattened. The separations between past, present, and future are stabilized through a spatial system where there is only the possibility of regression, progression, or stabilization. Or, in early psychosis clinics—psychosis, recovery, or staying in this place, whatever this place may be. What if, rather than being uncovered, psychosis timelines, made magical, can make psychosis even just slightly less singular.

CHAPTER SIX | Not Yet Psychosis

In *Bad souls: Madness and responsibility in modern Greece*, Elizabeth Davis (2012) treats psychiatric diagnosis as a "truth game." Diagnosis for Davis is an act of discernment in which a disease is identified by its symptoms, but an act where truth is produced, not discovered. She cites Foucault's definition of a truth game as:

> a set of rules by which truth is produced … a set of procedures that lead to a certain result, which on the basis of its principles and rules of procedure, may be considered valid or invalid, winning or losing. Since there is no effective strategy of thought outside the "field of obligation to truth." Critique can be achieved "only … by playing a certain game of truth," but "differently," at a distance (2012:55).

Diagnosis is a game not in the sense that it is contrived or not to be taken seriously, but rather in the sense that it is an interactive practice where 'truth' emerges through the play of social actors. Interrogation of truth games, and the power relations that sustain them, itself requires play. It will not work to cast off the game's rules as arbitrary or false. Instead, it is in the very relation to power that truth becomes a possibility. By analyzing psychiatric diagnosis as a truth game, Davis refocuses the question of diagnostic truth away from scientific validity or clinical outcome and onto the relations within which diagnosis is established, relations that include the anthropologist.

In this chapter I take diagnosis in early psychosis clinics as a truth game in the sense that Davis gives. Diagnosis is a practice constituted by relations between social actors who play various roles using dynamic strategies. Diagnosis within the prodrome is open to significant improvisation due to of the lack of clarity—or commitment—to the category itself. As I detail in Chapter 2, the category is simultaneously contested and reified as it is codified as an un/stable diagnosis in the DSM-5. Critiques of the category are overt. This engagement is at once a diagnosis of the category and the condition… In diagnosing the prodrome, it is not only symptom presentation that manifests as everything and nothing, but also diagnostic categories and clinical phenomenology. Nothing feels stable or constant except the distress. The categories are there, but conditioned, or conditioned some places and not others. The hope for *cure* demands prediction from clinical phenomenology while already knowing in advance that it is unfair to do so.

Inspired by Davis's approach (2012), I pursue psychiatric diagnosis of early psychosis by looking to the social relations that produce and stem from its truth. The stakes are significant as players reconcile not only the rules of the game, but their orientation to the truth and truth telling. In this chapter I focus on three social relationships integral to the diagnosis of early psychosis: first, the relationship between expertise and truth telling; second, the untethering of psychosis symptoms from schizophrenia; and finally, the temporal distancing between symptom onset and the appearance of clinically observable psychosis. What emerges is *not-yet psychosis,* a radically uncertain condition simultaneously not yet and forever, where psychiatric expertise must know and not know.

Not Telling the Truth of Psychosis: Expertise in Early Clinics

Davis builds on Pierre Bourdieu to argue that diagnosis, as with other social practices, is a game that social actors with various dispositions play with varying skill and effect. For Bourdieu, game playing is a metaphor with which to understand social relations. While players in actual games, such as chess, are acutely aware of the arbitrary and contrived nature of the rules, players engaged in the "real play of social practices" are unaware of the ontological truth or social function of the game. Davis moves beyond Bourdieu, citing the transparent and known uncertainty of psychiatric diagnostic practice, to argue for an analysis of the social relations of diagnostic practice as actual, not metaphorical, games:

> It is in light of this transparency of practical logic itself that I characterize the clinical encounter as a game—although not metaphorically, as Bourdieu would have it, since its constructedness is very much in play. This game does not exclude as "unthinkable" questions about its ultimate truth. In their everyday confrontation with patients, the clinicians I cite here were well aware of disputation over the truth of diagnosis, and thus over the legitimacy of their authority to practice it. Far from being uncritical automatons caught in *illusio*, these clinicians self-consciously operated in a space of play, where they occupied a variety of moral positions within and between partial regimes of truth… They were aware that the apparatus of clinical diagnosis naturalized their privilege and authority, which arouse from grounds additional to their mere expertise; and that the truths it yielded were inconclusive, unstable, and strategic. In practice as I observed it, this awareness was voiced—not as transcendental truth, but as context-specific doubt—in consultations and arguments among clinicians, in their negotiations with patients, and in my conversations with them. It in this lack of scientific and moral certainty in the clinical orientation to truth—this witting absence of secure grounding, often expressed in the mode of irony—that leads me to view diagnosis as an "actual" game (2012:57).

In Davis's ethnography, psychiatrists are not only observed playing the game (through the lens of anthropology), but they are also observers of the game.

In Chapter 2, I introduce *everything and nothing* and argue that diagnosis of prodromal psychosis requires attunement to the (im)materiality of early psychosis symptoms. Such attunement calls attention to unreason at the individual level but also in the sociocultural context of individual’s worlds. Parsing psychotic symptoms then is a matter of not only identifying psychosis but distinguishing ordinary from pathological unreason. Critique of the predictive validity of prodromal psychosis as a psychiatric category further destabilizes the concept, making the rendering of symptoms of psychosis radically uncertain as a characterization of individual experience and as a diagnosis. Such radical uncertainty destabilize not only the rules of the truth game, but how players relate to possibilities of truth.

It is midmorning and I am interviewing a clinician, Adalia, in her office. We are talking about her transition to the early psychosis clinic from her previous job in a community mental health center. She is telling me that working in a new clinic, based in the Psychiatry Department of a University Health Center setting, introduced a demand for expertise.

> **Adalia**: Parents were expecting me to be an expert. I would let them down if I didn’t take the role. I am desensitized to it now a little bit. “Oh yeah, you want me to be an expert. Okay.” I know what to do now. I know how to take on that role, but in the beginning, it was so anti-my way. I felt anxious. I felt like I can’t do this. This isn’t how I work. I am not going to give you what you want, and you are going to be upset and disappointed.

The rules had changed, and the new clinic demanded new strategies and a new relationship to expertise. In her previous job, she had to work to earn the trust of parents. She had to collaborate with them, which required disabusing any sense of expertise and actively reassuring them that she was not a threat. She tells me, “I had to be horizontal. Because that is the only way I was going to get into the family.”

> **Melina**: Being an expert there would be bad?
>
> **Adalia**: It would be violence. Basically. In the relationship.
>
> **Melina**: Do you feel like more of an expert now?

> **Adalia**: Are you kidding me? No. It is a performance. But I mean, I am myself. Before it was a performance. Now I am integrated a little bit. I can be like, "here is what we know." I don't say, "this is the way it is." I always say, "there is a lot that we don't know. Here is what the data says." I do that now. I didn't know how to do that, "Here is the information that we know." "We," as in, who is the we? [laughs] I can adopt this language, which I can use to satisfy their need for expertise. And, I feel as though I can be at peace with that a little bit because I am just saying what the data says. I didn't know how to do that before I got here. I was just like, "You want me to deliver you the truth about psychosis?" [laughs] Yeah, that is a role I can't take.

Adalia fundamentally refuses a *true* representation of psychosis, or at least refuses to play a role in espousing one. I ask her if she feels more confident now that she is skilled at mobilizing data. She responds celestially.

> **Adalia**: I feel like there is a universe of constellations. That is a way of making sense of this. And, that is a way of making sense. And then there is the space of their experiences. It can be so vast and different. So, I have to give the parents the constellations and give the young people some places to put their feet—so that we can feel a kind of sense of expansiveness, so that there is hope of a personalized story that it is not colonized by the data—or colonized by these discourses of what psychosis is via, *"it is only in the brain."* I do believe there is a biological component, and I also don't want to underprivilege or under-center experience.

I ask her if she feels alone in her view at the clinic. She says no. Others feel similarly. She mentions one colleague in particular and describes that he is able to

> step away from essentializing something as—this is the way it is, or this is a thing. Or psychosis is a thing. He can back up a lot and going in and back up and go in. And be like, diagnosis—yeah. He can go places and not get stuck in saying this is the knowledge. This is the truth. Like, hung up on that at the expense of someone's story.

The move here is not getting stuck in rigid claims to knowing, all the while meeting the demands of expertise. Good diagnosis means not holding on too firmly to the truth of diagnosis nor the possibility for a true understanding or representation of psychosis. Accommodating doubt in this way requires skill—a skill not entirely unlike how young people are asked to relate to experiences of prodromal psychosis. Satisfying the need for expertise requires this clinician to speak with a new kind of voice, with data. Data allows Adalia to explain what we know rather than how it is. Early psychosis is a difficult game to play, not only in the sense that terms are tenuous (e.g., diagnostic category) and symptoms are (im)material, but also in how it asks clinicians to cultivate expertise inside of doubt.

Psychosis as Symptom: Distancing Psychosis from Schizophrenia

> *Symptom*: A physical or mental feature, which is regarded as indicating a condition of disease, particularly such a feature that is apparent to the patient. (Oxford English Dictionary)

Within a couple of weeks of fieldwork I am no longer sure what psychosis is. I start asking clinic staff. Many chuckle at the question. I think it is because they think the answer should be easy in a psychosis clinic when, in fact, it rarely is.

One resident responds:

> **Resident**: Yeah. Good question [laughing]. I mean, I think it means a lot of different things to different people. I would maybe describe it as some alteration, or a perceptual disturbance that someone is experiencing a different reality than the average.

This definition does not make a claim to a right or true reality, just a lack of access to a shared one. In fact, the trainee's use of "different" instantiates the premise of multiple possible realities.

> **Melina**: And how do you distinguish between when it is a feature or a symptom, or is it always—
>
> **Resident**: I think of psychosis as a symptom, not a disease or an illness.
>
> **Melina**: Now that you have worked in this clinic with people in adolescence, how do you think about normal adolescence now? Has it changed?
>
> **Resident**: I don't know that much has changed. I guess maybe the sort of breadth of maybe how much can change and what can be normal. I would say there is a, not necessarily in our clinic because we tend to see the people who are more seriously affected, but certainly a range of adolescents who have psychotic experiences or psychotic symptoms that emerge during this incredibly tumultuous period of adolescence but then don't go on to develop schizophrenia or any of these other things.
>
> And so, just developing an appreciation that, just because someone hears voices, doesn't mean they have schizophrenia or even that they are going to hear voices for the rest of their lives. But, just the period of adolescence being so incredibly overwhelming for the being, that you could develop a psychotic experience that doesn't necessarily mean that you have an illness.

The resident's definition of psychosis as a symptom runs counter to mainstream notions that equate psychosis with mental illness. The Merriam-Webster dictionary defines psychosis as: "a serious mental illness (such as schizophrenia) characterized by defective or lost contact with reality often with hallucinations or delusions." Such lay definitions instantiate a singular reality and characterize psychosis as fundamentally compromising a person's relationship to it. Additionally, its characterization as "a serious mental illness" establishes the experience of psychosis as essentially pathological. Whereas other psychiatric symptoms, such as anxiety—"apprehensive uneasiness"—or depression—"a state of being sad," have relevance in both normal and pathological experience, the definition for psychosis leaves no possibility for psychosis to not be a concern of mental illness, and therefore psychiatry.

In the exchange above, the trainee carefully refuses foundational components of such lay definitions. Psychosis is not itself a mental illness. Rather, it operates as a signal (symptom) of *both* mental illness and adolescence. Conceptualized as a symptom, psychosis is less similar to schizophrenia and more similar to a headache. It can indicate a disease, or it can be a part of a reasonable reaction to the tumultuousness of adolescence. As with a headache, psychosis can be debilitating or just bothersome. It can be a sign of something more serious or a passing state. It is never not a problem, but it is not necessarily a psychiatric one.

The argument that psychosis is not itself a condition of mental illness but a nonspecific symptom of a diverse set of mental illnesses is fairly well accepted in psychiatry. What is more interesting about what the resident has learned is that psychosis can be a symptom that does not index disease or illness at all. Psychosis can refer to, or originate from, "normal" adolescent turbulence. What the trainee did not understand before she worked in an early psychosis clinic is that psychosis does not always foretell mental illness. The acquired skill, the specialization, is not so much an expertise in isolating and psychiatrically intervening upon unreason, but rather seeing the possibility of unreason in the average. The overt and forever character of psychosis that medical trainees may learn in an inpatient unit no longer resonates in outpatient and prevention oriented early psychosis clinics. Instead, attenuated symptoms dissipate before being captured. In early clinics, psychosis's status as a symptom is in question, not only insofar as it lacks specificity but also because it seems as though it can be a symptom without a cause.

> **Melina**: You were just saying that during this tumultuous time, there are potentially things that look like psychosis that do not register to a concern about disease or illness for you. Can you give me some examples? Or, how do you discern the difference between those things and something you would think of as [indicating] an illness?
>
> **Resident**: I mean I think it is sort of, time will tell. You would still raise concern. They would all still meet criteria for a research study or being in the high-risk category. So, someone who is hearing voices, is that because this is the early signs of a primary psychotic illness? Is this just isolated voices? Is this depression with psychotic features? It is sort of impossible to know. It is, time will tell. There is certainly the sort of standard questions that we ask, and the research studies try to get at, what is the conviction of the patient? How sure are they that this is happening? And then, the level of distress. How much is it impacting their daily life and functioning? But then, you just sort of have to wait and see what happens.

I am asking for a distinction between psychiatric and everyday psychosis; the clinician refuses the possibility of knowing for sure. Only time will tell. When psychosis is a symptom, it may not mean schizophrenia. It could signal depression or even just a thoroughly overwhelmed adolescent. But, it also may not mean "any of these other things." She is concerned either way. It may not point to any one disease, but it indexes a problem, even if a social one, as I trace in Chapter 2.

Any possibility of getting closer to knowing whether psychosis as symptom indicates a condition of illness, and if so, which one, relies on understanding how the subject, or patient, relates to the symptom. How sure were they? How distressed? Diagnosis is not a matter of identification, but rather a practice of observing reactions, effects, acceptance, and refusal between people.

The concept *psychosis* was originally used by psychiatry as a euphemism meant to reduce the harm attached to such terms as insane or mad (Sommer 2011). Historically, psychosis referred to any mental state or process, not just an altered one. In the late nineteenth century, psychosis morphed into referencing a unitary mental disorder affecting a person's cognitive, perceptual, or linguistic functioning. Synonymous with insanity, further iterations of the concept distinguished it from neurosis, a disorder of the nervous system, and established psychosis as a unitary symptom of underlying brain disease, different than dementia, mania, and idiocy (Thomas 2001).

The resident's conceptualization of psychosis retains the possibility that psychosis is a symptom of an innate biological defect but introduces the sense that it can also be a symptom of other things, such as adolescence. Essentially, the resident's *psychosis as symptom* refutes the concept's original use as euphemism, troubling the automatic way it stands in for insanity or madness. In early psychosis clinics such as these, The resident learned to maintain a characterization of psychosis not as insanity but rather as a sign of its possibility, a sign that can come and go and indicate many things.

Just Psychosis

I am sitting with Anna in a cafe. We are talking about her daughter, who was recently diagnosed with schizophrenia. She and her daughter are unconvinced of the diagnosis. She is telling me that when her daughter was first diagnosed with schizophrenia, it had made sense.

> **Anna**: Yes it was like, this is what's wrong. Because when you do your own research, it's like early warning signs and it starts to manifest early in your twenties. And you're withdrawn. You don't want to be around friends. You get depressed, and there were some things. She's always been very clean. So even when she cut her hair off, she's always been very, like, shower clean. She just didn't care as much about her appearance. Voices, that kind of thing, even when I was taking her to the doctor, I told them, she doesn't have these. They said, well usually those things manifest later when you're kind of talking to yourself and seeing things and hearing things. These come later, but she has depression and withdrawal.
>
> **Melina**: So, did you walk away from that conversation feeling like that was what was to come?
>
> **Anna**: Yeah that was what was going to happen to her, and it never did.
>
> **Melina**: And do you feel that way now?
>
> **Anna**: Yeah, no she's not at all. I trust her in the house. She goes to church on her own. She's, not at all. The only thing I fear is when she is just worried about, am I doing the right thing? Am I saying the right thing at work? What if I answer the phone, and I don't answer the phone right? Did that just make sense, what I just said to you mom? She's just very unsure of herself. It's almost like her insecurity is heightened to like 1,000. But that's as bad as it gets.

> **Melina**: It’s interesting, it’s hard to get—
>
> **Anna**: I know. I stopped emailing [the clinicians]. But, I’d be emailing, well what about this? What about that? She just has this adamant, like psychosis. Can she grow out of it? But, it’s like she grew into it. I don’t know. If you can’t tell me how or why, then you can’t tell me it can’t go away.

Anna finds a punishing uncertainty here that both torments her and offers her hope. This particular psychiatric diagnosis was not given in a context of uncertainty. She was told her daughter has schizophrenia. The clinicians had not wavered. What seemed obvious to her at first, that her daughter has schizophrenia, becomes uncertain over time. Her critique is less about whether or not her daughter received the right diagnosis and more a refusal of the permanence.

Anna is clearly working hard against the serious and intractable notion of schizophrenia, and her daughter is giving her a lot to work with. Anna wrestles with how in some ways the diagnosis fits, but in so many other ways it does not. Her daughter does not hear voices. She has gotten better. She works full time. And, it turns out, there is not even a genetic predisposition in the family. Part of this uncertainty is the false notion that having schizophrenia automatically negates the possibility that a person can do things like work, clean the house, go to church. The image of the person with serious mental illness living on the streets is a specter for the schizophrenia diagnosis that continues to instill fear and stigma.

Anna’s biggest concern is her daughter’s insecurity. Her daughter seems to have regressed. Anna explains, “I try to rationalize the basics for her. When you are talking to her, it is like you are talking to a 12-year-old. I don’t even know who she is anymore.” She wants to think her daughter will grow out of this psychosis, but she catches herself in this hope and relents that she actually grew into it. Anna describes an exhausting toggling between being worried and wishing her daughter would just “get it together.”

Her fears that her daughter would start seeing things, hearing things, talking to herself, those have not happened. Anna struggles with this “adamant psychosis” but uses clinical uncertainty about its cause to refuse the possibility that it will not go away. I ask her what her goals were in sending the emails.

> **Anna**: Tell me. Give me something that tells me what is happening with her. Because this is not. […] what are the chances of her just developing it? She didn’t have anything traumatizing. She doesn’t have the symptoms of schizophrenia. Then what is it? And, it was just psychosis.

Just psychosis. I take her to mean psychosis as a symptom that does not point to any cause or underlying disease. It gives her no indication of what is coming. She has an idea in her head of what schizophrenia would be, and it is not what her daughter is experiencing. Severed from its origin, as only a symptom, psychosis lacks meaning to her. She goes on to tell me a story about a friend of a friend’s son who has been diagnosed with an “acute psychosis breakdown.” He was medicated, but the antipsychotic medication did not help. The mom knew her kid. She knew that something was not right. She took him off medications and supported him in changing his job. He fully recovered and is now psychosis and medication free. She explains:

> So, when you see things that happen and you’re telling me my daughter has psychosis, but you’re not able to say this is why. This is what happened. This is attributed to these foods. Or, this genetic predisposition is what triggered it. If you can’t tell me, then you can’t tell me that—what can you tell me? You can’t just do this forever.

Melina: So, basically what you know right now is that something is making things hard for her. Something is making her different, and then the meds right now help make that not as bad.

Anna: That thing, what is that thing?

Melina: But, beyond that you don't feel there's been any kind of clarity, right?

Anna uses cancer treatment as an analogy. Taking a round of chemo will lower the cancer, she explains. Her daughter is going to therapy, taking medication, but Anna struggles to figure out what to hope for.

Anna: […] this program is two years. So, in two years, she will be able to what? What is going to happen in two years that's magical? And, what has happened to other people? Are they un-psychotic? Do they just stay on?

Melina: So, the question that you're asking is what's at the end of two years.

Anna: Right, and is there an end for us? Or, are we going to do this for the rest of our lives kind of thing, which you know I don't want to hear that but if that's the case…

Diagnosis is inadequate, and treatment that simply addresses symptoms is as well. The clinic cannot tell Anna what caused her daughter's symptoms or what she can expect to happen in the future. Schizophrenia does not seem to capture the experiences her daughter has. The ones that are *just psychosis* do not fit the condition's symptom profile, at least the profile available when you do your own research. Even as just a mechanism for accessing services, the diagnosis underperforms. Two years' worth. The diagnosis is permanent, but the services are far from guaranteed. What happens after that? For now the diagnosis seems to raise more questions than it answers. I ask Anna how parenting is different than she thought it would be.

> **Anna**: You know I thought she would be different. I thought she would be more independent. I didn't think I would worry as much about her. I worry about her every single night and every single day. And every single day I want her to be okay, to be able to function. It's changed everything, and it makes me question. I was wondering, what did I eat when I was pregnant? I'm going back to all this stuff, so it makes you question everything because no matter what happens, you just want to have answers, right? So, even if I can blame myself, at least I can say, well this is what happened. If I can blame whoever, whomever just to say okay, this is why this happened to my baby. You want to do that because I really do want the answer. This "we don't know why, we don't know when" makes it hard. So, it makes me question a lot.

Psychiatric uncertainty is untenable. It is not enough for the clinic to admit what it does not know.

Sussing Out What Is Really Going On

Often, it is the job of the anthropologist to see what those enmeshed in social relations cannot themselves see. In Davis (2012), the anthropologist is observing expert players reconciling their own actions and relations within a social practice. Such optics are made available by the "lack of scientific and moral certainty" in psychiatric clinics. Diagnosis for Davis is provisional and generally unfinished, if mostly because it is based on "speech in all its potential ambiguity and duplicity" (2012:59). Viewing diagnosis as a truth game, Davis is able to show how lying in the diagnostic scene forms and maintains the conditions of an ambivalent intimacy in the clinic, where psychiatrists are compelled to respond not only to signs and symptoms, but also to an uncertainty founded in suspicion. Davis explains, "The uncertainty of their motives, further clouded by their ambiguous communication, derails the diagnostic procedure and calls for a strategic response on the part of the psychiatrists" (2012:74). Both patient and speech become suspect, and in so doing require the psychiatrist to maneuver diagnostically, to play. It is not a matter of how well diagnosis corresponds to truth, but rather the strategic play of both clinician and patient that creates the conditions for a "true" diagnosis. In Davis's field site, these conditions include, or perhaps rely on, lying. By insinuating her own methodology as part of the truth game, Davis reveals how attending to sites of diagnostic derailment opens up the distance necessary for critique. As with all games, rules and strategy become most obvious during moments of creativity and improvisation that are required when things do not go as planned.

As with the psychiatrists Davis describes, the clinicians and researchers who work in early psychosis clinics openly reflect on questions of the ultimate truth of the diagnostic game they all play. Part of what torments in these scenarios is they demand players to sit with doubt while assuming an acceptance of the rules so profound as to be unobservable.

I am sitting with a clinician, Michelle, after an afternoon of back-to-back appointments. She looks a little beat but agreed to talk. The clinician begins by stating how important the recovery frame is to her work. Michelle tells me that stigmatizing and use of non-recovery language used in the clinic really bothers her. She worries particularly about "what people believe about schizophrenia." Recalling an intake interview we had both attended a few weeks prior, she struggles with how a young man had been diagnosed with schizophrenia. He subsequently refused care, and Michelle feels the diagnosis played a part in his refusal. She explains, "he is not getting any care now because he came here and we said, 'you have schizophrenia.'" At issue is not just that the schizophrenia diagnosis is harmful, but also that she fears it was given in error. As she reflects back on the intake, Michelle tells me it could have been schizophreniform, but not schizophrenia:

> You know, definitely there is oddness. There has been maybe an episode of psychosis in the past and then spontaneous recovery. And just because someone has had an episode of psychosis in the past does not mean that they have schizophrenia. Everything that we labeled it on was based on that he was functioning a little bit differently than other people his age. We could pathologize that and give him a harmful label, or we could maybe decide to not do that and figure out how we could work with him to help get him on track to be functioning more like his peers—if that is what he wants.

The young man's ambitions and desires take center stage for Michelle. Her claim is that they could have during the diagnostic process as well. As she continues to process the intake interview, Michelle partially blames a lack of common definitions of psychosis and related diagnoses across the multidisciplinary team. For her, psychosis and schizophrenia are both heterogeneous, representing many different types of experiences, levels of severity, and etiologies. She tells me she finds no value in thinking of schizophrenia as a brain disease and yet acknowledges that this model is the driving hypothesis for some of her colleagues. She recognizes the potential value in discovering biomarkers for disease states but worries about the overdetermined relationship between psychotic experience and pathology.

Michelle is not alone in her thinking of schizophrenia as heterogeneous (e.g., Insel 2010; Tandon et al. 2013). In fact, just weeks earlier a psychiatrist in the same clinic also challenged the logic that maintains the notion of schizophrenia as an intractable and highly debilitating disease:

> If I was going to get angry at DSM, sometimes it just sort of gives you obvious prognostic information. A thing that has been present for six months is likely to continue. Thanks a lot.

> Sometimes when people use it to justify disease arguments I wonder, how do you know that schizophrenia is a disease entity? We call schizophrenia a chronic illness, but, we have defined it as chronic. So, of course they [patients] do [experience chronic illness]. What does that prove?

Diagnostic criteria for schizophrenia require that signs of a disturbance persist, even if only in attenuated form, for at least six months prior to diagnosis. Within these six months there must be at least one month of symptoms and markedly reduced functioning. The psychiatrist’s critique of the DSM-5 does not destabilize the category. It just asks for a little humility. From the psychiatrist’s perspective, the schizophrenia diagnosis helps group people with similar experiences together because they are defined by the type, duration, and frequency of those shared experiences, not necessarily because they all suffer from the same disease.

Michelle seems to be making a different but corollary critique. Her point is that the focus should be on what is known—that protective factors and social supports help with recovery. She also tells me, accurate diagnosis requires getting to know someone and seeing them over time. She explains that the young man had presented as very disorganized, which likely led to the diagnosis. But, as the young man continued to come in for visits and get to know the team of clinicians, the disorganization became less and less apparent. I wondered if her primary concern was around stigma related to schizophrenia or if she is making a more general critique of the possibility of diagnosis. I ask, “What is the difference between schizophrenia and psychosis in this clinic? There are lots of things that can be psychosis that are not schizophrenia—“

> **Michelle**: Yeah. No, and I think most people would agree with that. [Schizophrenia] is when you have had at least one episode of psychosis and then also functional decline. Which is the part, as we talked about today, [that] is entirely culturally contextual. So, for

> this young man we are talking about, because his family is so high functioning. They all went on to college. Because he didn't and is not hanging out with his friends on the weekend, that is a functional decline. And, it is, if he used to hang out with friends and now he is isolating. That's different. That could be depression. That could be trauma. That could be being bullied and so many other things besides schizophrenia. And so you try to get enough data to say, "all these things are happening." And that is enough of a picture to be schizophrenia. But until you have all that data, you can't really say for sure. Because it could be due to a lot of other things.
>
> [After a pause], So mostly that functional decline piece. That is the hard part because people themselves don't have insight into that all the time. So, we are getting collateral from other people, which is a different, subjective opinion about what they are noticing about someone else. Which is then how it really becomes social pathologizing of people who are different, in maybe ways that scare us or we think are odd. This is what we were talking about in the meeting in terms of "this is an odd belief but more normative." So that person [discussed at the meeting] is probably less likely to be given the schizophrenia label versus if he was talking about aliens or other weird things.

Staff in early psychosis clinics spend a lot of time attempting to differentiate oddness from psychosis. As I described in Chapter 5, one attending psychiatrist often reminded the team that psychosis and oddness are distinguishable precisely because psychosis marginalizes, is entirely singular, and oddness has at least the potential to affiliate. This distinction, he explained to me, cannot be discerned through reality-testing. He uses the example of people who meet for alien conventions to argue that while they are not thinking "with reality," their odd beliefs lead to affiliation, not marginalization. In this way, believing in aliens is not psychotic. Psychosis is when your beliefs lead to alterity—to you being "othered" within the context of your relationships, or yourself. Marginalization, he said, is what better differentiates psychosis. Psychosis is not just oddness, but an oddness that is not motivated by or productive of affiliation. And yet, a recent ethnographic engagement with *becoming aggrieved* by Laurence Ralph (2015) complicates this formula by showing how there is the possibility of affiliation in madness.

So, the young man's diagnosis depended not only on his having had "maybe" an episode of psychosis but also on his having experienced a functional decline that he could not be relied on to report. Getting the diagnosis right then requires that the young man supply an account not only of what he experiences but also of any changes in his behavior, experiences, and desires over time. Did he use to hang out with friends? Did he want to go to college? Does he now? Such reflections offer a kind of truth, perhaps his truth, but because of the ever-looming possibility of lack of insight, they cannot be entirely relied upon. Evidence must be gathered from other sources, such as parents. And yet, these sources cannot be relied on either. Their input is subjective and polluted with parental aspiration, social norms, and fear. It takes "all that data" to say for sure.

The problem Michelle is having is partially a product of what early psychosis has made possible, the manifestation of psychosis as a symptom, but one that does not necessarily indicate schizophrenia. One early psychosis researcher frames the dilemma as stemming from the transition of early psychosis concepts from research to clinical or "real-world" settings:

> **Researcher**: Because there has been funding for early intervention in psychosis, there are models that have been developed to treat people in the real world. And when you treat people in the real world, it's a very different perspective. It's a much broader definition because you are doing it not on the basis of these very structured diagnostic categories,

> and more on the basis of clinical need and impairment. These are difficult diagnoses to differentiate. It takes a lot of training to tell the difference between schizoaffective disorder and schizophrenia and bipolar disorder with psychotic features. Especially in someone who is 18, and it's their first episode. So, in the real world, people don't make those distinctions that much, and they lump everything together.
>
> **Melina**: Do you think differentiating is something that you learn over time, that you get a sense of? Or do you think it's something that you'll always need an instrument for?
>
> **Researcher**: You will always need an instrument.
>
> **Melina**: Why?
>
> **Researcher**: Because the definitions are so specific and arbitrary. I mean, literally, it comes down to exactly what is the timeline between these different sets of symptoms, and you have to walk someone through it. So, for example, with schizoaffective disorder what's the overlap between the psychotic symptoms and the mood symptoms, and how much overlap was there, for how long? Has there ever been a period of time where they've had one without the other? That's not something someone is going to be able to do without some sort of structure.

I ask why it all comes down to the timeline. The researcher says that timelines are important to the DSM not because they are necessarily meaningful on their own, but "because they had to come up with something." This quip isn't a flippant critique. Rather, the research is quickly referencing a complex logic that undergirds psychiatric diagnosis, whereby the needs of psychiatric research to ensure demonstrable validity and reliability of findings drive and structure DSM definitions (see Lakoff 2005; Young 1995). We continue:

Researcher: And there are some differences between the disorders in some ways, but no one in this field thinks they're different diseases or anything. They're just different variants.

Melina: The schizoaffective versus—

Researcher: Yeah versus schizophrenia or something like that. You know if someone has manic episodes, that is qualitatively different than if someone doesn't. But, there's also a lot of overlap. There's genetic overlap between bipolar disorder and schizophrenia. There's probably all kinds of pathophysiological overlap. I mean some that we know about, some that we don't know about. But, there's also differences, and you just don't know.

Melina: One of the things that I've heard from people who are trained abroad is what's unique with the United States is that there's such an emphasis on diagnosis. Do you have a sense for why that is?

Researcher: Sure, that's because psychiatry is fighting to prove that they are just as based as other professions in medicine here.

The institution desires to prove that it is scientifically based, and it attempts to demonstrate this fact through diagnosis. And yet, recognizing the impossibility or arbitrariness of psychiatric diagnoses does not free a psychiatric professional from using them. Diagnosis is inscribed in the very fabric of the institution itself, in the way psychiatry is funded, how psychiatrists are promoted, how psychiatry is taught and how quality services are ensured, and of course, how psychiatric knowledge is produced. This difficulty in diagnostic discernment is not new or unique to early psychosis. It dates back to early deliberations over the qualification of *dementia praecox* and schizophrenia. It is ingrained into the DSM and therefore in any psychiatric institution that uses it for research, diagnosis, or billing. The problem does not go unnoticed by psychiatry professionals. Critiques of the DSM abound.

An impossible double imperative emerges within the tension between early psychosis science and early psychosis clinics. Psychosis can be apprehended and discerned, but it cannot be apprehended or discerned solely in the clinic. As this researcher explains, when funding shifted from being primarily oriented toward research studies on early psychosis to supporting early psychosis intervention, diagnostic practices moved from science to clinics in the "real world." This transition is not a simple relocation because concepts, terms, categories and practices morph to fit their new environments. The privileging of the evidence base in the proliferation of early psychosis clinics means that the clinics must work in relation to research studies at least to some degree. The researcher explains that it is prohibitively difficult to differentiate schizoaffective disorder from schizophrenia and bipolar disorder with psychotic features. And yet, this difficulty, while widely recognized, does not necessarily keep clinicians from trying. I observed clinicians work diligently to give young people and families accurate and specific diagnoses and prognoses. Families often demand them. In the midst of profound uncertainty, when diagnosis is put fundamentally in doubt, these diagnostic and prognostic practices reveal institutional inadequacies and ethical dilemmas.

In such clinical practices as the one Michelle is critiquing, "data" must be accumulated through repeated visits and relationship-building rather than with scientific instrumentation. Such instruments are prohibitively time consuming and resource intensive for typical clinics.

> **Melina**: You talked about the importance of getting to know someone and having "good enough" evidence—what evidence about social decline do you trust the most as a clinician?

> **Michelle**: Heard from them or from parents?
>
> **Melina**: Both.
>
> **Michelle**: Really, when there is a really significant change. If someone has always been uncomfortable around people, never really liked to hang out with people, and now they are isolated in their room, that is less of a, but still, maybe a change. Versus, they used to go out all the time and text people and date, and now they don't do any of that. Or, they were getting As and now they are really getting Cs and Ds. More objective changes. When you can see behavioral outcomes that are different rather than parents describing vague ways that now they are different or not doing what they want them to do. These are still important because parents know people the best, but I think that we have to suss out what is really going on and not just take a parent's perspective on something and align with them. Which, I think is hard to do because I think a lot of people really believe that parents know what is going on and what is best.

Sussing out what is really going on requires an accounting of fraying social ties—a young person severing friendships, no longer dating, not texting. The locus is no longer just on the patient. Diagnosis extends to interrogate the quality and condition of the patient's relationships to others, both inside and outside the home. These are the real indicators, but you cannot see them in vague descriptions of parental concern. Expressions about how a child is different or how they are not meeting expectations are inadequate. As with the personal account, seeing the behavioral outcomes necessary for diagnosis requires a parent's perspective but demands that the diagnostician approach it skeptically.

> **Melina**: You said something earlier, you said one of the things that makes giving a diagnosis such as schizophrenia difficult in these two instances that we were talking

> about is that they had had experiences in the past. Is it that you are relying on their recollection that makes it difficult or unreliable for you, or is it that you can't actually observe them having these experiences in the present moment?
>
> **Michelle**: When we observe them having symptoms in the present moment, it is much easier to say, okay, there is active psychosis right now. Has it been going on for more or less than six months? Is there any mood component related to it? And, then you can figure out easily between the three main diagnoses in the DSM. When there is not, then I guess you are focusing on, well, are there prominent negative symptoms?
>
> For someone like him, with something like what we could say is a negative symptom, depression, alexithymia, are these types of features of schizophrenia, or just a risk prodrome? I guess, yes, he has all of those. But, can we say, okay that episode of psychosis actually happened? We don't know how convinced he was and if he was acting on all of this. We could have delved in much harder to try to figure it out. I am not entirely sure what the benefit of that would be because we are here now. He has had some spontaneous recovery.

When there are fully realized symptoms of psychosis, behaviors that are readily apparent to the diagnostician in the clinic, diagnosis becomes much easier. But, when the signs are not present, diagnosis must reach beyond the clinic to assess information from the memories of parents, peers, other professionals. In these instances, diagnosis depends on the subjective experience of the patient and parents, even the clinician, and yet the premise of undermined veracity creates a fraught relationship between diagnosis and personal account, where knowing oneself, or one's child, or one's clinical instincts is at once valued and refused as truth.

Our conversation began with the question of accurate diagnosis, a demonstration of how difficult it is to determine what psychosis as a symptom indicates. Schizophrenia? Schizophreniform? Adolescence? But in the end, there is a shift. The clinician returns to the importance of knowing more about how the young man experienced the suspected psychosis and the difficulty of knowing if it "actually happened." Recollection is inadequate here to know for sure. Truth could be had through more delving, but even the value of such effort is in question. Whatever it was, it has gotten better. Michelle assumes resignation, at least temporarily, to not knowing what is really going on.

Her concern is misdiagnosis, but not necessarily in the sense of clinician error (the young man had been noticeably disorganized). Rather, she worries about an impossibility of precise diagnosis without more "data" on context and relationships, the kind of data you can only get over time. I naively ask Michelle if a diagnosis could be retracted. Michelle says no, "there is nothing you can do. I mean you can go about it with an addendum probably." The young man's biography, at least the one told by his medical charts, is forever changed. And his is not the only one. Across the sites, I would hear about many young people requesting to have details in their charts revised, including their diagnoses. Each time, in every institution, the answer was the same. It is not possible. Even with the widely acknowledged uncertainties, the diagnosis, once inscribed in a chart, becomes so certain as to be immutable. Once there is a diagnosis, even a doubted one, the only possibility is to gain more. The diagnosis, even when its "truth" is radically in question, once charted, cannot go away. Michelle thinks the diagnosis is the reason the young man is no longer accessing services. And, it is permanent.

I have argued that in early psychosis clinics, psychosis is conceptualized as a symptom, but one whose status is put radically, principally in doubt. I've attempted to show how within the disjuncture between science and the clinic, early psychosis introduces a fundamental diagnostic uncertainty wherein business as usual, or acting as if arbitrary categories are objectively meaningful, becomes untenable. Psychosis as symptom is nonspecific but more than that can become entirely detached from its cause. Every day in these clinics, psychiatric professionals work with young people and their families to enact a practice of apprehension and discernment that is known in advance to likely elude them all. They must speak the truth of their symptom to a diagnostic rationality that is destined to misapprehend it, at least until time reveals fully realized symptoms of a psychotic disorder. This demand has real consequences. The implications of the (im)possible double imperative are significant and inescapable for those who provide or receive psychiatric services in these early psychosis clinics.

I have shown how, in early psychosis clinics, psychosis is a symptom, albeit an unreliable one. I traced how psychosis evades apprehension and often cannot distinguish between various conditions of illness. But even in the midst of psychosis's shortcomings as a symptom, diagnosticians earnestly try to get it right. I observed very little apathy in this regard. Clinicians, particularly as they gained experience, openly discuss the uncertainty of psychiatric diagnoses with patients and families. While the ethical intentions of this practice are readily apparent, telling the truth about the uncertainty of psychosis as symptom often has its own harmful consequences. I came to realize that confessions of psychiatric uncertainty are themselves not benign. The idea of definitive diagnosis may be impossible, but an uncertain one is also inadequate.

Not Yet Psychosis: Psychosis as Threat

Deborah and I start by talking about her daughter as a child. She tells me her daughter has always been a voracious reader, "read almost everything in the school libraries," she says. Then a pause as she returns to the present, “And you know what is really sad, she is hardly able to read. I’m not sure what it’s all about, if it’s distraction from the voices, being depressed, there’s a lot of things I think. But it’s sad to see something that was so important to her kind of vanish.”

I have heard this example from other young people and their parents, this specific experience of having loved reading and then lost it to symptoms, medications, to a “lot of things.” As the descriptions of reading being lost piled up, I could tell this loss went beyond cognition. Rather, it removes access to beloved worlds, to respite, to joy. Wanting to imagine that the reading will return, I ask Deborah if she has hope that it will come back.

> **Deborah:** Yes and no. You know in contrast to how I’ve lived most of the time, investigating everything, I’ve kind of not investigated a lot with this so far. And I think, well I don’t know, if it’s good or not, I just haven’t psychologically been able to do it. It just feels too difficult.

Deborah is reluctant to hope without evidence, but she tells me she is too scared to seek evidence out. She wonders aloud if it is her bleak sense of schizophrenia that makes researching this subject so difficult. Then she pivots, telling me about a handful of memoirs she read about people with lived experience of serious mental illness. Those help, she says.

Pointing to an early psychosis article on her desk, she says, “I just found this really interesting.” Deborah tells me that the author says prodrome is a misnomer and misleading because it implies inevitable progression to disorder. This concern is a common critique of the clinical use of prodrome in early psychosis as detailed in Chapter 2. I ask Deborah if it is this new diagnosis that scares her. She corrects me:

> **Deborah**: Well, she doesn’t have a diagnosis. She is just clinically high risk.
>
> **Melina**: What the clinicians have told you—

> **Deborah**: Well, they just call it CHR, clinically high risk. I talked to [therapist] today and she was emphasizing that she doesn't have a diagnosis because she hasn't had any psychotic episodes. She just has these voices that are very hard.

She tells me that the article on her desk is helpful because it further distances her daughter's voices from psychosis, from schizophrenia. Being "just" at CHR does not mean inevitable progression to schizophrenia or even psychosis. In her assessment, prodrome seems to offer only the measly consolation that she has not yet converted. While risk as a concept maintains the possibility that it will be nothing, a prodrome produces an absence of psychosis by introducing its immanent possibility. In so doing, the "not yet" of the prodrome instantiates a presence of psychosis.

And yet, any comfort she gets from the idea that her daughter is just "at risk" seems to quickly dissipate as she is left acknowledging the very hard voices. She tells me that they never relent and are very critical. They talk all the time. Deborah describes them as similar to a newscaster, talking over everything, constant critical commentary. The family works on befriending them, and it helps some of the time. But new ones will emerge, meaner ones, demanding new strategies. She tells me, "I just worry about her getting worn out. I mean there's only so much people can take." She will later tell me that the voices are getting worse, louder and more aggressive. No diagnosis does not mean no symptoms.

She wonders how the experience of the voices relates to her daughter's intense love of books and storytelling. Her daughter has been "creating stories her entire life. That's what she loves to do. It kind of felt like that got hooked up with these voices and they became like characters in a book." Deborah's explanation of this "hooking up" is not at all that her daughter is making them up. The voices are not just fiction. It is more that the voices and her daughter's literary abilities are related, not causally or conditionally, but rather co-creating, punishingly symbiotic.

I ask how the family found the clinic. She tells me they were referred by their community psychiatrist. She recalls that earlier she had come across the program's website but taken it to be for psychosis and not for "people who were not yet psychotic." But as the voices became increasingly disruptive and some concerns of paranoia emerged, the community psychiatrist ultimately made a referral and they ended up here, in the clinic that had seemed as though it was for psychosis.

From the beginning, Deborah tells me, the clinic's approach seemed focused on determining whether or not her daughter had converted to psychosis. After determining that she was CHR, attention shifted toward prevention. She recalls:

> I felt like we were just focused on, "oh please, don't let her transition." And then, I started to realize that never transitioning and just living with voices could be hell. I mean it could be its own totally horrible life. So, it's not all about transitioning or not. I do feel there's a little bit of an emphasis on that, that's the thing everybody looks for.

In light of this realization, that never transitioning could be its own totally horrible life, I ask her if it still matters whether her daughter is CHR or if she converts to a psychotic disorder. She says: yes, "because I think it means that people treat her differently when they see it." Deborah explains that she knows the medical system enough to know that any diagnosis here would be just a best approximation, a code you have to put down for insurance purposes. But, she tells me, she also knows that not everyone sees it that way.

Her concern is not that her daughter receives an accurate diagnosis. In fact, she seems to refute that as a possibility. She knows the rules of the game. She is not struggling to find a diagnosis that captures what her daughter is going through. She concedes that her daughter "just doesn't really fit any of these things." Her desire is to avoid a diagnosis that will impose more harm than it alleviates. She knows that any diagnoses will follow her daughter and change how she is treated. In this way, she anticipates a different kind of conversion, not of her daughter's state but of her possible relationships. For Deborah, her daughter is at-risk here from both psychosis and the socio-emotional harms of psychiatric labels.

Mostly, she is worried about what is being deprioritized or ignored. She explains that her daughter has other diagnosed mental health conditions, and "it's as if that just doesn't exist anymore except that she's been on these medications. But, it's been completely superseded by the high-risk stuff." Deborah worries about not attending to these other experiences, about missing an opportunity to address something that causes her daughter distress in the interest of preventing potential psychosis. Deborah is concerned not only by the anticipatory logics that demand she act on her daughter's potential conversion now, but also by what that demand displaces, the myriad other issues that distress her daughter, the other diagnosed conditions her daughter endures. Anticipation not only demands some action in the present, but also forecloses others.

Deborah has described a complicated scene of not-yet psychosis where she both fears and finds solace in her daughter being at-risk. Not having a diagnosable psychotic condition matters to Deborah. It means that her daughter does not have to carry the diagnosis of a psychotic disorder. People will not treat her differently—yet. But, it does not mean that her daughter's symptoms do not torment. The voices are severe and highly distressing. It helps Deborah to know that more and worse psychosis is not inevitable. CHR does not mean future schizophrenia. But being at-risk cannot make the voices go away or make them be more friendly. It has not brought the reading back. And it means other things are going unaddressed. It is itself a pretty horrible place, and as a prodrome, it feels as though it is forever.

> **Deborah**: In the family meeting the [psychiatrist] repeatedly said, “not yet.” I don’t think he was making it specific to her. He was just being very careful, I think, that people not think that there was no risk. I really don’t know. I need to ask him about it sometime because he repeated that many times.
>
> **Melina**: And the issue with it is a concern that the “yet” means it is coming?
>
> **Deborah**: Well, it really made it sound that way. He wasn’t saying “if,” he was saying it was almost like “when.”

I ask Deborah where she sees her daughter in ten years.

> **Deborah**: I think about that of course, and I really have almost two opposite, I have two pictures that both seem very possible to me. One is the bleak one which is that she will—Well I guess there’s maybe three. Really bleak is that she wouldn’t be able to stand this and she would kill herself. I think that’s always a possibility. The other would be that she stands it, but she’s very dysfunctional and lives with us, and she has a very restricted life. And, I can also see her coming through it, whether she transitions or not.

Her most bleak version, in which her daughter dies by suicide, corresponds not to a psychotic future but rather to the highly distressing experiences in the space of not-yet-psychosis. Preventing conversion is not enough. Not transitioning cannot hold all the hope.

Enduring means not only withstanding the symptoms but also accommodating a very restricted life. Hope, for Deborah, seems to reside in some kind of transformation, an emergence from her daughter’s current experience, that may or may not include transitioning to psychosis.

Her imagined best hope is not for preempting psychosis. She does not wish to stay where they are. Rather, her hope is for getting beyond it, her daughter coming through it one way or another.

In Davis's account of psychiatry in Greece, the potential for lying within psychiatric relationships produces "suspicions of deception." It is concern, she argues, that creates the terms for a clinical intimacy. Such suspicions hold relationships between clinicians and psychiatric subjects together by demanding that clinicians work to *know* their patients amidst the eminent possibility for unreliable speech. This demand necessitates longer relationships, more narration, and sets the stage for "a temporality of clinical care: an expectation and satisfaction that makes a future appear out of an unlivable present" (2012:111).

In early psychosis clinics, doubt functions in a similar way, rooted not necessarily in the lie, but rather in the eminent possibility of the miss—a (mis)diagnosis or missed symptoms. Clinicians hold off on diagnosing psychotic disorders, they probe a little extra on the timeline, spend a bit more time establishing conversion. In this way, the temporality of clinical care in early psychosis strives to function in a similarly anticipatory capacity to that of the lie. It is an attempt to hold space for possible futures. But, Deborah's *not yet psychosis* shows that the temporality of care in early psychosis clinics also operates as threat.

Within the anticipatory logics that undergird early psychosis, intervention prior to conversion is the only possibility for cure. It makes sense. It is a given. Critiques question the possibility of its execution, not the value of the goal. Early psychosis clinics respond to threatening psychosis.

Brian Massumi begins "The Future Birth of The Affective Fact: The Political Ontology of Threat" by asking, "How could the nonexistence of what has not happened be more real than what is now observably over and done with?" He traces the political abandonment of the past as legitimation for action and its replacement with what he calls superlative futurity. Threat replaces danger as the motivation for action. In his analysis of political threats, including weapons of mass destruction and avian bird flu, Massumi distinguishes between affective and actual facts, arguing that preemptive action is legitimized not in the facticity of actual threat but by fear, the manifestation of affective facticity. Threat is real because it is felt, regardless of its actualization as danger.

> Threat is from the future. It is what might come next. Its eventual location and ultimate extent are undefined. Its nature is open-ended. It is not just that it is not: it is not in a way that is never over. We can never be done with it. Even if a clear and present danger materializes in the present, it is still not over. There is always the nagging potential of the next after being even worse, and of a still worse next again after that. The uncertainty of the potential next is never consumed in any given event. There is always a remainder of uncertainty, an unconsummated surplus of danger. The present is shadowed by a remaindered surplus of indeterminate potential for a next event running forward back to the future, self-renewing.
>
> Self-renewing menace potential is the future reality of threat. It could not be more real. Its run of futurity contains so much more, potentially, than anything that has already actually happened. Threat is not real in spite of its nonexistence. It is superlatively real, because of it.
>
> Observation: The future of threat is forever (Massumi 2010:53).

For Deborah, what is so punishing about the prodrome is not only it’s diagnostic implications (that her daughter is at risk for psychosis)—but that it threatens indefinitely, a not-yet. For her and so many others with whom I spoke in the context of early psychosis clinics, the lack of discernible psychotic symptoms is presented to her not as a question of “if,” it is a question of “when.” As with psychiatric diagnoses more generally, threatened psychosis is permanent even in its absence.

Psychiatry as An Affective Institution

As I have detailed above, clinicians and family members often use uncertainty as a diagnostic strategy to create the possibility that what clinically looks like a prodrome is not necessarily prodromal schizophrenia. And yet, the clinicians and researchers who participated in this study overwhelmingly refused the idea that they are providing treatment for young people with potential future conditions. Rather, they argue time and again that they are providing much-needed care to young people suffering from unquestionable problems in the present. Their point, the need for intervention, is obvious regardless of a lack of diagnostic or prognostic precision specific to psychosis. In the clinic, there may be uncertainty at the level of knowing what is wrong, but not at the level of whether or not something is wrong. Diagnostic uncertainty does not destabilize sure pathology.

At the same time the clinicians acknowledge the difficulty of deciphering things that *seem a little like … huh*, they consistently and adamantly insisted that the young people they treat in their early psychosis clinics are already suffering. Deborah’s depiction of not-yet psychosis confirms this claim as she struggles with the *very hard* impact of the attenuated voices her daughter experiences. More general concerns about pathologizing healthy kids or treating the worried-well were strongly refuted in interviews and throughout observation. One clinician argued: “Everybody we treated needed intervention, and actually most of the people had been trying to get help for a long time.” Another explained, “These kids needed intervention, they were not doing well. We didn’t get many calls about, ‘hey my kid is doing great but they’re just a little weird.'" Given the difficulty of accessing mental health services in the US, it is likely that the young people who do reach these clinics are already significantly distressed, and many of them have other diagnosed or diagnosable mental illnesses. But, these compounding aspects may only partially account for these clinicians' insistence on pathology.

In "The No/Name of the Institution," Ian Whitmarsh proposes the use of kinship as an analytic for animating our understanding of institutions. His goal is to make it possible for them to become as interesting as the subjects they produce. He defines institutions as "things with the authority to author the no/name, to confer the taboo." Whitmarsh builds on psychoanalysis and structuralism to show how institutionally sanctioned naming conditions a subject's becoming through a declaration of what it is and what it cannot be. It is a boy (and not a girl). As this example shows such naming necessarily exacts a damage (a foreclosure), can be violent, and transgression is built in. Seen as affective, institutions become fundamentally ambivalent and desirous—working exclusively through neither violence nor love, but always both.

Much scholarship attends to the affective subject, and her agency or lack thereof within structures of power, including, of course, psychiatry. But Whitmarsh introduces the possibility of an *affective institution* that at once disciplines and nurtures, always perversely. And as with affective subjects, these institutions can be seen as driven by infinite desire. He explains, as "with authority relations—such as a mother or a sovereignty—what we seek is more convoluted than any need, and what we get is never quite what we asked, always less than we desired, and more than we bargained for" (Whitmarsh 2014:866). The challenge given to us by this frame is to pursue institutions as ambivalent authoritative entities rather than all-powerful and rational forces without desires of their own. Such an analytic extends Foucault's argument that psychiatry acts as and through family (Foucault 2006), capitalizing on the expansiveness of kinship studies in anthropology (e.g., Franklin and McKinnon 2001). This frame troubles easy distinctions between acts of institutional violence (e.g., naming/psychiatric labeling) and acts of institutional care (e.g., mothering/prevention), instead providing a lens to see that institutions recognize and discipline subjects through practices of naming (e.g., diagnosis) that are simultaneously violent and caring.

When viewed with Whitmarsh's provocation to look at institutions through kinship, the necessity to frame "distress" as pathology can be seen as motivated not only by processes of medicalization, psychiatry extending its domain into adolescence, but also by institutional desire for inclusion. In this way, pathologization, or diagnostic labeling, is not only a violent form of "othering" but also the mechanism by which psychiatry establishes "these kids" as "our kids." What looking at *not yet psychosis* through a lens of institutional affections reveals is the possibility for psychiatry to discipline its subjects through love, not in lieu of it. But the real value of the concept is to remind us that such acts of love are inherently perverse. In this case, the institution establishes affinity, or belonging, through the very naming processes that ascribe or threaten otherness.

Considered as the act of an *affective institution*, psychiatric diagnosis emerges as ambivalent, never either just pathologization or accurate and rather always potentially both. Within biomedicine, discussions of the ethics of prodromal psychosis are concerned primarily with the possibility that young people will be inaccurately identified as at-risk for psychosis. Within these considerations the *problem* with uncertain diagnosis is that there is a high false positive rate (i.e., most young people who are positively identified as at-risk do not convert to psychosis) and no stable validated biomarker. These considerations obscure the perversion of accurate risk prediction—the harm that the institution does to all its subjects, in order to care. I worry that alone, they cannot provide a route to an ethics capable of accommodating the ambivalence of *not-yet psychosis* or *just psychosis*. Looking at diagnosis of everything and nothing from the lens of an affective institution raises alternative questions: Why does psychiatry in the US desire diagnosis; why does it keep its subjects so long; what is lost in the service of prevention?

CHAPTER SEVEN | Am I awake? A conclusion of sorts …

Josephine and I are just getting started with an interview. She recently joined the clinic to get support with voices that had become increasingly disruptive in her life. After her initial assessment, she was told she is at clinical high risk for psychosis. I start by asking her about school.

> **Josephine**: It was good at first, but then with all the voices it became harder because it was hard to concentrate in classes. You know, I didn't know whether to respond to them or not. Plus, I didn't know I was hearing voices at first.
>
> **Melina**: When you say you didn't know whether to respond or not, you weren't sure if someone was actually asking you something or talking to you?
>
> **Josephine**: Yeah, I didn't want to say something that was wrong.

I say that it must have been difficult to feel that way in class. She nods but responds by telling me how stressful it is to have so much homework in high school. She has so many classes, and she wants to do well in all of them. I ask her if she hears voices all the time. She says she used to, but now just a few times per day, maybe more. The biggest difference, she explains, is that she does not notice them as much now. This not noticing helps her concentrate. She is relieved that they have relented, but the experience has left her questioning her judgment.

I ask her how she handles that. She explains that since generally people do not say mean things directly to other people, when she hears mean things she assumes they are voices "in her head." I ask her if her voices are always mean. She says they were, but now they mostly try to protect her. The difficulty is that they try to protect her from getting hurt by introducing hurtful ideas. She gives the example of when they tell her to kill herself so she never gets hurt or to hurt people before they hurt her. She says they are nice, “just not very smart.” She tells me she has the sense that the voices are both her and not her.

> **Josephine**: It kind of feels like someone is pushing me to do it, but it is just me. It is this fear I have. Yeah, the voices are me, but they are not who I am as a person. You know what I mean?

The voices are her, but they are different than she is. I ask her if they ever give her good advice.

> **Josephine**: It’s not like they give advice. They just are there.

Her initial refusal and her clarification, “they are just there,” makes me reimagine “voices” altogether. I had been thinking of noise, of talking, but that no longer seems quite right. They may be difficult to distinguish from people’s voices, but I can no longer think of them as sounding the same.

We begin to talk about a recent increase in her medications. She tells me she thinks the clinicians made the increase because she is still hearing voices. I ask if the clinic’s goal is to have them go away altogether. She says, she thinks so. I ask if that is what she wants as well.

> **Josephine**: I don’t mind hearing them always. It is kind of nice to talk to someone so long as they are not mean. But, if I tell them to go away, they go away.
>
> **Melina**: So they obey you?
>
> **Josephine**: Yeah.
>
> **Melina**: When you talk to them and you like them, what kinds of things do you talk about?
>
> **Josephine**: They just listen. They don’t talk, but they are there. It’s kind of nice. It feels like I am never really alone.
>
> **Melina**: What will it mean for you if this new dose of medication makes them go away?

Josephine: I think I am sad… People think I am crazy for liking my voices.

It seems to me that she cannot find a place where she does not feel as though people think she is crazy. She explains that she is not ashamed of hearing voices, but she does not talk to people outside of the clinic about it. Josephine tells me, “you don’t want to end up being the freak kid, you know.” And yet, there is no space for her voices in the clinic either. There, she is made to feel crazy for liking her voices. The implication is that she should want them to go away. People will think she is crazy for having them, and people will think she is crazy for liking them, even just parts of them.

Josephine is clear throughout our conversation that she is glad her experiences are not “psychosis.” She has been diagnosed as Clinically High Risk (CHR). From an early-psychosis clinical perspective, her voices, as she calls them, constitute an early warning sign of potential psychotic illness, not a symptom of a fully realized one.

Josephine: He [her psychiatrist] doesn’t think that I am near psychosis. Which is good. I don’t want any psychosis. It is not something that you want. […] But he did say that you don’t get lost in it forever. You can get out.

Melina: So, he said to you that he doesn’t think that you are close to psychosis, but that even if you did experience psychosis, that it is not forever?

Josephine: Yeah. I know that. It is just that I got scared with that term. It just sounded like, going crazy.

Melina: Yeah. I can totally understand that. What did you think psychosis meant?

Josephine: You know, like people on the street, talking to themselves. And they have no idea what is real or not. It’s like that. But it is hard to see people on the street. On the train.

Melina: Do you still think that is what psychosis is?

Josephine: No.

Melina: What's changed your mind?

She goes on to tell me about watching a YouTube video of a professional woman talking about living with psychosis. I ask what was most reassuring.

Josephine: Someone who had gone through that, come out on the other side. She entered psychosis basically. She thought they were real for a while. I think. She didn't stay there.

Melina: She didn't stay there.

Josephine: No. […] You are not stuck there. Who wants to be stuck there?

I ask her what she thinks will help prevent her from experiencing psychosis. She tells me the medicine helps. Going to her therapist helps.

She continues by telling me that one of the main distinctions between psychosis and pre-psychosis is continuing ask what is "real" and what is "not real." She tells me that she has gotten pretty good at distinguishing. For example, she knows that something crawling on her skin is a visual hallucination when she can see it but cannot feel it. But she will also ask her parents for help.

Josephine: I always ask them if this is real. Is what's going on really happening and they always say, yes. Only problem is they say that in my dreams too.

Melina: When you are dreaming. I didn't get that. When you are dreaming you ask your parents?

Josephine: Uh huh.

Melina: You tell them about your dreams when you wake up?

> **Josephine**: I ask them in the dream. Am I awake? And they tell me I am awake, and then I wake up. And I am like, “I wasn’t awake at all.”

Her explanation troubles the possibility that we could ever know when Josephine is awake, and therefore if *this* is real. It is disorienting. But, Josephine does not have psychosis precisely because she continues to ask the question, maintains a state of disbelief toward what she experiences. Perhaps the implication is not that Josephine is nearly failing the project of modern subjectivity, but rather that she is realizing an *awkward* version. Her subjectivity manages to maintain an exterior position relative to her unreason but seemingly within the boundlessness of psychosis.

In early psychosis clinics, psychosis must first make a case for itself, it must demonstrate itself as a symptom. And yet, it resists apprehension in the clinic, revealing itself only when the “right questions” are asked. I have shown that by listening to the uncertain testimonies of early psychosis, we may learn more about what psychosis is from an experiential perspective—a symptom, a breakthrough, acting fine and not being able to act fine, a metaphor—sometimes one you cannot speak. It is ambivalent, caring, tormenting. You can grow into psychosis, and it can just go away. It is extraordinary and mundane. It exceeds the psychiatric institution and its diagnostic practices, but it often finds its way there eventually. It is idiosyncratic, but also fundamentally relational.

As ever more precise and certain conceptualizations of progressively earlier-stage psychosis are pursued, which perhaps must happen, there is a risk of losing sight of what exceeds our increasingly narrowing view. What escapes as this movement advances might be the implications described above for young people, families, and clinicians who are asked to speak the truth of psychosis when their truth is already radically in doubt. A young man is given a permanent diagnosis and the clinician laments the likelihood that she will never see him again as a result. A child becomes untrustworthy. A mother is left disoriented by “just psychosis,” endlessly questioning what happened and having to stake ethical claims to the possibility of what is to come. Young people, who like Josephine desire to maintain the prodrome, are set to the task of asking, again and again, from a position of doubting their own judgement: “is this real?” This question, a diagnostic practice so boundless in reach, that it makes demands in dreams, even the dreams of psychiatry itself.

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