

Also by Esmé Weijun Wang

The Border of Paradise

THE
COLLECTED
SCHIZOPHRENIAS

ESSAYS

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Graywolf Press

Diagnosis

Schizophrenia terrifies. It is the archetypal disorder of lunacy. Craziness scares us because we are creatures who long for structure and sense; we divide the interminable days into years, months, and weeks. We hope for ways to corral and control bad fortune, illness, unhappiness, discomfort, and death—all inevitable outcomes that we pretend are anything but. And still, the fight against entropy seems wildly futile in the face of schizophrenia, which shirks reality in favor of its own internal logic.

People speak of schizophrenics as though they were dead without being dead, gone in the eyes of those around them. Schizophrenics are victims of the Russian word *гибель* (*gibel*), which is synonymous with “doom” and “catastrophe”—not necessarily death nor suicide, but a ruinous cessation of existence; we deteriorate in a way that is painful for others. Psychoanalyst Christopher Bollas defines “schizophrenic presence” as the psychodynamic experience of “being with [a schizophrenic] who has seemingly crossed over from the human world to the non-human environment,” because other

human catastrophes can bear the weight of human narrative—war, kidnapping, death—but schizophrenia’s built-in chaos resists sense. Both *gibel* and “schizophrenic presence” address the suffering of those who are adjacent to the one who is suffering in the first place.

Because the schizophrenic does suffer. I have been psychically lost in a pitch-dark room. There is the ground, which may be nowhere other than immediately below my own numbed feet. Those foot-shaped anchors are the only trustworthy landmarks. If I make a wrong move, I’ll have to face the gruesome consequence. In this bleak abyss the key is to not be afraid, because fear, though inevitable, only compounds the awful feeling of being lost.

According to the National Institute of Mental Health (NIMH), schizophrenia afflicts 1.1 percent of the American adult population. The number grows when considering the full psychotic spectrum, also known as “the schizophrenias”: 0.3 percent¹ of the American population are diagnosed with schizoaffective disorder; 3.9 percent² are diagnosed with schizotypal personality disorder. I am aware of the implications of the word “afflicts,” which supports a neurotypical bias, but I also believe in the suffering of people diagnosed with the schizophrenias and our tormenting minds.

I was officially diagnosed with schizoaffective disorder, bipolar type eight years after experiencing my first hallucinations, back when I first suspected fresh hell in my brain. I remain surprised by how long it took. I was diagnosed with bipolar disorder in 2001, but heard my first auditory hallucination—a voice—in 2005, in my early twenties. I knew enough about abnormal psychology to understand that people with bipolar disorder could experience symptoms of

1. The National Alliance on Mental Illness.

2. Daniel R. Rosell et al., “Schizotypal Personality Disorder: A Current Review,” *Current Psychiatry Reports* 16.7 (2014): 452. PMC. Web. 26 Oct. 2017.

psychosis, but were not supposed to experience them outside of a mood episode. I communicated this to Dr. C, my psychiatrist at the time, but she never uttered the words “schizoaffective disorder,” even when I reported that I was dodging invisible demons on campus, and that I’d watched a fully formed locomotive roar toward me before vanishing. I began to call these experiences “sensory distortions,” a phrase that Dr. C readily adopted in my presence instead of “hallucinations,” which was what they were.

Some people dislike diagnoses, disagreeably calling them boxes and labels, but I’ve always found comfort in preexisting conditions; I like to know that I’m not pioneering an inexplicable experience. For years, I hinted to Dr. C that schizoaffective disorder might be a more accurate diagnosis for me than bipolar disorder, but to no avail. I believe she was wary of officially shifting me from the more common terrain of mood and anxiety disorders to the wilds of the schizophrenias, which would subject me to self-censure and stigma from others—including those with access to my diagnostic chart. Dr. C continued to treat my condition with mood stabilizers and antipsychotics for the next eight years, never once suggesting that my illness might be something else. Then I began to truly fall apart, and switched to a new psychiatrist. Dr. M reluctantly diagnosed me as having schizoaffective disorder, bipolar type, which remains my primary psychiatric diagnosis. It is a label that I am okay with, for now.

A diagnosis is comforting because it provides a framework—a community, a lineage—and, if luck is afoot, a treatment or cure. A diagnosis says that I am crazy, but in a particular way: one that has been experienced and recorded not just in modern times, but also by the ancient Egyptians, who described a condition similar to schizophrenia in the *Book of Hearts*, and attributed psychosis to the dangerous influence of poison in the heart and uterus. The ancient

Egyptians understood the importance of sighting patterns of behavior. Uterus, hysteria; heart, a looseness of association. They saw the utility of giving those patterns names.

My diagnosis of schizoaffective disorder, bipolar type resulted from a series of messages between my psychiatrist and myself, sent through my HMO's website.

From: Wang, Esmé Weijun
Sent: 2/19/2013 9:28 a.m. PST
To: Dr. M

unfortunately i have not been doing well for a few days (since sunday)

by end of sunday i was upset because the day had passed in a "fog," i.e. i could not account for what i had done all day despite having painstakingly [made] a list of what i had done that day, i could not remember having done anything, it was like i had "lost time"; i was also very tired and took 2 naps (i did not take any more klonopin than usual that day, in fact i would say i took less, maybe 2 mgs)

monday i realized i was having the same problem; trouble functioning at work, especially with concentration, i would stare at the same sentence for a long time and it would not make sense; i took a nap on a couch in the office; again i felt the day had passed without my existing in it; by 4 i was unsure that i was real or that anything else was real, also having concerns with whether i had a face, but not wanting to look to see if i had a face and feeling agitated at the prospect of other faces. symptoms cont. today

From: Dr. M

Received: 2/19/2013 12:59 p.m. PST

Ok, just re-read this again—definitely sounds more like psychosis is the problem. Increasing seroquel could be the answer (to 1.5 pills—max dose is 800 mgs). I think you may have schizoaffective disorder—a slightly different variant than bipolar I.

Btw, have you read Elyn Saks's *The Center Cannot Hold*? I'd be curious to know your thoughts about it

Years later, I read between the lines of Dr. M's brief response. She describes schizoaffective disorder as "a slightly different variant than bipolar I," but does not specify what she means by "variant"—a variant of what? Schizophrenia and bipolar disorder are both considered *Diagnostic and Statistical Manual Axis I*, or *DSM* clinical disorders; perhaps "variant" refers to that broad realm, which includes the worlds of depression and anxiety in its geography.

Dr. M tosses in, as though it's an afterthought, a mention of the most well-known schizophrenia memoir of the last thirty years, written by MacArthur Genius Grant winner Elyn R. Saks. The mention of Saks is a potential buffer for her bad news of a terrible diagnosis. It can also be seen as Dr. M's way of emphasizing normalcy: you may have schizoaffective disorder, *but we can still talk about books*. In fact, in four years schizoaffective disorder will be a diagnosis that Ron Powers, in his hefty examination of schizophrenia titled *No One Cares about Crazy People*, will repeatedly call worse than schizophrenia, and in four years, I will draw exclamation points in the margins and argue with Powers in pencil. And yet there is also a predecessor for me to admire: Saks, who used her MacArthur money to create a think tank for issues

affecting mental health, for whom schizophrenia has shaped her calling. Those who like to chirrup that “everything happens for a reason” might point to Saks’s research and advocacy, which likely would never have happened had she been born neurotypical, as part of God’s plan.

This is how the *Diagnostic and Statistical Manual (DSM-5)*, a clinical bible created by the American Psychiatric Association (APA), describes schizophrenia:

Schizophrenia, 295.90 (F20.9)

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these³ must be (1), (2), or (3):
1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized or catatonic⁴ behavior.
 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning⁵ in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or

3. The first two are symptoms of psychosis. I have yet to experience the third.

4. Catatonic behavior in the clinical sense is not the same as catatonia in the layman’s sense. According to the *DSM-5*, catatonia can also include excessive motor activity.

5. To be diagnosed with schizophrenia, a person must be low-functioning, though a person living well with schizophrenia may also be considered high-functioning.

when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Clinicians use these guidelines in order to discern the presence of schizophrenia. Medicine is an inexact science, but psychiatry is

particularly so. There is no blood test, no genetic marker to determine beyond a shadow of a doubt that someone is schizophrenic, and schizophrenia itself is nothing more or less than a constellation of symptoms that have frequently been observed as occurring in tandem. Observing patterns and giving them names is helpful mostly if those patterns can speak to a common cause or, better yet, a common treatment or cure.

Schizophrenia is the most familiar of the psychotic disorders. Schizoaffective disorder is less familiar to the layperson, and so I have a ready song-and-dance that I use to explain it. I've quipped onstage to thousands that schizoaffective disorder is the fucked-up offspring of manic depression and schizophrenia, though this is not quite accurate; because schizoaffective disorder must include a major mood episode, the disorder may combine mania and schizophrenia, or depression and schizophrenia. Its diagnostic criteria, according to the *DSM-5*, read as follows:

Schizoaffective Disorder, Bipolar type 295.70 (F25.0) This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

- A. An interrupted period of illness during which there is a major mood episode (major depression or manic) concurrent with Criterion A of schizophrenia. Note: The major depressive episode must include Criterion A1: Depressed mood.
- B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

- D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

To read the *DSM-5* definition of my felt experience is to be cast far from the horror of psychosis and an unbridled mood; it shrinks wraps the bloody circumstance with objectivity until the words are colorless. I received the new diagnosis of schizoaffective disorder after twelve years of being considered bipolar, in the middle of a psychiatric crisis that went on for ten months. By then, the trees had long shed their dead leaves. But in the beginning of 2013, the psychosis was young. I had months to go of a frequent erasure of time; a loss of feeling toward family, as though they had been replaced by doubles (known as Capgras delusion); the inability to read a page of words, and so forth, which meant that the agitation I felt at realizing something was badly wrong would only go on and on and on and on.

Though the German physician Emil Kraepelin is credited with pinpointing the disorder he called “dementia praecox” in 1893, it was Swiss psychiatrist Eugen Bleuler who coined the word “schizophrenia” in 1908. Bleuler derived the term from the Greek roots *schizo* (“split”) and *phrene* (“mind”) to address the “loosening of associations” that are common in the disorder. The notion of a split mind has led to a lousy—as in, both ableist and inaccurate—integration of “schizophrenia” into the vernacular. In a 2013 *Slate* article titled “*Schizophrenic Is the New Retarded*,” neuroscientist Patrick House noted that “a stock market can be schizophrenic when volatile, a politician when breaking from party lines, a composer when dissonant, a tax code when contradictory, weather when inclement, or a rapper when headlining as a poet.” In other words, schizophrenia is confusing, off-putting, nonsensical, unpredictable, inexplicable,

and just plain bad. Schizophrenia is also conflated with dissociative identity disorder, more commonly known as multiple personality disorder, due to the vernacular use of “split personality” to refer to a disorder unrelated to fractured personalities. And though psychosis is a phenomenon shared by disorders other than schizophrenia, the words “psycho” and “psychotic” are used to refer to everything from obnoxious ex-girlfriends to bloodthirsty serial killers.

Though Bleuler’s coinage is his most enduring legacy, he also went on to conduct the bulk of pioneering work on schizophrenia, including the seminal monograph *Dementia Praecox, or The Group of Schizophrenias*. As Victor Peralta and Manuel J. Cuesta describe in “Eugen Bleuler and the Schizophrenias: 100 Years After” (*Schizophrenia Bulletin*), Bleuler conceived of schizophrenias as a “genus rather than a species.” As a concept, the schizophrenias encompass a range of psychotic disorders, and it is a genus that I choose to identify with as a woman whose diagnosis is unfamiliar to most—the shaggy, sharp-toothed thing, and not the wolf.

The *DSM* is published by the APA, which released its long-awaited, updated “bible for mental disorders,” the *DSM-5*, in May 2013. Updates to the *DSM* aren’t set like clockwork; after all, the *DSM-IV* wasn’t released until 1994, and the *DSM-III*, which infamously contained the diagnosis of “ego-dystonic homosexuality,” came out in 1980. I’m not a psychiatrist, psychologist, or therapist, but I am a patient whose life is affected by the labels that the *DSM* provides, and so I was curious to see what, other than the switch from roman to arabic numerals, would change. After all, it is easy to forget that psychiatric diagnoses are human constructs, and not handed down from an all-knowing God on stone tablets; to “have schizophrenia” is to fit an assemblage of symptoms, which are listed in a purple book made by humans.

With the arrival of the *DSM-5* came the psychiatric bible’s most significant change: not the actual diagnoses within the *DSM*, nor the symptoms that make up the diagnoses, but rather the idea of defining psychiatry itself. NIMH, a component of the US Department of Health and Human Services—immortalized by the 1982 animated movie *The Secret of NIMH*, which depicts the organization as a sinister and unethical entity—shifted the landscape by decreeing that the *DSM* is “no longer sufficient for researchers,” according to NIMH director Thomas Insel. No longer would the APA and NIMH stand together in a uniform discussion of “what psychiatry is”; rather, NIMH declared that it was, and had been, striking out on its own.

Psychiatry emphasizes a clinician’s judgment as the primary tool for diagnosis. Someone suffering from mental health complaints may first be given a blood test or a brain scan by a primary care physician. If those tests come back clean, it’s the psychiatrist’s role to ask questions intended to suss out whether the sick person qualifies for one of the hundreds of diagnoses delineated by the *DSM*, all of which rely on groups of symptoms and sighted or self-reported patterns. (The disorders are indexed with decimal numbers, making the endeavor seem even more capital-S Scientific. I spent much of my adolescence squinting at the numbers on my charts, trying to memorize them so that I could look them up later. Schizophrenia is 295.90; my diagnosis of schizoaffective disorder, bipolar type is 295.70 [F25.0].) Humans are the arbiters of which diagnoses are given to other humans—who are, in most cases, suffering, and at the mercy of doctors whose diagnostic decisions hold great power. Giving someone a diagnosis of schizophrenia will impact how they see themselves. It will change how they interact with friends and family. The diagnosis will affect how they are seen by the

medical community, the legal system, the Transportation Security Administration, and so on.

The most common complaint about the *DSM-5*, and the *DSM* versions that came before it, is that the disorders it lists are based on clusters of symptoms rather than objective measures. I realized just how arbitrary such definitions are in practice while working as a lab manager at the Stanford Department of Psychology, where I ran clinical interviews to assess potential subjects for study. At the time, Stanford's Mood and Anxiety Disorders Laboratory relied on the Structured Clinical Interview for *DSM-IV*, or SCID, to determine whether someone qualified for the diagnosis we were trying to research. I went through a year of training, including months of practicing phone interviews, taking a written test, running through a battery of simulated interviews with coworkers, and supervision during several official interviews, until I was qualified to run the two- to three-hour-long SCIDs alone.

To "run a SCID" means taking a potential subject through a battery of questions taken from the SCID binder—a hefty stack of paper with a spine several inches wide. The interview begins by collecting preliminary demographic information, and goes on to run a person through a diagnostic flowchart. For example, "Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking? Were you awake at the time?" moves on to "What did you hear? How often did you hear it?" if the answer is yes. If the answer is no, the next question becomes "Did you ever have visions or see things that other people couldn't see? Were you awake at the time? How long were they present?" At the end of the interview, the researcher determines the interviewee's primary diagnosis, and writes it on the front in ink.

In our lab, running SCIDs was not only the most prestigious task an employee could do but also the most emotionally draining.

Running a single SCID often meant listening to a litany of someone's most excruciating experiences and memories. We were not permitted to cry during these interviews, but I often bit back tears during the most intense of them. It was frustrating to see interviewees come in and reveal an underbelly of bloody wounds, only to have to turn them away from participating in the experiments for which they'd applied, and often for what seemed like insignificant reasons. An Eeyore-esque man who wept at random and clearly seemed depressed could be eliminated from our "major depressive disorder" (MDD) subject pool for not meeting the full criteria. According to the *DSM-IV*, he would need to meet five or more of a list of nine symptoms—including fatigue or loss of energy, weight loss or gain, or feelings of worthlessness—for most of the time during the same two-week period. At least one of the symptoms would have to be a depressed mood, or a loss of interest or pleasure (known as anhedonia). If the depressed person had only four of the nine symptoms, or came into our office at the one-and-a-half-week mark, he would be recorded as "sub-MDD," because it was not a therapeutic clinic but a research lab, where our subjects needed to be as "clean" as possible—and doing hundreds, if not thousands, of interviews made it clear to me that diagnoses were rarely cut-and-dried.

As a researcher, I lacked the luxury of being able to bend criteria. However, psychiatrists can, given that their job is to ameliorate symptoms and the suffering that accompanies them, rather than to find, diagnose, and study spotless instances of any given disorder. A psychiatrist attempting to make a diagnosis might go through a flowchart similar to the one that the SCID comprises. They might ask, using plainspoken language, the same questions found in the weighty binders I carried from the interview room to the main office; but someone that I would have labeled "sub-MDD" would likely be diagnosed by a psychiatrist as clinically depressed, with a

Prozac prescription not far behind. Clinical flexibility has its benefits. It also has the potential for human error, as well as the ability to harm.

With the advent of new technologies and genetic research, psychiatry is increasingly turning toward biology, with NIMH leading the charge. In a press release about the *DSM-5*, published on April 29, 2013, NIMH spoke about the so-called weakness of the *DSM's* categorizations made via observed or reported clusters of symptoms, announcing that “patients with mental disorders deserve better.” Simultaneously, NIMH promoted its own project—a surprise to those outside of the scientific community—called the Research Domain Criteria project, or RDoC. RDoC’s aim, according to the 2008 NIMH Strategic Plan, is to “develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures.” In other words: let’s bring more hard science to psychiatry.

Identical twins, according to seminal twin studies in the 1960s, have only a 40 to 50 percent chance of both developing schizophrenia, despite their shared genes. According to the diathesis-stress model of psychiatric illness, a genetic vulnerability to a disorder blooms only if enough stressors cause those vulnerable genes to express themselves. When I worked as a lab manager, we researchers spoke of the possibility that our studies might one day bear practical fruit. Someday we might be able to inform parents of their children’s genetic risk for mental illness, and those parents might be able to employ preventive measures before the first signs made themselves apparent. We did not discuss the practicalities or ethics of taking such action.

Some stressors appear to be prenatal. People diagnosed with schizophrenia are more likely to be born in the winter than in the

summer, perhaps due to maternal infection during pregnancy—I was born in the swelter of a Midwestern June. Difficult births, obstetrical complications, and stressful events suffered by the mother, such as assault and war, are also correlated. My head had lodged behind a bone in my mother’s pelvis, which hints of an intergenerational transmission of trauma; stress causes the flooding of cortisol and other chemicals into the brain, and my newly immigrated, newly married young mother had her own psychiatric issues to contend with. Who knows what happens to the malleable and muddy assortment of feral cells because of such strain?

Once during a train ride in Taiwan with my mother, I asked her about my great-aunt, who I knew had been insane. On the small, pull-down lap desk, my mother placed a notebook and sketched a family tree. She drew X’s to signify those known to have some sort of mental illness. What surprised me weren’t so much the three X’s that did exist—the great-aunt who’d been institutionalized for most of her life, despite having been a first-generation college student, and who lived a tragic existence as the madwoman in the attic; my mother’s cousin who had killed himself, ostensibly after a bad breakup; and, of course, me—but rather how many unknown entities there were, with branches leading to blank spaces on the page. “No one talks about these things,” she said. “No one wants to question what genetic legacies might lurk in our bloodline.” When asked point-blank by my first psychiatrist, over a decade ago, whether there was mental illness in the family, my mother said no, there was nothing. Even now, she doesn’t consider herself an X on the family tree, preferring to keep herself a mild circle, absolved on the page despite her own history of suicidal ideation, panic, and hiding in closets. My father’s side of the family has other concerns, primarily addiction, but is not considered responsible for my so-called bad genes. I’ve inherited a love of writing and a talent for the visual arts

from my mother, as well as her long and tapered fingers; I've also inherited a tendency for madness.

The APA's response to this ill-timed potshot from NIMH came in the form of a statement from the chair of the *DSM-5* Task Force, David Kupfer. Kupfer publicly responded that RDoC "may someday . . . revolutionize our field," but added that people with mental illness are suffering in the present moment. Having biological and genetic markers as diagnostic tools would be wonderful, but "this promise, which we had anticipated since the 1970s, remains disappointingly distant. . . . [The *DSM-5*] represents the strongest system currently available for classifying disorders." Speaking directly to the urgency of public need, Kupfer said, "Our patients deserve no less."

What is perhaps most interesting about the RDoC announcement, however, is just how complex an RDoC-*DSM* marriage might become—and it's a problem that researchers are working on solving. Dr. Sheri Johnson, professor of psychology at the University of California, Berkeley, said to me, "I think we are a long way away from that marriage. RDoC is a fascinating initiative, but it's really designed to help us understand some of the key neurobiological dimensions involved in mental health. There's a lot of work to be done . . . Once we have those dimensions more clearly mapped, it may shift the way we think about diagnosis enough that we won't really be using the same types of categories that appear in [the] *DSM*."

Dr. Victor Reus, a professor of psychiatry at the University of California, San Francisco, and psychiatrist, is similarly skeptical about the use of biomarkers as diagnostic or clinical tools—at least until genetic research grows by leaps and bounds. "I think trying to do biomarkers of schizophrenia as an entity is probably a hopeless task," Reus told me in an interview, "because there are just so many

different ways in which people can develop a syndrome that looks like schizophrenia, or that fulfills the criteria of schizophrenia as we now define it." And yet this may not be the case for other disorders. "Certain categories," Reus states, "as crude as they are, are still useful in capturing a group of individuals that probably have more in common in terms of etiology or basic mechanism than they are different. And certain disorders are better than others in that regard. So autism has proven to be a pretty useful thing. Bipolar disorder has proven to be, I think, more useful than schizophrenia. Obsessive-compulsive disorder is probably one of the more specific ones. Major depression is problematic. Generalized anxiety disorder is very problematic."

As of 2017, NIMH continues to vigorously fund research into the schizophrenias. The 2017 NIMH budget describes an increase of \$6 million (up to a total of \$15.5 million) for programs designed to address psychosis and its treatment; the goal of initiatives such as Recovery After an Initial Schizophrenia Episode (RAISE) and the Early Psychosis Intervention Network (EPINET) is to "ensure that lessons learned from research and clinical experiences are systematically and rapidly put to use to improve [lives]."

For now, psychiatrists continue to rely on the *DSM*, and on the *DSM-5*, which means that changes in the bible of psychiatry continue to affect people's lives. The definition of "schizophrenia" changed with the *DSM-5*. Schizophrenia's subtypes—paranoid, disorganized, catatonic, and undifferentiated—no longer exist in the new *DSM*, which means, among other things, that pop culture has lost "paranoid schizophrenia" as a diagnosis upon which to hang criminal acts. The five key symptoms are listed as: (1) delusions, (2) hallucinations, (3) disorganized speech, (4) disorganized or catatonic behavior, and (5) "negative" symptoms (symptoms that

detract, such as avolition). A person must now demonstrate at least two of the specified symptoms; previously, only one symptom was required. At least one “positive” symptom—delusions, hallucinations, disorganized speech—must be present.

Schizoaffective disorder changed as well. When I first heard that its criteria had been altered, my nerves twitched—had my diagnosis been erased? If the diagnosis hadn’t been erased, would my association with it be, if I no longer fit the criteria? But as I skimmed “Highlights of Changes from *DSM-IV-TR* to *DSM-5*,” a PDF created by the APA to accompany the *DSM-5*’s release, I realized that I still fit the mold. According to the document, “The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder’s total duration after *Criteria A has been met*” (*italics mine*).

In “Schizoaffective Disorder in the *DSM-5*,” Dolores Malaspina et al. explain these changes by pointing out that psychotic symptoms and mood episodes frequently happen at the same time. A person with bipolar disorder may experience psychosis during a manic or depressive episode; a person with major depression may experience psychosis during their depression. As a result, schizoaffective disorder was diagnosed more often than warranted for a diagnostic category that “was originally intended to [only] rarely [be] needed.”

The new *DSM* definition of schizoaffective disorder is intended to look at a lifetime of illness, and not an episode of illness; a longitudinal look at schizoaffective disorder means that there must be at least one two-week period of psychosis *without* clinical mood symptoms, and full mood disorder episodes must have been present “from the onset of psychotic symptoms up until the current diagnosis.” In other words, schizoaffective disorder is intended to be an uncommon diagnosis, and it is meant to be diagnosed based on

a lifetime of illness—both of which will be true if the *DSM-5* does its job. Under its auspices, I remain a rare bird who, according to the APA, will likely be sick forever. The *DSM* is what we use to define the problem, yes, but it attempts to do so in a way that accommodates humanity’s wide and nuanced spectrum, which may not be a realistic goal. If I were still a researcher studying *DSM-IV* or *DSM-5* categories, grant proposals to NIMH would need to include something about the implications for RDoC. However, NIMH’s public rejection of the *DSM-5* has no impact on me as a layperson, or on my insurance company, my therapist, or my psychiatrist. And although blood tests or brain scans for mental illness diagnoses are either far-off or never to come, RDoC’s first benefits may give us a better sense of what biological features mark susceptibility to already established disorders, as well as what types of stressors are most likely to transform those susceptibilities into illness.

I remain skeptical that we’ll see either outcome in my lifetime. I am accustomed to the world of the *DSM*, which remains the heavy purple bible-o’-madness that sits on a clinician’s shelf. It is, like the Judeo-Christian bible, one that warps and mutates as quickly as our culture does. The *DSM* defines problems so that we can determine whether a person fits into them, or whether a person has lapsed out of the problem entirely—which is not to say that their life changes, even if their label does.

For causes and explanations, there are still other avenues to pursue. Nine months after my diagnosis of schizoaffective disorder, when I was beginning to experience serious physical symptoms as well—fainting, chronic pain, allergies, weakness—my psychiatrist sent me to a complementary and alternative medicine (CAM) consult, a division within my HMO. The doctor, a Southeast Asian man, looked at my tongue. He used the Chinese three-finger method of

examining the pulse in both of my wrists. He told me that my problem was obvious: it was a classic case of a Fire typology that had burned out of control, therefore explaining my ambitious personality, pain, inflammation, anxiety, depression, and symptoms of schizophrenia. He indicated a few acupressure points that I could try, including one in the dip of my sternum called the Sea of Tranquility. He advised me to eat less meat and fewer spices. I sipped a chai latte from a to-go cup in his office, and between sips I became anxious that he would smell the chai on my breath, and chide me for feeding an already raging conflagration.

Later I consulted *Beyond Heaven and Earth: A Guide to Chinese Medicine*, by Harriet Beinfield, LAc, and Efrem Korngold, LAc, OMD, which explains that when the Qi of the Fire type is too strong, “the Qi of the Heart can attack the Lung, . . . leaving the envelope of the skin open and loose, unable to guard the body and contain the Essence and Spirit.” Resulting emotional problems include the person’s “[becoming] restless and sensitive—easily moved from laughter to tears and prone toward melancholy and anxiety.” A condition recognizable as psychosis may also result, as the authors warn about “altered states of perception in which reality becomes plastic and fluctuating.” To identify as a Fire type, in the same way that I might identify as a Myers-Briggs INFJ or a Gemini with Capricorn rising, is to accept the baseline Fire characteristics of being intuitive and empathetic, and believing in the power of charisma, as well as risking the Fire problems of “anxiety, agitation, and frenzy” and “bizarre perceptions and sensations.”

This period of acute and terrible illness in the winter of 2013, ultimately diagnosed in 2015 as late-stage Lyme disease, resulted in genetic testing for an MTHFR mutation, and came with a wealth of extra information. Based on preliminary research of a marker at rs833497 in the DYM gene, my CC genotype places me at “slightly

higher odds” of schizophrenia, as opposed to CT (also “slightly higher odds”) or TT (“typical odds”).

Sometimes I encounter people who don’t believe in mental illness. These people may have been diagnosed with depression or anxiety at some point, but are usually symptom-free when I meet them. Often, they claim that such diagnoses are oppressive to those with unique abilities. To these people, “unique abilities” usually suggests those conferred by psychosis. They will cite John Nash, who has said that the same mind that produced his delusions produced his brilliant ideas. I am frequently told with great sincerity that in other cultures, a person who would be diagnosed with schizophrenia in the West might be lauded as a shaman and healer. *Have you ever considered, they ask, that schizophrenia might be a spiritual characteristic, and not a malady?* Often these people declare that they don’t believe in medicine. They are likely to be the type who boast about never taking aspirin for a headache. I mention these people with some cynicism, but I, too, have wondered if my experiences with psychosis are a spiritual gift rather than a psychiatric anomaly.

In 2014 an astrologer visited me at my cottage in the woods, where I was staying during a writing residency. Since Neptune was conjoined to my ascendant, Saturn was conjoined to Pluto, and Taurus was in my fourth House, she informed me that I was susceptible to intense dreams and psychic abilities. Due to my fragile energetic field, she said, I would be well advised to live a gentle life. Another astrologer, whom I consulted for a second opinion, informed me that the Neptune conjunction is a dramatic placement. “Neptune is divinity; it is access to the gods,” she said. “But no one ever came out of a conversation with the gods for the better, right?”

In 2016 I enrolled in a yearlong program in the so-called sacred arts, also known as syncretic mysticism, or, less accurately,

witchcraft. The instructor for the course in magic—a woman with a sweet voice and a lineage of sacred artistry—suggested that I study the liminal, which is the theme running through the psycho-spiritual claim that I am sensitive to the thin skin between the otherworld and that which we call reality, the “fragile energetic field,” the “access to the gods.”

These are what I call explanations, rather than causes, because embedded within spiritual narratives are ideas about Why with a capital W, providing larger, more-cosmic reasons for the schizophrenias to occur.

We could consider the role of evolution as yet another kind of cosmic reasoning. Researchers such as Steve Dorus, an evolutionary geneticist at Syracuse University and the coauthor of the paper “Adaptive Evolution in Genes Defining Schizophrenia,” devote their careers to investigating schizophrenia’s curious evolutionary persistence. Despite schizophrenics’ reduced reproductive fitness (defined as an individual’s reproductive success, as well as their average contribution to the gene pool), Dorus et al. have noticed that twenty-eight of seventy-six gene variations connected to schizophrenia are actually preferred. One potential explanation suggests that the evolutionary development of speech, language, and creativity, while bestowing significant gifts, has “dragged” along less desirable genetic tendencies with it; from this perspective, schizophrenia is simply the price humanity pays for the ability to write heartrending operas and earthshaking speeches. Another argument: schizophrenics are, evolutionarily, meant to be ad hoc “cult leaders” whose bizarre ideas split off chunks of the human population. This in itself is neither bad nor good, though one’s perspective on the matter could depend on whether one believes cults or cultish ideas are inherently bad or good.

Or we could say that schizophrenia *itself* has evolutionary ad-

vantages. Some have suggested that schizophrenia persists because it promotes creativity, much like the argument emphasized in MacArthur Genius Grant winner Kay Redfield Jamison’s *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. As tempting as this perspective is, I worry that seeing schizophrenia as a gateway to artistic brilliance glamorizes the disorder in unhealthy ways, therefore preventing suffering schizophrenics from seeking help. If creativity is more important than being able to maintain a sense of reality, I could make a plausible argument for remaining psychotic, but the price of doing so is one that neither I nor my loved ones are likely to choose to pay.

In these investigations of why and how, I am hoping to uncover an origin story. Pan Gu the giant slept in an egg-shaped cloud; once released, he formed the world with his blood, bones, and flesh. God said, “Let there be light.” Ymir was fed by a cow who came from ice. Because *How did this come to be?* is another way of asking, *Why did this happen?*, which is another way of asking, *What do I do now? But what on earth do I do now?*

front of a group of such people, even as a free woman, ratcheted up the rhythm of my already frantic heart.

When it was my turn to speak, I tried to sound eloquent. I slid “avolition” back into the talk. I emphasized, again, my education. I played up the entrepreneurship, mentioning the digital products I’d built and the clients I’d worked with. I added an extra bit of information about my time as a lab manager, when I was the head of a multisite study about bipolar disorder, and made weekly visits to the Stanford Department of Psychology’s respected Bipolar Disorders Clinic as a researcher and not as a patient. The Bipolar Disorders Clinic is one of the best of its kind in the country, and I briefly wondered if these clinicians would even be able to find work there, which was a defensive and sour thought. All this posturing reads as paranoia, and even unkindness, toward the professionals who came to the clinic, who were not making as much money as, say, a psychiatrist at the Bipolar Disorders Clinic, and who did this good work because they’d been called to do it.

I finished my talk. No one was crying. The scowling man was still scowling, but less aggressively so.

As I sank back into my folding chair, Patricia asked if there were any comments or questions. A bespectacled woman raised her hand. She said that she was grateful for this reminder that her patients are human too. She starts out with such hope, she said, every time a new patient comes—and then they relapse and return, relapse and return. The clients, or patients, exhibit their illness in ways that prevent them from seeming like people who can dream, or like people who can have others dream for them. When she said this, I was fingering the skirt of my exquisite dress. I’d fooled her, or convinced her. Either way, I knew, was a victory.

Yale Will Not Save You

The moment I received my acceptance letter from Yale University was one of the happiest of my life. I stood at the bottom of my driveway, where two tin mailboxes nestled against one another, and found a large envelope waiting inside. Large envelopes from publications were a bad sign; they almost always bore my own handwriting, and usually held a rejected manuscript and a perfunctory note. But a big envelope from a university—an envelope with instructions, with welcome, with a full-color look-book—*that* was news. I stood at the mailboxes, shrieking. I was not the type of girl to shriek, but I was seventeen, and I had gotten into Yale. I was to be in Jonathan Edwards College, Class of 2005.

I was an overachieving child, the Michigan-born daughter of twenty-something Taiwanese immigrants who came to California with their baby girl. My parents were broke. They applied for food stamps; they told one another that someday they’d be rich enough to eat at Pizza Hut anytime they wanted. Eventually we moved for the

sake of a different school district, and while raising me and my baby brother in a largely white small town, my parents told me that school was all-important and that I should always do my best. In elementary school, I assigned myself essays to write while on vacation. In fifth grade, I wrote a two-hundred-page novel about a kidnapped girl who becomes a cat. Soon my parents were both working in tech jobs at the height of the boom in Silicon Valley, and were no longer broke. They never spoke the words “American dream,” but that was what their lives signified, and so in middle school I chose to take a 7:30 a.m. class in C++ programming, and I wrote a short story that my English teacher went on to teach even four years after that. In high school, when I told my mother that I was thinking of suicide, she suggested that we kill ourselves together, which I didn’t fully recognize as the bizarre response it was until I told the story again and again over the following decades of my life. I won a gold medal at the Physics Olympics, was a California Arts Scholar, and crossed the stage at graduation with a GPA that belied the hundreds of self-inflicted scars lurking beneath my nylon gown. I chose to go east for college because I wanted to get away from the chaos—the accusatory fights, the sobbing—that occurred inside our home too often to take note of them.

I dated someone briefly at the end of my senior year of high school who broke up with me because I was undiagnosed and frightening, but before he ended our relationship he invited me to a poolside barbecue. He wore girls’ jeans. We stood around the glassy pool at his apartment complex and his mother asked me what I was doing after graduation.

“I’m going to Yale,” I said.

She did a double take. “Good for you,” she said. Even back then my instability was clear to most.

“I went to Yale” is shorthand for *I have schizoaffective disorder, but I’m not worthless.*

Yale is the third-oldest university in the country, after Harvard, which is the oldest, and after the College of William and Mary, which was established in 1693. Yale used to be called the Collegiate School, but was renamed for Elihu Yale after a succession of gifts from the English merchant and philanthropist, including books, exotic textiles, and a portrait of George I. These generous donations, the sale of which helped to fund the construction of Yale College in New Haven, were vigorously encouraged by Puritan minister Cotton Mather, who also vigorously encouraged the Salem Witch Trials. In troubled Salem, babbling and odd movements could signify witchcraft. The bewitched Goodwin family children, he said, “would bark at one another like Dogs, and again purr like so many Cats.” We all know what happened to the witches.

I was diagnosed with bipolar disorder the summer before I left for New Haven, the summer before the spring I was first hospitalized at Yale Psychiatric Institute (YPI). My then psychiatrist informed my mother and me that I had bipolar disorder. This diagnosis was the culmination of a month in which I demonstrated most of the classic signs of mania, including a hectic manner of speech and an uncharacteristic affair with a man eleven years my senior. Although the new diagnosis meant I required different medications than the ones I had been taking for depression and anxiety, she said, she would not prescribe me those new medications while I was under her care. It would be better if I waited until arriving at college, where I could have a doctor there prescribe the appropriate pills; the presumption was that my future psychiatrist would be able to monitor me appropriately. (Later my mother would tell me that had she

truly understood what the doctor was saying, she never would have let me move cross-country to attend Yale.)

When school started, I began to see a doctor at what was then called the Department of Mental Hygiene at Yale University Health Services. Stigma clouded the visits, but I quickly learned that I could pretend to be visiting the Gynecology Department, which was on the same floor. I would exit the elevator and wait a few beats for the doors to close behind me before finally turning right, where students kept their eyes on their textbooks, notebooks, or hands—on anything instead of one another; if we looked long enough, it was possible to recognize the instabilities lurking.

The Department of Mental Hygiene didn't believe in assigning students both a therapist and a psychiatrist, which would create the inconvenient need for back-and-forth communication, and so I saw a woman that year who served as both. She prescribed me Depakote, also known as valproate or valproic acid, which is an anticonvulsant used as a mood stabilizer. She returned again and again to the subject of my mother, whom she blamed for most of my emotional difficulties. During my first semester at Yale, my mother swelled and grew monstrous in my mind; she loomed as someone whose emotional lability had imprinted me with what I frankly called an inability to deal with day-to-day life.

Much of the time, I told the doctor, I felt too sensitive to cope. I was in constant agony. I liked my doctor well enough, but I didn't seem to be improving, and the skittish feeling beneath my skin warned of trouble. Eventually, I would stop sleeping for days at a time; then off I would go.

Yale introduced me to swooning over course descriptions in the Blue Book; "shopping period"; my being openly queer; life without my family, whom I avoided calling for months; WASPs; the attitudes

and postures of Old Money; goat cheese; people who bought six-hundred-dollar boots; the understanding that six-hundred-dollar boots existed; legacy students who'd known the fight songs since birth; Gothic architecture; Beinecke Plaza; Audiogalaxy; theory; statistical analysis; a shy young man in ill-fitting jeans I met at a party, who would eventually become my husband; 9/11 and the War on Terror; Islamophobia; Wong Kar-Wai and *In the Mood for Love*; secret societies; falafel and lemonade; binge-drinking screwdrivers; Animal Models of Clinical Disorders; being offered, but never taking, cocaine; carillon bells ringing out Handel and "Hit Me Baby (One More Time)" as I walked to class, or stared out my dorm window; how to dress for snow; saying "I love you" and meaning it; eggnog in December; feeling so very special, as though virtuous, simply because of where I went to school.

Yale is mocked for its determination to be elite from the get-go—for fashioning itself in the likeness of Oxford and Cambridge, and then having acid dumped on itself to simulate age. Yale is, in the world of elite universities, a prepubescent girl swiping on mascara before the first day of middle school. Yale's campus is still the most beautiful campus I know.

Many of my classes, including Introduction to the Human Brain, took place in Linsly-Chittenden 102. Larger than a seminar room but smaller than a lecture hall, LC 102 is famous for an elaborate Tiffany window along one wall, titled *Education*. Art, Science, Religion, and Music are depicted as angels across its panes. The center section depicts Science surrounded by personifications of Devotion, Labor, Truth, Research, and Intuition.

(Why is Intuition the province of Science? Why is Inspiration governed by the angel of Religion, which is to the right of it, and not by the angel of Art?)

During a manic episode, I scribbled nonsense along the center and edges of my notebook pages, where I was ostensibly taking notes. The words crawled like spiders. *Look. The edge why position not under where? Lit light like night.* The center figure of *Education* was a trifecta of the things I wanted from my Ivy League schooling: Light—Love—Life.

In the elevator, among a group of acquaintances—other members of an Asian American performance art group I'd joined—the topic of the Mental Hygiene Department arose.

Someone's eyes widened. "Watch out for that place," she said.

"I have a friend who went there," someone else said. "He stopped because he knew they'd put him in [Yale Psychiatric Institute] if he kept talking."

"They'll put you in YPI for *anything*," the first person said.

"Never tell them you've thought about killing yourself," they counseled me. I was a freshman. They were taking me under their wing, offering me wisdom. "Never tell them you're thinking about killing yourself, okay?"

I think about that advice now: never tell your doctor that you're considering killing yourself. Yet this was sound advice, in the end, if I wanted to stay.

Margaret Holloway, known as "the Shakespeare Lady," hustled on campus by reciting Shakespeare for spare change. According to rumor, she'd once been a student at the esteemed Yale School of Drama, but had dropped out after a psychotic break. (In truth, she had graduated from the School of Drama in 1980, and experienced the first symptoms of schizophrenia in 1983.) Like most students, I'd heard that the Shakespeare Lady possessed encyclopedic knowledge.

I encountered the Shakespeare Lady only once. One night, my

then boyfriend, now husband, C., and I decided to pick up dinner at Gourmet Heaven, the bougie convenience store on Broadway that carried an astonishing variety of Haribo gummies. I'd never seen such thick fog in New Haven. Holloway appeared like something out of a dream: thin, and asking us for twenty dollars. She needed it to get into the women's shelter, she told us, and she wanted a specific brand of yogurt that she could get only at Gourmet Heaven, but she was banned from the store because of the corrupt police. I know now that in 2002 she was arrested for blocking the entrance of Gourmet Heaven, and apparently was arrested several times after that for other small crimes. In 2004, when I was no longer a student at Yale, she had gotten down to ninety pounds, and in 2009 she was in the local news for "cleaning up her act." On that foggy night, I gave her more money than she'd asked for, and waited with her while C. went to buy the yogurt she'd requested. I didn't ask her to recite Shakespeare.

In 2002, I asked my therapist-slash-psychiatrist—not the woman I'd originally been assigned, but a man who became my doctor after my first hospitalization, and who looked like Gene Wilder—"Are there any students here with schizophrenia?"

"Why do you ask?" he asked.

I didn't answer, but what I'd meant was: *Is there anyone here who's worse off than I am?*

The fog was still pressing its velvet paws to the windows when C. and I returned to his dorm that night. I rested my face against his shoulder, and he asked me what was wrong. I asked him if he thought I could become the Shakespeare Lady. If my mind might go so far it couldn't make its way back.

"It won't happen to you," he said, though I had asked a question that resisted reassurance, and I knew it. In truth, neither of us could know. Still, I needed to hear his promise that I would be okay.

I would ask him variations on this question over the next decade or so: "I'm not going to be crazy forever, am I?" But we never spoke of the Shakespeare Lady again.

Michelle Hammer did not go to Yale, but she was one of those mysterious college students with schizophrenia whom I tried to learn about through my Gene Wilder psychiatrist; I learned of her through the advocacy-focused clothing line she runs, called Schizophrenic.NYC. In high school, Michelle told me, she believed that her mother was trying to kill her; once she was accepted into college, where she would play lacrosse, she was relieved by the notion that she would be safe from harm. Within a few months at school, however, Michelle began to fear that her roommate was trying to kill her. It was at that point, she told me, that she came to a realization: "It's me; it's not everybody else. Why do I think this way?"

Michelle went to the student health center. She hoped to be diagnosed with something, because the idea of being "crazy" scared her, and the promise of treatment offered some kind of hope. After an initial evaluation, she was told she had bipolar disorder, and made an appointment with a psychiatrist, who prescribed Zoloft. "It didn't go well," she said. "[The psychiatrist] never told me that these medications can make you more depressed or more upset. So I would take it, [but] I would not take it; I would take it; I would not take it, and then . . . So that's all first semester going into the winter break."

It was during the winter that things got truly bad. There was a snowstorm, Michelle said, and classes were canceled. She was getting drunk in the dorm—a forbidden activity—when she began to become afraid: "I'm thinking, I'm gonna get in so much trouble. All the terrible stuff. I took a piece of glass and slit my wrist."

The girls down the hall found out. Someone from the univer-

sity police department (UPD) showed up—"this six-foot-tall, hmongous woman," Michelle said—and tried to figure out what was going on. Everyone, including Michelle, was shepherded into the dorm's common room.

"So everybody's in there," Michelle said, "and we're all in a semi-circle around her . . . She goes, 'I heard there's a problem here. Everybody lift up your sleeves.' So pretty much she starts on the left, everybody's lifting up their sleeve and they're all good. And she gets to me, and I go, 'Yeah.' And then she goes, 'Well, I wanna see your arms.' And I go, 'Well, how about we just go into my room.' 'Cause this is about three feet away [from everybody else], and I could just show her in my room, 'cause it's very embarrassing to do that to anybody. Especially in front of all these people."

According to Michelle, she turned around to go into her bedroom—and the woman from UPD grabbed the hood of her sweatshirt and threw her onto the floor. Michelle tried to crawl under her desk. "All of a sudden," she said, "my neck gets stepped on with a huge boot. And she steps on me and she puts her pepper spray right in front of my face, and she says, 'Don't move or I'm gonna spray you.'" Finally, Michelle was handcuffed. Despite the woman's repeated questioning, she continued to refuse to pull up her sleeve—even as she was pinned up against a wall on the floor—even as she kicked her leg out and booted the UPD officer straight in the face. In the end, the officer took Michelle to a hospital.

It was clear, in hearing all of this, that Michelle remains resentful about how she was treated by the officer who came to assess the situation. Without prompting, Michelle gave me the full name of the woman. She said, "It took me about nine years to be able to tell that story." It isn't clear whether the officer was given crisis de-escalation training, or any kind of training at all in dealing with mentally ill students. I can easily picture the scenario: a campus cop goes into

a dorm, knowing only that a student has cut her wrist. The dorm-mates are whipped into chaos because of alcohol and a snowstorm and the dramatic, self-destructive behavior of one of their own.

Periodic blood tests need to be taken when on Depakote, the medication I was prescribed when I arrived at Yale—not only to monitor the level in the blood, but also to check the health of my liver. I'd had my blood tested several times before the spring of 2002. No one had ever told me anything was wrong.

A few weeks before spring break, I started needing less sleep. Instead of growing tired at night, the day would crowd in on the empty space, demanding to be filled by activity. My thoughts skittered through like messages on ticker tape, and I wanted to run instead of walk; I punched a tree on Cross Campus, shuddering with an energy my body couldn't contain. The mania was at first a welcome change from the inexplicable fifteen hours of sleep I often needed each night. As most manic episodes do, however, the mania swiftly escaped my control—my thoughts rearranged themselves into nonsensical, violent shapes, and soon I stopped sleeping completely. If anyone noticed, they kept it to themselves, although C. was concerned and said so. I'd told him about my diagnosis of bipolar disorder, but bipolar disorder had no visceral corollary for him. He not only lacked the experience to know what the illness truly meant, but he also had no plan for what to do in a psychiatric emergency.

After the wild high came the low. My thoughts leaped to suicide—my entire life had been marked by illness and depression, and there was no reason to think that it wouldn't continue in the same way. I was convinced that I would be depressed forever, though the previous week alone had proved this belief to be erroneous. My vision remained myopic and dim as I wrote two lists in a notebook, marking down the pros and cons of permanently re-

moving myself from my life. The cons list was longer than the list of pros, but I knew that I was in trouble.

Around this time, I received a phone call from the student health lab with the results of my blood work, which surprised me because they'd never called before. "Your liver looks fine," they said, "but did you know that you've never had a therapeutic level of Depakote in your blood?"

Upon hearing this, the clamor in my head soured, becoming what is known in mood disorder parlance as a "mixed episode." Such episodes occur when a person is experiencing symptoms of both a manic and a depressive phase, such as in episodes of agitated depression. It is considered a dangerous state to be in if that person is suicidal; a severely depressed person will find it hard to summon enough energy to plan and execute a suicide, but a severely depressed person shot through with norepinephrine is reckless enough to do both. My doctor, it seemed, had never adjusted my Depakote to a therapeutic dose while I was in her care. I couldn't get over the incompetence. If she couldn't be bothered, why should I bother to keep living when it was so hard to be alive? Suicide seemed like a good option, and yet I walked with my lists to the Mental Hygiene Department; despite the warnings I'd been given about expressing suicidal ideation to a Yale psychiatrist, I didn't actually want to die. At Mental Hygiene, I was assigned to Urgent Care, and when the psychiatrist on call heard about the lists, I was dispatched to YPI. I wasn't strapped down—I would be the next time, after taking an overdose—but I was placed in an ambulance. A nurse at Mental Hygiene reassured me that my doctor would meet me at the hospital. As it happened, she never came.

After over a week at YPI, I reached a compromise with the dean and the head of psychiatry: I could stay at Yale if my mother came to stay with me, off-campus, for the rest of the year. (Upon hearing

of this plan, a friend who knew of my family history said, “I thought they wanted you to get *better*.”)

My mother lived with me in a small two-bedroom apartment that was close to both my residential college and a stretch of loud bars. Slowly, our relationship improved, even if my illness didn’t. Between classes I escaped to the bathtub; because hot water was scarce in the apartment, my mother carried in stockpots of hot water from the stove. She made Taiwanese noodle dishes. She wrote elaborate medication charts on watercolor paper. She called my psychiatrist when I lay writhing on the floor, sobbing, caught in knotty torment.

Somehow, I made it through that year. I had a summer away from Yale, at home in California, and then I went back in the fall, when the weather was still hot and damp like the inside of a feverish mouth. I was shaken, and wanted more than anything to be okay.

I’m still trying to figure out what “okay” is, particularly whether there exists a normal version of myself beneath the disorder, in the way a person with cancer is a healthy person first and foremost. In the language of cancer, people describe a thing that “invades” them so that they can then “battle” the cancer. No one ever says that a person *is* cancer, or that they have *become* cancer, but they do say that a person is manic-depressive or schizophrenic, once those illnesses have taken hold. In my peer education courses I was taught to say that I am a person with schizoaffective disorder. “Person-first language” suggests that there is a person in there somewhere without the delusions and the rambling and the catatonia.

But what if there isn’t? What happens if I see my disordered mind as a fundamental part of who I am? It has, in fact, shaped the way I experience life. Should the question be a matter of percentages of my lifetime, I’ve spent enough of this lifetime with schizoaffective disorder to see it as a dominant force. And if it’s true that

I think, therefore I am, perhaps the fact that my thoughts have been so heavily mottled with confusion means that those confused thoughts make up the gestalt of my self; this is why I use the word “schizophrenic,” although many mental health advocates don’t.

My friends with anxiety disorders, for example, tend to speak of anxiety as a component of their personalities. Laura Turner writes, in her essay “How Do You Inherit Anxiety?,” “It is from Verna Lee Boatright Berg that I inherited my long face, my quick hands, my fear that someday soon I will do something wrong and the world will come to a sharp end.” In their minds, there is no tabula rasa overlaid by a transparency of hypochondria, generalized anxiety disorder, or obsessive-compulsive disorder; such thoughts are hard-wired into their minds, with no self that can be untangled from the pathology they experience. Another friend’s obsessive-compulsive disorder has calmed significantly since she began taking Prozac, but she continues to be most comfortable when things are tidy, even though her tidiness is no longer disruptive. She still washes her hands more thoroughly than anyone I know.

There might be something comforting about the notion that there is, deep down, an impeccable self without disorder, and that if I try hard enough, I can reach that unblemished self.

But there may be no impeccable self to reach, and if I continue to struggle toward one, I might go mad in the pursuit.

I left Yale for good in early 2003, although I did not know at the time that it was the end. I’d been hospitalized for the second time at the institute—two times in one year, was the way the head of psychiatry put it, although it was two times in two school years—and because of this breach of etiquette, they asked me to leave.

The dean at my residential college gave me the choice of declaring my departure to be a voluntary medical leave. If I officially

named it for what it was, he explained, an involuntary medical leave would be a black mark of which I could never rid myself. Offering me this choice was meant as a kindness, but I was unable to see anything that they did to me that month, including putting me in two-point restraints, as a kindness.

Yale told me to leave immediately. I was not allowed to reenter campus, and so someone confiscated my student ID, and my busy father, who had flown from China to be with me, was tasked with packing my things. I was told to be at JFK on the same night that I left the hospital—so urgent was Yale's desire for me to leave. But my father, in his largesse, instead arranged for C. and me to stay at the New Haven Hotel for a night. By then C. and I had been together for over a year; the next few years would be spent in a long-distance relationship, although at the time we had no idea how we'd manage to stay together. Upon my expulsion from Yale, we had one night to say good-bye.

While sitting in my father's hotel room, talking things over before leaving for ours, my father's phone rang. He answered it. It was someone from Yale. "Are you in New York?" they asked.

"Yes," he lied.

The only thing I remember from our night in that hotel is that I fell asleep early while C. watched *Showboat*. I would never return as a student again.

In 2014, Katie J. M. Baker published an article in *Newsweek* titled "How Colleges Flunk Mental Health." It was the piece I'd been waiting for—after blogging about my Yale experience, I'd received a flood of emails from students battling to stay in their colleges, students on enforced leave from their colleges, and former college students who, like me, were never allowed to return to school. In her article, Baker makes the case that psychiatric illness is punished

by colleges and universities that instead ought to be accommodating students under the Americans with Disabilities Act (ADA). Rather than receiving help, mentally ill students are frequently, as I was, pressured into leaving—or ordered to leave—by the schools that once welcomed them. The underlying expectation is that a student must be mentally healthy to return to school, which is difficult and unlikely to happen to the degree the administration would like. This is saying, essentially, that students should not have severe mental illness.

How the ADA works for mentally ill students varies from school to school. I have no memory of Yale telling us anything about registering as a disabled student, though such an explanation might have happened. When I transferred to Stanford, in 2003, the Office of Accessible Education reached out to me in order to set up accommodations, which felt like a godsend. At the University of Michigan, where I received my MFA in fiction, it is possible to register a mental health condition as long as the diagnosed illness or disorder "substantially limits one or more major life activities." "It is important to note," the student life website states, "that a mental disorder in or of itself does not necessarily constitute a disability." Students seeking to register their disabling mental disorder must send a completed verification form, and if they qualify, they will be assigned a disability coordinator. This system is worlds better than it was when I researched disability accommodations for mentally ill students a handful of years before this writing. In 2009, I was also told during my graduate student instructor training to never give accommodations to students claiming to be depressed, because it was easy enough to pretend to be depressed.

Baker adroitly points to the difficulties colleges and universities face when it comes to dealing with students with mental health issues: institutions of higher education fear liability, because no

school wants to be sued over a student's suicide, or held responsible for a mass shooting. According to many who live and work at them, colleges and universities can't realistically be expected to give students with severe mental illness the treatment they need.

What hope does exist for improved conditions rests in the hands of organizations such as the Office for Civil Rights, which is "actively developing policy" regarding best practices—although the progress of such policy development is opaque at best. The Saks Institute for Mental Health Law, Policy, and Ethics held a 2014 symposium called *Many Voices, One Vision: Assisting College and University Students with Mental Illness Make the Most of Their Academic Experience*, which included sessions on "reasonable accommodations" and "preventing fear, risk management, and miscommunication from derailing a successful academic experience." The Jed Foundation, a national nonprofit that describes itself as "[existing] to protect emotional health and prevent suicide for our nation's teens and young adults," announced in 2014 that fifty-five colleges are examining their health services, with a focus on mental health policies. A cursory online search, however, indicates that in higher education not much has changed for mentally ill students, who are still being regularly ejected for being too crazy for school.

In a 2014 article in the *Yale Daily News*, Rachel Williams describes her experience with an evaluating official at Yale who, after hearing that she cut herself, told her that she needed to go home. "Well the truth is," he says, "we don't necessarily think you'll be safer at home. But we just can't have you here."

I went on a yearlong voluntary medical leave. I took classes at UC Berkeley and the California College of the Arts, and I worked as a web designer too. I dabbled in marketing. Always, I planned to go back to Yale, where C. was finishing his senior year. He was sane; he

could still freely roam the campus and its outskirts. I made a list of things that I would do once I returned: go to more art shows, join clubs, make new friends. I concocted plans to live in an apartment off-campus with an avant-garde blond and a pothead friend who had a crush on me.

I flew to New Haven for four interviews that would determine whether I was fit to return. The only interview I remember is one in which a jolly man I'd never met told me I seemed ready to come back. I flew home to California and waited to hear back from them, and when I did, the answer was no.

From an email I sent to Yale University's head of psychiatry:

Dear Dr. X,

My mother and I left messages yesterday and today in hopes of reaching you, but we never heard back or received any hint of when we might possibly hear back. I thought I would try the email approach, although you are probably deluged with emails all of the time.

I was surprised (as were all of my friends, family, etc.) to hear that I had not been readmitted, even though I had tried to prepare myself for the worst. Dean C told me to call you, as you would have information on how to "make [my] application more viable the next time." If you do have such information, I would like to hear it. It frustrates me to know that I was not readmitted, because I have become quite certain in the past year that I am more than ready to return—my friends know this, my family knows this, and my doctors at home know this. Unfortunately, the litany of people who know that I am ready to return does not include the readmission committee. I am not sure why there is

such a disparity of opinion, but I am hoping that you will be able to give me some idea through your knowledge of what makes a more viable application. I keep wondering what it is that I did wrong. Was it my grades? My essay? The recommendation letters? Was it something I said during the interview process? (Unfortunately, one of the interviewing deans even told me that he/she would give me “a glowing recommendation.” I guess that glowing recommendation did not do much for me in the end.)

One statement that kept coming back to me during the interview process was that the committee was deciding not *whether* I could return to Yale, but rather *when*. I surmise that the committee has decided that it is in my best interests to keep me away from school for another semester, probably to “grow” or “mature”—I can’t speak for them and you, obviously; I can only guess. And I know that I will have to, out of self-preservation, find interesting things to do during that semester. The disappointing part is that I know that this semester (and maybe even more semesters after that—the way the process looks to me right now, I can’t fathom how these decisions are made or how they are swayed) will probably go by the same way this past year on medical leave has gone by: with me at the end feeling fine, excited to go back to school, and knowing that my fate is being judged based on how well I show off just how very fine I am.

I was also wondering why you never contacted my doctors at home, considering they know me very well and have worked with me during my leave, and also considering the fact that you told me you would at the end of the week I went to the interview.

I would like it very much if you could respond to my questions as much as possible, as this has been a few days of frustration and disappointment (with no end in sight) and it would help to understand the process behind what seems right now to be a

very arbitrary and incorrect decision. Also, I am at a loss as to what to do this next semester. I do not think a school would allow me to register to take classes this close to spring semester. What is required of me if I want to reapply again?

As stated before, a response would be very much appreciated. Thank you for your time.

In the end, Yale owed me nothing, not even an explanation. It did not have to admit me a second time once I’d proved lunatic, nor does it have to acknowledge in its alumni magazines, all these years later, that I was ever a student; it does not have to allow me into the Yale Club in Manhattan.

And I owe Yale nothing. I recycle the donation requests C. receives without opening them. Same goes for the alumni magazines.

When I was a Yalie, I used to shoplift. Rarely did I take anything substantial: a pen here and there from the art store, a headband once from Urban Outfitters. One day I was holding a stack of books at the campus bookstore on Broadway and saw that the line was a long one. Impulsively, I held my head high and walked out of the store, still carrying the books. No alarms went off. No one chased me. I look back and tell myself that I was young and stupid; then I catch myself. One of the few photographs I have of myself from college is a snapshot of me standing in front of the Urban Outfitters on Broadway, holding up a sleeveless shirt I’d bought on sale. I have a big smile and chopped-off bangs. I am young and full of mistakes that I have yet to make, but I’m not the only one who erred back then.