

Psychiatric Selves: Managing Disorder in Community Mental Health

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Abstract

This dissertation examines the aftermath of psychiatric emergency among a group of young adults who were hospitalized with severe symptoms of mental illness. I trace the experience of this cohort of young people over time as they prepare to leave psychiatric rehabilitation facilities in Minnesota and transition into a variety of independent community living arrangements. My aim in conducting this research was to understand how the encounter with psychiatric knowledge in rehabilitative settings causes people to reconsider the ways in which they engage in processes of self-fashioning and reconceptualize the possibilities for personhood as they make their way toward a future that they expect to be punctuated by the unpredictable occurrence of symptoms of chronic mental illness.

I argue that community rehabilitation facilities function as key sites for psychiatric subjectification where the objective status of diagnostic categories and discourses of chronic risk are addressed through a series of illness management activities that emphasize ethical self-governance intended to produce a form of personhood characterized by independence, autonomy, productivity and self-determination; this is a fraught process that is unsettled by the divergence between diagnosis and lived experience. In addition, individualistic conceptualizations of community recovery obscure the challenges of living with mental illness inherent in the structurally-vulnerable socioeconomic positions that many participants occupy, and I find that the methods through which people conceive of meaningful ways of being are bound up with everyday struggles and negotiations over relatedness and social belonging in their local worlds.

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Chapter I. Introduction

Key Issues

This dissertation examines the aftermath of psychiatric emergency among a group of young adults who were hospitalized with severe symptoms of mental illness. I trace the experience of this cohort of young people over time as they prepare to leave psychiatric rehabilitation facilities in Minnesota and transition into a variety of independent community living arrangements. My aim in conducting this research was to understand how dominant psychiatric discourses and forms of knowledge are enacted on the ground in the context of the decentralized, small-scale settings where contemporary community mental health treatment modalities and recovery models are implemented. In addition, I wanted to understand how the encounter with psychiatric knowledge in rehabilitative settings causes people to reconsider the ways in which they engage in processes of self-fashioning and reconceptualize the possibilities for personhood as they make their way toward a future that they expect to be punctuated by the unpredictable occurrence of symptoms of chronic mental illness. My inquiry is structured around a set of key questions:

- How does psychiatry categorize and explain those symptoms that it takes to be its objects, and how do the frameworks through which it does so come to bear on the delivery and receipt of mental health services in community treatment and rehabilitation settings?

- How are processes of psychiatric diagnosis and rehabilitation entangled with practices of self-making and the emergence of forms of personhood that people come to desire and hope to achieve?
- What are the structural conditions that shape the communities in which participants grapple with the implications of a psychiatric diagnosis for the future that they want to inhabit? How do these structural conditions interact with the forms of relatedness and sociality that help to constitute participants' local worlds to both produce and foreclose possibilities for psychiatric care and recovery?

In this dissertation, I demonstrate how the convergence of a set of historical processes involving deinstitutionalization, the rise of biological explanations for mental disorder, and advances in psychopharmacology has produced a contemporary psychiatric reason—the dominant organizing logic through which psychiatry apprehends symptoms and transforms them into objective disease categories to be acted upon—that understands mental illness to be a frequently-chronic neurobiological disease that should be primarily treated in community settings using pharmacotherapy. I argue that state-sanctioned community treatment and rehabilitation facilities such as the ones that I studied in Minnesota function as key sites for psychiatric subjectification where the objective status of diagnostic categories and discourses of chronic risk are addressed through a series of educational and therapeutic activities that reinforce ways of acting upon the self intended

to produce a form of personhood that emphasizes independence, autonomy, productivity and self-determination.

At the same time, my findings suggest that the subject positions associated with psychiatric reason often fail to fully encompass participants' complicated lived experiences of disorder. Diagnosis, a vital component of subject formation, was often revealed to be a fluid, unstable process that reflects the situational and bureaucratic demands of rehabilitation and produces categories that are sometimes countered by alternative participant interpretations of symptomatology emphasizing contextual factors. Lastly, I examine community as a site for psychiatric recovery and trace the lived experience of young people as they attempt to establish a place for themselves in the world while managing symptoms of mental illness. I argue that individualistic discourses of community recovery obscure the challenges associated with adjusting to life with mental illness inherent in the structurally-vulnerable socioeconomic positions that many participants occupy, and I find that the methods through which people conceive of meaningful ways of being are bound up with everyday struggles and negotiations over relatedness and social belonging in their local worlds.

My research, then, is an account of what it means for a group of young adults to descend, as Das (2007:1) puts it, "into the recesses of the ordinary" in the aftermath of extraordinarily taxing, unmooring psychiatric emergencies. Das suggests that extraordinary events seep into the ordinary in subtle ways that cast doubt on the viability of a once-familiar social world and one's place as a person in it when such events exceed

the limits of what is imaginable. The onset of unfamiliar, debilitating symptoms and their distillation in a psychiatric diagnosis constitute such an event. In the context of this project, the ordinary consists of the local worlds that participants inhabit during and after rehabilitation, the everyday neighborhood spaces that are structured by unequal material conditions and linked together through various networks of relations. The appearance of extraordinary events in the form of severe illness and the manner in which illness is dealt with on a long-term basis within the realm of the ordinary offers a unique vantage point from which to understand how the possibilities for care and personhood among participants intersect with dominant psychiatric assumptions and the obstacles posed by precarious social conditions.

As young adults beset with severe symptoms struggle to make sense of diagnoses and participate in rehabilitative practices, they do so in circumstances informed by complex historical processes—namely, the transformation of psychiatry in the 20th century, as well as the legacy of deinstitutionalization and the socio-political choices that informed it; these processes have culminated in the privileging of a biomedical explanatory framework that compels those diagnosed with disorder to adopt an individualized view of recovery which assumes their ability to exercise autonomy and responsibility as they enact ethical forms of self-governance. Attending to the ordinary conditions of community recovery exposes the limits of psychiatric reason; people recovering from psychiatric emergencies re-enter their local worlds to find that their suffering is inherently social. Attempts to reestablish oneself as a person must contend with bureaucratic obstacles to care designed for the management of the undesirable poor,

the exercise of coercive power by mental health courts intended to limit choice, the pressures to become a productive citizen via limited employment and educational opportunities, and the everyday strain of getting by without much economic, social, or cultural capital. The experience of all of these challenges is mediated by complicated forms of relatedness that have the potential to both support and undermine efforts to live with mental illness.

Setting the Scene

On a bright July morning some time ago, I drove north from Minneapolis on I-35 toward Duluth, Minnesota, a scenic port city on the shores of Lake Superior. The purpose of this two-hour trip was to conduct some of the early interviews for this dissertation with several young adults who were receiving psychiatric rehabilitation services at an Intensive Residential Treatment Services (IRTS) facility, Minnesota's primary intermediary setting between the hospital and independent living arrangements for those recovering from symptoms of mental illness.¹ IRTS provide time-limited services to a relatively small group of clients with the goal of fostering psychiatric stability and self-sufficiency. A long-term byproduct of the era of psychiatric

¹ Munoz (2016:2) provides an overview of Minnesota IRTS:

An IRTS facility is a place for individuals to receive time-limited mental health treatment, usually ranging from 30-90 days. IRTS facilities provide around the clock supervision or assistance as needed while individuals receive intensive mental health treatment consisting of 1:1 therapy, group therapy, treatment planning, nursing services, independent living skills and other activities. IRTS programming is designed to develop and enhance the individual's psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that will help the transition to a more independent setting. Individuals seeking services at an IRTS program often need a higher level of care than outpatient services, or may be transitioning from a more restrictive setting (such as hospitalization or jail). There are currently 47 IRTS facilities throughout the state of Minnesota that range in capacity levels of 10-16 beds. This includes nine IRTS licensed programs which offer only shorter-term crisis stabilization services.

deinstitutionalization that began to unfold in mid-twentieth century America, these facilities dot the neighborhoods of cities around the state and have largely replaced larger state hospitals as the main sites for the provision of psychiatric rehabilitative care. Similar community-based facilities and treatment options exist in a variety of incarnations around the country.

The drive into Duluth, a city with a population of about 85,000, is a pleasant one. As I approached from the south, Lake Superior came into view on the outskirts of town before I began a gradual descent into the heart of the city. I exited the highway and made my way west through the downtown business district and into a quiet, somewhat weathered residential neighborhood full of homes dating to the first half of the twentieth century, when Duluth's economy was at its peak. My destination did not bear a sign, nor did its architectural style cause it to stand out from neighboring homes, all of which were of a similar style; it was a large old colonial revival, and there were few hints of activity inside. I rang the doorbell and was greeted by one of the facility's administrators, a middle-aged woman with whom I had spoken over the phone and who had graciously agreed to assist me with the scheduling of the interviews. I introduced myself and she led me down a hallway off the main entrance to a small office where I was to conduct my interviews. Along the way, we passed a large, sparsely decorated living room where a few casually-dressed people sat reading, as well as a kitchen where someone stood scanning the contents of the refrigerator; the house showed its age but was clean and tidy. I found the space quiet and, to my surprise, largely devoid of activity. The administrator explained that I had arrived during something of a mid-day lull; several of the mandatory

daily group activities had already occurred, and many of the residents were either relaxing privately or were out attending various appointments. Over the course of my research, I would encounter this sort of scene again and again in cities, their suburbs, and far-flung communities throughout Minnesota.

Despite being familiar with the history of American deinstitutionalization, I nonetheless began this research naively expecting to encounter psychiatric facilities bearing some sort of traditional institutional imprint; however, the circumstances that I encountered at the aforementioned IRTS facility in Duluth were, it quickly became apparent, the norm. If one is not looking for them, IRTS facilities are more or less invisible; the converted homes and small apartment buildings that house IRTS clients integrate seamlessly into the residential neighborhoods in which I always found them, and, on more than one occasion, I found myself knocking on the door of a wholly unremarkable building that I had passed many times before in the course of my everyday life without so much as a second glance. I was firmly ensconced in the world of everyday community mental health treatment and social work practitioners, not locked psychiatric wards and orderlies.

The mundane character of IRTS facilities and their location in residential neighborhoods are, of course, by design. Over the last fifty years, American mental health policy has been characterized by attempts of varying success to decentralize psychiatric services and make them available at the community level, allowing people to recover from and manage illness in settings that are familiar and supportive. In the case

of IRTS, clients are not quite ready to strike back out on their own as they rebound from often-devastating incidents of psychiatric distress, but they are the sorts of people that are expected to be able to gradually learn to manage various forms of mental illness and lead independent, fulfilling lives. For such people, IRTS facilities come to function as a kind of liminal space in which they receive around-the-clock support from a staff comprised of mental health professionals (mainly social workers) as they complete a ninety-day residential rehabilitative program; this program aims to impart techniques for ameliorating symptoms and help clients adapt to pharmaceutical regimens that often yield a host of side effects. At the same time, the atmosphere at IRTS facilities is informal, and clients are also afforded ample time to venture out into the community in order to complete various tasks that will pave the way for their impending transition to independent living (e.g., submitting applications for public benefits or inquiring about housing options). Clients often come from the general geographic region in which the IRTS they are residing in is located, thus on any given day they may come and go multiple times as they visit nearby family and friends or frequent familiar recreational spaces during their downtime. While IRTS clients are formally in residence at a facility during their rehabilitation, which they sometimes termed a “break,” the stress and worry of everyday life is never far away. While IRTS provide their clients with time-limited support and structure, both the residents and the facilities are simultaneously inside and outside of community.

IRTS facilities’ unique status as intermediary residential rehabilitation centers that attempt to blend into local communities and refrain from applying many restrictions on

client choice and mobility distinguishes them from the sorts of spaces that appear in social scientific renderings of life in mental institutions. Early accounts of the mental institution began to appear in the mid-twentieth century, and these works generally depicted mental hospitals as closed systems in which staff use authoritarian forms of control to force people to accept diagnostic labels, conform to psychiatric expectations of submissive patienthood, and submit to long-term confinement (Belknap 1954; Rosenhan; 1973; Scheff 1966; Stanton & Schwarz 1954). Goffman's (1961) classic work on the asylum—perhaps the definitive treatment of this institutional site—was published during this period, and in it he argued that mental hospitals can be described as “total institutions” that remove patients from society for a prolonged period of time. In this setting, sharp distinctions between staff and patients are drawn as the latter group inhabits an “inmate world” in which they are depersonalized and stripped of existing social roles; a variety of “adaptive processes” involving public humiliation and invasions of privacy are then employed to coerce patients into adopting the staff view of dependent, obedient mentally-ill patienthood. Goffman uses the notion of the “moral career” to describe the trajectory of self-transformation wrought by the various adaptive processes that culminates in acceptance of one's self as mentally-ill; this concept highlights the importance of acting on the self to the maintenance of institutional order, but unlike contemporary forms of mental health treatment, Goffman found little therapeutic value in the self-processes he observed, instead characterizing them as a means of submitting to clinical ideology.

At a broader conceptual level, Foucault (2006, 1975, 1979), in his work on biopolitics and the birth of the asylum, clinic, and prison developed an extraordinarily-influential characterization of the modern institution as a key site for the exercise of disciplinary power. In Foucault's view, institutions did not simply exist as containers for problematic populations; rather, the micro-practices of discipline across various sorts of institutions become interesting in light of the way that they reveal the logics and ideas underlying modern regimes of power. Within the institution, one can glimpse the ways in which a configuration of myriad techniques, procedures, and forms of classification contribute to the development of a distinctly modern relationship between subject and object. The modern institution thrives upon the management of bodies through seemingly perpetual observation, classification and comparison with norms, and, subsequently, the production of forms of "normal" conduct through various regulatory methods; in this way, the institutionalized person becomes both an object of knowledge and the subject of disciplinary measures. In Foucault's rendering of the modern institution, power is abstracted from the intentions of any one individual and seems to be caught up in a diffuse machinery used to act upon subjects in all manner of circumstances. Within the anthropology of mental health, Rhodes (1991; 2004) has deftly applied the Foucauldian disciplinary framework in her notable study of staff and patients in an urban emergency psychiatric unit and later in her later work on the contradictions of confinement for mentally-ill prisoners in a maximum-security prison.

As a kind of quasi-institutional research site that bridges clinic and community, IRTS offers a unique opportunity to build upon foundational insights into the nature of

institutions and the exercise of power therein. Per Goffman, IRTS facilities bear the imprint of the total institution in the way that they attempt to foster a setting that encourages certain ways of reengineering the concept of the self in the wake of serious illness experiences; however, relative to that seminal account of the asylum, self-making at IRTS has less to do with the coerced acceptance of a rigidly-defined sick role (Parsons 1951) and is more oriented toward the therapeutic recovery of one's true self that seemingly exists prior to and potentially alongside the symptomatic self. Following Foucault, we might view the standardized organization of space and time at IRTS as bound up with disciplinary measures involving the application of psychiatric norms and standards to the interpretation of client behavior; however, the extent to which clients spend their period of rehabilitation in the community as well as the clinic complicates any neat method of clinical observation and normalization.

As IRTS clients occupy clinical and community spaces simultaneously, the possibilities for psychiatric personhood are not wholly circumscribed by the biomedical discourses undergirding treatment and rehabilitation; these possibilities are animated by the lived experience of individuals beyond the walls of institutions where dominant ideas about illness and its management collide with and are filtered through the structural and intersubjective characteristics of local worlds. These local worlds and the forms of sociality and structural violence that prevail in them interact with attempts by rehabilitative facilities to provide clients with a framework for acting upon the self in a way that encourages the emergence of a particular kind of autonomous, self-determining

form of personhood that is thought to be fundamental to productive community participation.

With a few notable exceptions, quasi or non-institutional community mental health settings have not regularly featured as field sites in the anthropology of mental health and psychiatry literature. The landmark work on this topic remains Estroff's (1981) ethnography of mentally-ill people receiving assistance from a community after-care facility. Estroff's study is important for the way in which it uses ethnographic methods to capture a historical moment when the promise of deinstitutionalization began to fade and the inadequate supply and coordination of community-based services led to the increasing socio-economic marginalization of people coping with severe psychiatric symptoms. As was the case in my research, Estroff focused mainly on young adults (mostly twenty-somethings) participating in a model community care program; at the time of her writing, this population comprised the first cohort of people to come of age in the era of deinstitutionalization. Tracing the lives of recently discharged psychiatric patients, Estroff finds that their pursuit of wellbeing is routinely undermined by the stigma of labeling, exclusion from the labor market, and hostile treatment by people in their community; ultimately, Estroff suggests that the lack of community support causes mentally-ill people to congregate and develop a kind of fringe, marginal subculture. More recently, ethnographic work on community mental health and community psychiatry has focused on the moral dimensions of decision-making among social workers in mobile community treatment teams who face burdens that often force them to make compromises with their own ideals regarding competent care (Brodwin 2008, 2010,

2013, 2014). Myers (2015) examined the provision of recovery-oriented services at a large community-based mental health organization and found that it has been reorganized in order to align with moral conceptions of mentally-ill personhood emphasizing rationality, autonomy, and the demonstration of worth through employment.

My use of IRTS as a research site allows me to reconsider and elaborate upon existing work that addresses the interface between the institutional and non-institutional in the provision of mental health services. Like Estroff, I strive to situate this site in a particular historical moment in the aftermath of deinstitutionalization; my account unfolds during a time when community mental health paradigms have acknowledged the failings of deinstitutionalization and have attempted to rectify shortcomings by inflecting service provision with a philosophy of person-centeredness and incorporating standardized treatment modalities that reflect the biological turn in psychiatric diagnosis and symptom management. The historical moment also reflects an ongoing scaling back of public services, and there is a congruence between the emphasis on ethical self-determination and the restructuring of social policy that makes benefits increasingly inaccessible. IRTS is, on the one hand, a statewide, local-level instantiation of psychiatric treatment and rehabilitation universals that implements evidence-based, nationally-embraced best practices; at the same time, IRTS professionals consciously foreground the discourse of community as they strive to integrate their facilities and client experience of rehabilitation into the neighborhoods, towns, and cities that host them. The constant tacking back and forth between inside and outside that is built into the IRTS client and staff experience offers a methodological vantage point from which

one can begin to interrogate the ways in which community as an element of psychiatric discourse figures into rehabilitation practices and their attendant self-fashioning projects, while also keeping in the frame participants' reckoning with the day-to-day constraints and opportunities afforded by the actually-existing and desired forms of community in which the possibilities for psychiatric personhood emerge. For my participants, these circumstances are further complicated by the fact that they are entering a phase of "emerging adulthood" (Arnett 2000, 2014) in which young people increasingly develop a sense of agency, define life goals, and begin to consider how to pursue a meaningful future; the presence of mental illness and the absence of social support can make this period incredibly hazardous to navigate (Osgood et al. 2005).

Orientations

This project draws upon a diverse set of scholarly literatures as it addresses themes related to psychiatric knowledge and practice; self, person, and subjectivity; and structural violence, vulnerability and health. In the following chapters, I delve into the various literatures pertaining to these aforementioned themes, but in this section I frame the research project by providing a broad overview of the key scholarly trends within these overlapping theoretical domains.

My research is committed to situating contemporary psychiatric practice in historical perspective. While there can be no doubt as to the reality of the pain and suffering that afflicts those with psychiatric diagnoses, the various ways in which

psychiatry is practiced in the contemporary era—and the categories, diagnostic practices, and modes of treatment that it deploys—cannot be viewed solely as the outcome of linear scientific progress. In his *History of Madness* (2006a) and *Psychiatric Power* (2006b), Foucault reckons with the conditions that allowed for the emergence of modern psychiatry, finding that madness—and, in particular, the exclusions and pathologized others that it produces—is variable over time. Foucault argues that this variability in who falls on either side of the distinction between reason and unreason, is, in crude terms, an expression of the structuring power relations present at a given historical juncture. In Foucault’s view, the differing treatments and conceptualizations of madness over passages in Western history are important insofar as they point us toward ruptures, decisions, and interventions that amount to the sorts of social transformations that enable us to conceive of, experience, and address madness in a particular way in the first place.

A number of influential historical and social scientific accounts have attempted to grapple with the conditions that allow for the emergence and transformation of various madness-related phenomena and the categories, treatments, and forms of governance that accompany them across time and space (Barrett 1988; Fassin & Rechtman 2009; Gaines 1982; Hacking 1986, 1995, 1998; Healy 2002; Kitanaka 2012; Kleinman 1980, 1986, 1988a; Lakoff 2005; Luhmann 2000; Martin 2007; Rose 1996, 2007; Rose & Abi-Rached 2013; Young 1995). While the theoretical persuasions of the scholars working in this vein are complex and not exclusively Foucauldian, they all share a commitment to examining the production of new psychiatric categories in changing social and political circumstances; the symbolic work that psychiatric categories perform; the configurations

of scientific knowledge production that are engaged in producing particular forms of psychiatric practice; and the cultural ideas about human potential and capacity that accompany various iterations of psychiatric practice. Contemporary psychiatry and its objects of knowledge—the various clusters of symptoms that cohere around categories of disorder—make for particularly compelling ethnographic objects given their status as what Hacking (1999) has called “interactive kinds,” types of classifications that interact with the thing that is being classified; psychiatric categories are capable of conjuring certain forms of previously unimaginable people into existence, but not without a response from those who are categorized.

As psychiatric categories enter the world and are modified, they function as a key medium for understanding the types of people that we believe ourselves to be, as well as the boundaries around what is assumed that we can and cannot do as people; new classifications create different possibilities for and limitations on action and intention for people engaged with psychiatric “regimes of living” (Collier & Lakoff 2005). For anthropologists and other social scientists, psychiatry is fascinating in large part due to the apparent malleability of its disease categories over time and its ability to reflect shifts in cultural values and social conditions as different iterations of illness classification come into being. Lakoff (2005:2) argues that “the experience of psychiatric disorder dynamically interacts with the ways that experts recognize and name it, its diagnosis is a moving target. Psychiatry, whose objects of knowledge emerge in the encounter between patients’ subjective reports and clinicians’ interpretive schemes, has had a difficult time shifting the disorders under its purview into durable things in the world.” In light of this

observation, ethnographic approaches have attempted to trace diagnostic categories as moving objects that struggle to attain stability and validity as they encounter unique epistemic communities, politics, and everyday exchanges between experts and non-experts.

In this dissertation, I situate my participants' experience of the current neurobiological model of mental disorder in historical perspective by locating its origins in a revolutionary moment in the history of American psychiatry that saw a shift away from psychodynamic theories toward an emphasis on diagnostic specificity that opened the door for advanced research into the organic correlates of symptom clusters (Horwitz & Grob 2016; Horwitz & Wakefield 2007; Mayes & Horwitz 2005; Rose 2007; Rose & Abi-Rached 2013; Shorter 1997; Wilson 1993; Young 1995). A complex, intersecting set of considerations involving changes to health policy, the mobilization of new social movements, the professional status of psychiatry, and the political economy of health care culminated in the codification of a starkly different means of classifying and diagnosing mental illness. The transformation of psychiatry was paralleled by and converged with the accelerating deinstitutionalization of state mental institutions and advances in psychopharmacology; the intersection of these historical developments allowed for the emergence of community mental health treatment models anchored by the widespread prescription of psychopharmaceuticals. As Foucault contended, psychiatry and its forms of treatment are, in any given era, dependent upon processes of exclusion, and the aforementioned changes were bound up with the pathologization of the poor and

other marginalized groups in ways that structure the delivery of services today (Hansen, Bourgois & Drucker 2014; Knight 2013; Metzl 2003, 2009; Raz 2013).

Intimately linked to psychiatric ways of knowing are core ideas about self, personhood, and subjectivity that have long been debated in anthropology and the human sciences more generally. While self and personhood are sometimes used interchangeably and have overlapping features, anthropologists have used the former category to encompass the culturally-conceived varieties of inner psychological experience, while the latter term typically refers to a socially-sanctioned, often-relational conception of the person that confers various entitlements and introduces social obligations (Daniel 1984; Fortes 1987; Dumont 1986; Geertz 1973, 1983; Lutz 1988; Mauss 1985; Rosaldo 1984; Shweder & Bourne 1984; Spiro 1993; Strathern 1988; White and Kirkpatrick 1985). Geertz (1983:126) fuses together elements of self and personhood as he describes the unique form of Western individualism as “a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment and action organized into a distinctive whole and set contrastively against other such wholes and against its social and natural background.” Characterizations of the sort that Geertz provides have been criticized for essentializing hegemonic Western assumptions about self and personhood, reifying the classic binary between subject and world, and denying the possibility for the qualities of other selves to emerge (Kondo 1988; Sokefeld 1999). In practice, the possibilities for selves and persons are multiple and often fragmented; they are enacted in relation to broader meaning systems and modes of interaction within specific social and political contexts which give rise to a multitude of

conceptions of personhood and experiences of self. In my work on IRTS, I found that dominant individualist ideas about self and person circulate in discourses of psychiatric rehabilitation and recovery. As participants are exposed to rehabilitative strategies, the individual is conceived of as the autonomous locus of control in attempts to impart illness management techniques at the level of the self; the successful implementation of these strategies is designed to produce a type of personhood that is recognizable to others by virtue of the person's productive, independent participation in community life.

More recently, medical anthropologists interested in changing forms of self and personhood have attempted to theorize subjectivity as a site for studying the world's increasingly complex and violent social formations and their interface with everyday modes of individual-level experience (Biehl, Good & Kleinman 2006; DelVecchio Good et al. 2008; Good 2012). In an influential volume on subjectivity, disorder, and postcoloniality (DelVecchio Good et al. 2008:2), the authors describe their rationale for re-theorizing subjectivity:

Subjectivity denotes a new attention to hierarchy, violence, and subtle modes of internalized anxieties that link subjection and subjectivity, and the urgent sense of linking national and global economic and political processes to the most intimate forms of everyday experience. It places the political at the heart of the psychological, and the psychological at the heart of the political. Use of the term 'subject' by definition makes analysis of the state and forms of citizenship immediately relevant in ways that analysis of the 'self' or 'person' do not, and 'disordered states' is a trope for both the political and subjective.

In this conceptualization, subjectivity becomes a way of connecting the classical concerns of self and person to the broad social disorders that wreak havoc on the contemporary world; it attempts to link the psychological subject to forms of subjectification central to the dimensions of large-scale socio-political processes. Similarly, Ortner (2005:46) argues for uses of subjectivity that bring a renewed attention to the ongoing restructuring

of experience and its attendant affective states, desires, and perceptions through their
interplay with cultural and social formations:

I have argued for the importance of a robust anthropology of subjectivity, both as states of mind of real actors embedded in the social world, and as cultural formations that (at least partially) express, shape, and constitute those states of mind...I have been particularly interested in understanding subjectivity in its relations to (changing) forms of power, and especially...subtle forms of power that saturate everyday life, through experiences of time, space, and work. In short I have been concerned to explore the ways in which such an anthropology of subjectivity can be the basis of cultural critique, allowing us to ask sharp questions about the cultural shaping of subjectivities within a world of wildly unequal power relations, and about the complexities of personal subjectivities within such a world.

Recent work on subjectivity informs my approach to understanding the management of psychiatric symptoms in a particular time and place, but I also retain the concepts of self and personhood as I seek to understand the trajectory of individual lives as they pass through IRTS facilities and make their way in the world beyond them. Much of the cultural labor involved in psychiatric rehabilitation is conceived of as unfolding at the level of the self and is intended to be productive of forms of personhood that prevail in contemporary America. Following Foucault (1978, 1998, 2006b) and Rose (1996, 1999, 2007), I view psychiatry as a site of subjectification in which the self functions as raw material to be molded and acted upon by individuals engaged in the management of symptoms; as symptoms are rendered visible at the molecular level, the techniques through people are taught to act upon themselves reflect an ethical imperative to intervene in biological processes. The work of biological citizenship (Rose & Novas 2004) is an ongoing process of self-governance and modulation that, in the case of my participants, comes to be taken as evidence of the restoration of rational, autonomous, productive personhood in the wake of psychiatric emergency.

While my emphasis is on the active making of self and person, I do not view these concepts solely as an effect of power or outcome of subjection; the overly-deterministic nature in which subjectification is often understood can detract from our understanding of people as reflective, experiencing subjects who seek to make meaning under various constraints. Jenkins (2010:6) argues that examining the self requires us to consider “the sum of the processes by which the subject is oriented in the world and toward other people.” For people struggling with mental illness, self and personhood, in Jenkins’ (2015:2) view, are emergent properties forged and reconstituted in the daily struggles of lived experience:

Perhaps paramount among fundamental human processes is the existential process of struggle. Recognition of struggle goes beyond the useful and increasingly prominent notion of human resilience in the face of affliction...Struggle is embedded in the often profound and even courageous social engagement with living, working, and caring for others despite an onslaught of *subjective* experiences diagnosed as schizophrenia and bipolar, depressive, and trauma-related conditions, along with the social stigma and discrimination that frequently accompany them.

Attempts to translate symptoms and affective states into accepted sets of meaning through the “work of culture” (Obeyesekere 1985, 1990) unfold against the backdrop of the lived experience of struggle and everyday dilemmas that people encounter as they attempt to navigate intimate social worlds. Anthropological approaches concerned with psychiatric selves and mentally-ill personhood must contend with the ways in which the effects of impersonal forces and discursive formations take hold in the thick of personal struggle and individual embodied experience (Csordas 1994; Desjarlais 1994, 1997). Such situations, Jenkins (2015:3) argues, “are invariably constituted by intersubjectivity, social and economic conditions of possibility and constraint, and the shaping of cultural expectations of persons in relation to gender, mental, and political status.” The meaning-making practices and illness management strategies that emerge from these

circumstances are never entirely encompassed or determined by subjectification processes that accompany psychiatric reason. Subjectivity, in a recent reformulation of the concept (Biehl, Good & Kleinman:14-15), “is not just the outcome of social control or the unconscious; it also provides the ground for subjects to think through their circumstances and to feel through their contradictions, and in so doing, to inwardly endure experiences that would otherwise be outwardly unbearable.”

Recent work by anthropologists engaged in the rethinking of self, person, and subjectivity has begun to explore the way in which the decisions about caring for and valuing the personhood of mentally-ill and chemically-dependent people is interwoven with domestic economies in precarious local worlds (Biehl 2004, 2005; Das 2015; Das & Das 2007; Garcia 2008, 2010; Han 2011, 2012). By focusing on what is locally at stake, this work sheds light on the moral conundrums associated with healing and care that emerge from and are decided through ordinary lived experience (Kleinman 1999, 2006). One of the strengths of this work is the way in which it grounds discursive and cultural formations of self and person in the lifeworlds and decisions of people who have been exposed to increasing economic insecurity as a result of neoliberal policies and now shoulder the burden for the care of others as public institutions are hollowed out. Rather than limiting the scope of its inquiry to the interpretation of interior, affective states, this body of work places emphasis on the ways in which everyday kin and other relationships absorb the tremendous burdens and responsibilities of caring for people whose complicated experiences of illness increasingly take shape beyond the clinical encounter, forcing those whom they rely upon to occupy unfamiliar care-giving roles in the absence

of other options. The question, as Han (2012) sees it, is not simply to do with whether or not the self has relational components, but how those relations are enacted and occupied:

Discourses of “self-care” and “self-responsibility” that are advanced in health and social policy presume a self that is sovereign, morally-autonomous, and transparent posed against social determinations of “the poor,” who must divest themselves of such determinations to be “free”...How self, agency, and collectivity are conceived through these discourses, however, comes into awkward tension with relations as they are actually lived, embodied, and experimented with. Any stable or certain notion of care becomes unsettled when ethnography explores *how* individuals are always already woven into relationships and how they awaken to their relationships.

The mere presence of relations, however, does not guarantee social support, and decisions made within intimate webs of relationships may undermine those struggling to lay claim to personhood in the wake of illness, sometimes resulting in social abandonment and social death (Biehl 2005; Bourgois & Schonberg 2010).

Finally, even if we seek to avoid privileging forms of structural determinism, it is also important to attend to the relationship between socioeconomic forces and health. The most influential anthropological conceptualization of the ways in which historical, socially-patterned inequalities systematically put people’s health at risk has been articulated by Farmer in his theorization of structural violence (Farmer 1996, 2003, 2004). Scholarship that employs the structural violence framework attempts to describe and explain the “social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people” (Farmer et al. 2006:5). In addition, structural violence is accompanied by processes of desocialization and erasure of historical memory that make its institutionalization seem natural and normal. In a similar vein, Kleinman (1997:321) has advocated the use of the

concept “social suffering” to describe the lived experience of pain and deprivation resulting from deleterious social conditions:

suffering is social, not only because social force breaks networks and bodies but also because social institutions respond with assistance to certain categories of sufferers (categories that institutions have constructed as authorized objects for giving help), while denying others or treating them with bureaucratic indifference. Thereby social institutions, through their policies and programs, frequently deepen certain forms of social suffering and become obstacles.

While these sorts of macrostructural accounts sometimes tend to collapse different expressions of violence and reify moral categories, they nonetheless force us to think through the ways in which the normalized challenges and barriers that threaten the health and wellbeing of marginalized people are linked to historical trends and policies that reflect the interests of those occupying privileged places within social hierarchies.

Many of my participants were people who, while perhaps not subject to the chronic “lumpen abuse” (Bourgois 2011) faced by those mentally-ill and destitute people living in “zones of abandonment” (Biehl 2005), nonetheless endure a number of difficulties related to their marginal social class position as they seek to manage severe symptoms of mental illness in the community. To interpret the relationship between these difficulties and social inequalities, I make use of the concept of “structural vulnerability” (Quesada, Hart & Bourgois 2011; Bourgois et al. 2017), which refines the notion of structural violence to emphasize the explicit effects of macro-level forces and how such effects vary across subordinated positionalities. Bourgois et al. (2017:210) summarize the concept in the following manner:

An individual's or a population groups' condition of being at risk for negative health outcomes through their interface with socioeconomic, political and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-

level statuses (e.g., immigration status, labor force participation) constrain their ability to access healthcare and pursue healthy lifestyles.

The concept is particularly useful for understanding the lives of my participants as they transition from IRTS into independent living situations in the community. Given their place in the socioeconomic hierarchy, many become bound up in the “psychiatrization of poverty” (Mills 2015) by way of “disability economy” (Knight 2013) that has emerged as a policy mechanism for managing undesirable and unproductive populations in the wake of welfare reform (Hansen, Bourgois & Drucker 2014). Lacking social and cultural capital, work is hard to come by and individuals are subject to a temporality of waiting by state and non-profit actors as they attempt to obtain various benefits; this forestalling of action undermines their access to the culturally-valued means of restoring personhood that circulated in rehabilitation settings. Such stressors naturally extend beyond the individual and spill over into her network of relations, where overburdened kin and others make difficult choices as they seek to juggle care with the ability to sustain their own wellbeing.

Notes on Research Design and Method

The research for this dissertation was largely conducted under the auspices of the Minnesota Exits and Entries Project (MEEP), a longitudinal, comparative study of young adult transitions from a variety of institutions to community or other non-institutional settings.² MEEP was launched by scholars of criminology interested in life course

² Christopher Uggen—currently Regents Professor and Don A. Martindale Professor of Sociology at the University of Minnesota—was the MEEP Principal Investigator. The various institutional domains of the project were managed by a small group of graduate students, mostly sociologists, who participated in the

trajectories of individuals re-entering communities after periods of institutionalization. The endeavor was guided by several overarching questions: How do young adults make the transition from different institutional settings into society? Are there common correlates of success or failure across the institutions from which individuals exit and re-enter society? Pre and post-discharge/release interviews were conducted with young people aged 18 to 25 exiting the following seven settings: mental health treatment; chemical health treatment; foster care; the armed forces; juvenile justice institutions; municipal jails; and the prison system.³ Given my research interests, I managed the mental health domain of the project; in this capacity, I was responsible for participant recruitment, data collection, and data analysis.

In the case of the mental health domain, it was not immediately clear which mental health treatment and rehabilitation sites would best fit the study parameters. After discussing the project with staff at state-run and local hospitals, it became clear that these institutions largely sought to provide relatively brief stabilization services to individuals in the wake of psychiatric emergencies and subsequently discharge patients to smaller facilities for extended treatment and rehabilitation when necessary. This state of affairs reflects the legacy of psychiatric deinstitutionalization, which has shifted the burden of long-term care away from closed psychiatric wards toward more informal settings where

development of research instruments and were responsible for participant recruitment, data collection, and data analysis.

³ The pre-post interview design was adopted by MEEP researchers to address a gap in the criminological literature on prisoner reentry, which, in the past, largely focused on the post-release experiences of the formerly-incarcerated (Visher & Travis 2003). The design also drew inspiration from the merger of criminology and life course theory advanced by Sampson and Laub (2003a, 2003b); this work draws upon principles of life course development to suggest that longitudinal analyses can better identify the socially-patterned events in one's life that lead to desistance from or continued involvement in crime over time.

a mental health professional workforce comprised largely of social workers provides an array of community-based services intended to support the independence of mentally-ill individuals. In twenty-first century Minnesota, IRTS facilities function as the key state-sanctioned intermediary between hospital and community; they provide a structured residential rehabilitation experience for people recovering from severe symptoms of mental illnesses while at the same time attempting to embed that experience within a particular neighborhood or community.⁴ IRTS facilities serve a maximum of sixteen people at any given time, and the period of rehabilitation is expected to last for approximately ninety days.⁵ Apart from forensic hospitals, institutions serving the mentally-ill in the contemporary era retain few of the characteristics of Goffman's (1961) "total institutions." IRTS facilities provide a temporary rehabilitative experience explicitly designed to integrate individuals into the fabric of everyday life in a community rather than removing them from it, and they help to coordinate services across an array of providers rather than acting as the sole therapeutic authority. As the key institutional site for addressing the needs of mentally-ill people who were capable of transitioning back into everyday life in their communities after an illness experience, they were a natural fit for the MEEP project.

⁴ The embeddedness of IRTS facilities in communities is most evident in their physical location in residential neighborhoods, but IRTS staff also encourage clients to independently complete tasks and activities outside the confines of the facility. IRTS allow clients to come and go with some restrictions when mandatory rehabilitative activities are not taking place, so many visit friends and family, as well as attend educational/other supportive programs.

⁵ Clients can discharge from IRTS early if they are doing well and meeting goals that were identified during their intake process. Conversely, in situations where clients are still in need of the type of assistance provided by IRTS after the initial ninety days, staff can apply help them apply for an extension to their stay of up to ninety days. My participants were all scheduled to leave IRTS around the ninety day mark, and none of them indicated that they were pursuing an extension.

A purposive sampling strategy was employed to recruit young adult participants from IRTS facilities for the study.⁶ Across the various domains of the MEEP project, potential participants needed to have spent at least sixty days in an institution and also be within thirty days of transitioning out of their institutional setting. IRTS facilities, while concentrated in the Twin Cities metropolitan area, exist throughout the state, and I emailed and called facilities and explained the project to staff members responsible for deciding whether or not their organization would be willing to collaborate in the research. Staff at IRTS facilities that were interested in being part of MEEP shared information about the research with eligible clients and worked with me to arrange interviews with people who volunteered to participate in the study. Ultimately, twenty young adults participated in pre-transition interviews, and these individuals were asked to provide contact information for themselves or another person that they were comfortable with the research team contacting in order to schedule a post-transition interview; follow-up interviews were conducted with half of the original sample.⁷

Interview data collection followed a semi-structured guide organized around the following topics: background and circumstances leading to institutionalization; experience of institutionalization (structure of everyday life, description of treatment modalities); plans for community transition; outline of community and attendant

⁶ Purposive sampling is a non-probability sampling strategy that allows for cases to be selected on the basis of some predetermined criteria, and it is important to acknowledge that various forms of selection bias are inherent in this approach. While purposive sampling limits the generalizability of findings, it is a common approach in qualitative research that seeks to describe and interpret phenomena rather than make claims regarding the nature and characteristics of an entire population (Abrams 2010).

⁷ A 50% attrition rate is consistent with the other MEEP domains. Attrition is an issue in any form of longitudinal study, but mentally-ill participants may be particularly challenging to remain in contact with in light of the potential for relapse and, in this cohort, instances of housing instability. In light of these considerations and relative to other domains, the attrition rate is reasonable.

resources (housing, education, employment); social support and social networks; current and future use of services (e.g., forms of public assistance, involvement with various sorts of mental health professionals); and short-term/long-term post-transition plans and goals. Follow-up interviews explored the same set of topics in the context of participants' community reintegration and occurred approximately ninety days after participants left institutional settings in order to allow for a period of community readjustment. While interview topics were shared across MEEP domains, the open-ended nature of the interviews allowed considerable freedom for the researchers to probe emergent concepts and ideas, as well as topics that were unique to a particular setting (for example, mental health interviews often included extended discussions of the meanings associated with diagnosis and the consumption of psychiatric drugs). In the case of mental health interviews, the project's emphasis on institutional trajectory brought the temporal dimension of experience to the fore and often inadvertently led participants to develop illness narratives through which they imbued symptoms and the conditions in which they manifest with meaning (Good 1994; Kleinman 1988b). I also attempted to apply a person-centered approach (Hollan & Levy 1998) to interviewing by adopting line of questioning that was intended to elicit responses describing the individual experience of bodily phenomena like symptoms and their accompanying context that is typically elided in formal diagnostic categories, as well as the feelings and hopes that animate the transitional horizon.

Pre-transition interviews occurred at IRTS facilities, while post-transition interviews were conducted in a variety of public and private settings (adult foster care

homes, libraries, coffee shops).⁸ Each interview was accompanied by a set of fieldnotes that highlighted initial observations regarding the interview site, participant, and key themes that emerged from the discussion. As interviews began to accumulate, the fieldnotes also provided a space for analytic memoing, in which preliminary conceptual linkages across cases were considered and worked through (Birks, Chapman & Francis 2008).

In a secondary stage of the research pursued independently of the MEEP project, I complemented initial data collection by conducting interviews with mental health professionals employed by IRTS facilities, including clinical directors, therapists, peer support specialists, and other staff.⁹ These interviews were facilitated by contacts in the mental health services world who connected me with senior managerial staff at IRTS facilities; IRTS staff then shared information about my research with appropriate staff members and helped me schedule interviews. Given my interest in the way in which psychiatric discourse informs the way in which people interpret illness experiences and craft new forms of personhood, I wanted to talk with IRTS staff in order to better understand how psychiatric ideas are mobilized in the context of IRTS rehabilitation and how those ideas are filtered through the backgrounds and experience of clinicians and other professionals. As Rhodes (1991) observes in her ethnographic work on an emergency psychiatric unit, mental health professionals are *bricoleurs* who pragmatically

⁸ Interviews typically lasted around one hour (though were occasionally much longer) and were recorded with participants' consent.

⁹ In this phase of the research, I settled on interview respondents who worked in a client-facing role and had thorough knowledge of IRTS practices (at least one year of work experience in an IRTS). Roles in IRTS facilities are often overlapping, so while people who work in them have distinct responsibilities, I found that coordinating client care and services requires them to know quite a bit about one another's jobs.

interpret official psychiatric categories and concepts in ways that meet the unique local demands of their professional settings and the clients that inhabit them. I was also interested in how mental health professionals characterize the challenges faced by their young adult clients both in clinical settings and the community and how such characterizations compared with what I heard from clients. These interviews took place at IRTS facilities and were recorded; they typically lasted thirty minutes to one hour.

While I carried out preliminary data analysis as a member of the MEEP research team, I later returned to the data and carried out a separate analysis for this dissertation. My analytic approach made use of coding strategies derived from grounded theory methodologies (Charmaz 2014; Glaser & Strauss 2017; Glaser 1992; Strauss & Corbin 1990). While grounded theory is sometimes conceived of as a tool for guiding the entire research enterprise through a largely inductive approach that aims to generate theoretical explanations for phenomena from raw data, I limit my adoption of the method to the recommendations of its proponents for the data analysis phase of research. Following Charmaz (2014), my approach to data analysis included three phases. First, in the open coding phase, I read through transcripts and applied an initial set of themes to chunks of text; here the goal is to attempt to reduce the data by identifying potentially useful conceptual components. Next, I engaged in a more focused round of coding (frequently described as “axial” coding) in order to refine and relate existing codes and thematic categories through a process of reviewing and comparing of themes across interviews; in this stage, I attempted to create subcategories that related the properties of concepts identified in the open coding phase. Lastly, in the final coding phase, I attempted to link

together the refined themes from the previous step and relate them to various phenomena under examination in my research in order to develop theoretical explanations for the social processes and conditions that participants had described. Much of this process was initially framed by readings of my fieldnotes, where I had sketched out some initial ideas and concepts expressed during conversations with participants.

Plan of the Dissertation

The dissertation includes three substantive chapters and some brief concluding remarks. I provide an overview of the structure of the dissertation below.

Chapter II: Contemporary Psychiatric Logic and Community Mental Health Practice

In this chapter, I examine the historical processes that converged to produce contemporary psychiatric reason and its accompanying forms of knowledge production, treatment modalities, and means of service provision. I use the concept of psychiatric reason to describe the dominant biopsychiatric framework through which various sorts of symptoms are transformed into disease categories demanding specific types of psychopharmaceutical intervention. Today, psychiatry understands mental disorder to be comprised of objective categories of disease that stem from neurochemical anomalies. The preferred—and often only—form of treatment available to those coping with psychiatric illness is pharmacotherapy, which involves the use of drugs that have been fabricated with the express purpose of intervening in neurochemical processes specific to

the diagnosis of the patient. For all but the most severe cases, treatment occurs in community settings where, in addition to drug treatment, individuals come to rely on a diffuse network of mental health professionals and social service agencies to achieve stability and maintain independence.

Prevailing psychiatric notions of disease, treatment, and the conception of community as a hospitable site for recovery have their origins in the resolution of a mid-twentieth century crisis of legitimacy in the field of psychiatry that involved a fundamental rethinking of what mental illness is and how it can be diagnosed. The resulting system of classification emphasized the correlation between observable symptoms and discrete disorders and largely set aside etiological concerns where they were not directly linked to human biology. Significant resources were directed toward large-scale research and development efforts that brought together an array of experts to refine this understanding of mental illness and develop psychopharmaceuticals intended to target specific disorders with increasing precision. These transformations were accompanied by the dismantling of traditional custodial settings and the projection of psychiatric reason onto quotidian community experience; communities were assumed to have naturally-occurring social support mechanisms that could meet the needs of the formerly-institutionalized.

Chapter III. The Work of Recovery

In this chapter, I examine the ways in which IRTS facilities engage clients in what I call the work of recovery, which encompasses diagnosis, illness management/education

activities, and pharmacotherapy. As young adults are faced with the onset of severe, often unrecognizable symptoms, they typically lack an interpretive framework through which unfamiliar affective states can be assigned meaning, challenging the very core of the self. In the wake of such crises, my research participants were hospitalized, stabilized, and referred to IRTS facilities to continue their rehabilitation and recovery. Mental health professionals in IRTS settings conduct diagnostic assessments of clients that isolate areas of concern of most immediate relevance to a person's ability to live independently; this process is entangled with evaluations carried out in other institutional settings and highlights the contingent nature of diagnostic pronouncements. While clinicians are concerned that sharing too much diagnostic information with clients may lead to labeling and self-stigmatization, it is often the case that clients are aware of their various diagnoses and sometimes craft explanatory frameworks that clash with authoritative explanations by disrupting their decontextualized application. Psychiatric reason offers clinicians few tools to deal with client perspectives on diagnosis that diverge from the disease model, and such perspectives signal that a client may perhaps be lacking in insight and less likely to embrace the recovery process.

Everyday life at IRTS facilities is organized around groups sessions that utilize evidence-based rehabilitation practices to address illness management and recovery, as well as health education topics and independent living skills. IRTS staff see themselves as empowering clients to act as agents in their own recovery and make choices that will help them to work toward meaningful life goals. At the same time, the principle of recovery without cure pervades group content; while clients may successfully manage

symptoms to minimize their impact on everyday life, the prospect of serious relapse always looms large. In light of this conundrum, clients are introduced to an array of “mood hygiene” strategies that facilitate the self-monitoring of symptoms, which in turn both solidifies diagnostic categories and produces knowledge that can be acted upon. Through these processes, an activist vision of the self emerges: the independent, recovered individual who successfully integrates into a community of their choosing is one who embraces the ethical imperative to responsibly and vigilantly engage certain techniques of self-governance. The concept of the activist self is ultimately anchored by pharmacotherapy, which assumes that the chronic risk associated with mental illness requires long-term management using the most advanced psychiatric drugs to act upon specific illnesses; compliance with a pharmaceutical regimen both enables and is a function of the activist self. Compliance with pharmacotherapy also acts as an “interiorization of the clinic” in that it signals acceptance of the various assumptions of psychiatric reason that are condensed into drugs.

Chapter IV. Structural Vulnerability, Relatedness, and Personhood in the Community

In this chapter, I examine the experiences of participants as they prepare for and transition into life in the community. While category of community occupies a privileged place in recovery discourse as a non-institutional setting where those managing mental illness exercise responsible self-discipline and, as a result, are empowered to determine futures of their choosing, I contend that participants face structural conditions that limit their ability to work toward and achieve the ideal forms of personhood underlying treatment modalities. Participants face complicated lives in the community where

recovery is typically hindered by structural vulnerability, a type of positionality that subjects individuals to various manifestations of violence as a result of their marginal socioeconomic status. Occupying structurally-vulnerable subject positions, participants must navigate a complex disability economy in order to access the resources that will provide them with some small, partial measure of stability in terms of income, health insurance, and housing. As participants are absorbed into this disability economy, the temporal conditions of their transition to community living become bound up with various processes of waiting, which undermines the agentive thrust of the recovery narrative and induces passivity at the moment when autonomy and choice are thought to become accessible. In addition to the subtler forms of social defeat that accompany this vulnerability, many participants find that their ability to independently address their needs is compromised by the exercise of coercive state power through civil commitment orders, which mandate adherence to treatment and surveillance conditions even beyond institutional settings.

Against this backdrop of structural violence and limited resources, participants face questions of relatedness and social belonging. The possibilities for personhood are not individually-determined, but also bound up with a host of existing and incipient relations that comprise community for many. The force and nature of relations goes a long way toward determining how participants understand and make use of others as sources of care as they manage illness and attempt to pursue goals that matter to them. I found relatedness to be an extraordinarily complex issue that cannot be reduced to a simple valuation of the presence or absence of social networks and bonds in one's life.

Relations are fragmented and fluid; people seek care and support in settings where estrangement, material deprivation, and desire for particular forms of sociality coalesce in individuals' local worlds, both precipitating symptoms and shaping the conditions in which those symptoms can be managed.

Contrary to the findings of recent anthropological scholarship regarding how the intersection of political economy of health care, domestic economies, and everyday practices of illness management intersect to produce social abandonment and even social death, I find that both the most marginal of my participants as well as those most deeply implicated in networks of relations become, by virtue of their structural vulnerability, enmeshed in a disability economy that has been erected to manage people whose psychiatric diagnoses and social status make them undesirable and unproductive. This economy includes a host of bureaucratic procedures that guarantee individual survival, and in the case of those who would otherwise face complete social abandonment, provides the infrastructure for locally-managed systems of care that indefinitely assumes responsibility for people's wellbeing; for those who find themselves anchored by more established networks of relationships and care beyond the human services apparatus, qualification for various benefits factors into calculations about social belonging and ideas about the type of life that might be possible as a mentally-ill person. Personhood, in the world of former IRTS clients, represents an unfinished, difficult-to-characterize project that unfolds in circumstances of structural constraint that interact with complex social lives and forms of relatedness causing certain aspirations to be valued and others to be foreclosed.

Chapter II. Contemporary Psychiatric Logic and Community Mental Health

Practice

Introduction

The young adults that I encountered at residential treatment facilities during the course of my research were fundamentally grappling with the question of how to make their way in the world as people with psychiatric diagnoses. Whether one was approaching this question upon receiving a diagnosis for the first time—as was the case for some who recounted stories of lives ruptured by recent psychiatric emergencies—or attempting to reconcile the shifting diagnostic pronouncements of various clinicians over time, the experiences that followed from the onset of symptoms to residence in an IRTS facility exposed participants to dominant forms of psychiatric reason. When I refer to psychiatric reason, I mean the organizing logic—and the norms and standards laid out therein—that governs how psychiatry, as a branch of medicine, goes about its basic work of translating illness complaints into objective categories of disease.

Embedded in this form of reason are claims about the correspondence between discrete categories of disorder that are represented by particular sets of symptoms and anomalies in specific sorts of underlying neurochemical processes. In the contemporary United States, the dominant form of psychiatric practice derives its epistemological warrant from a biological model of disease. The dominant strain of biological psychiatry has increasingly come to identify with the field of neuroscience, and its practitioners fix a

“neuromolecular gaze” upon the brain as they seek to stage psychopharmaceutical treatment interventions. (Abi-Rached & Rose 2010). Rose (2007:220) succinctly summarizes contemporary psychiatric logic in the following manner:

A way of thinking has taken shape, and a growing proportion of psychiatrists find it difficult to think otherwise. In this way of thinking, all explanations of mental pathology must “pass through” the brain and its neurochemistry—neurons, synapses, membranes, receptors, ion channels, neurotransmitters, enzymes...Diagnosis is thought to be most accurate when it can link symptoms to anomalies in one or more of these elements. And the fabrication and action of psychiatric drugs is conceived in these terms...A few decades ago, such claims would have seemed extraordinarily bold; for many medicopsychiatric researchers and practitioners, they now seem “only common sense.”

The IRTS clients who participated in my research encountered and received diagnoses from psychiatrists at various points during their journey through health care systems, but it was typically mental health professionals drawn from other fields—mainly social work—that assumed responsibility for disseminating psychiatric reason over the longer-term course of their treatment and recovery. The most common trajectory for these young people led from psychiatric emergency to crisis stabilization and intensive short-term treatment (using a combination of medication and therapy) at an inpatient facility (hospital and/or regional treatment center) and then discharge to an IRTS, which functions as a structured community mental health setting ideal for those not immediately prepared to make the leap to a more independent living situation. In IRTS and other forms of community treatment, the division of mental health professional labor requires social workers to guide clients through therapeutic curricula and act as conduits to a variety of resources (e.g., employment, housing, and public benefits). At this stage, psychiatrists have minimal day-to-day involvement in clients’ lives apart from occasional

medication management visits, a fact that was highlighted by research participants' tendency to refer to them simply as "med doctors."

Conversely, the obligations that social workers employed at IRTS facilities are tasked with are demanding and many. Chief among their responsibilities, perhaps, is facilitating a set of health education, therapeutic, and life skills activities that allow clients to learn about their diagnoses and consider the ramifications of being a person with a disorder. Therapeutic activities are iterations of evidence-based practices associated with dominant treatment models—most notably Illness Management and Recovery—and it is through local enactments of these models at IRTS facilities that psychiatric subjectivity is fostered among many clients. Clients participate in most activities as a group and are thus exposed to a biosocial dimension of what may initially appear to be a deeply individual experience. Crucially, this process of treatment and recovery occurs in the community, which is to say in professionally-managed group homes located in residential neighborhoods that afford their small client populations the freedom to come and go while making essential supports easily accessible.

This chapter traces the historical processes that are responsible for producing the plethora of community-based mental health facilities and services that dominate the treatment landscape in the United States and beyond. I attend to three key developments that allowed for the expansion of psychiatric treatment into non-institutional community spaces. First, one must recognize the revolutionary turn in American psychiatry heralded

by the 1980 publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) that reoriented the field away from the psychoanalytic/psychodynamic tradition and toward an empiricist science focused on the biological origins of disorder. Public policy decisions regarding deinstitutionalization unfolded in parallel during the second half of the 20th century, radically reducing the population of mentally-ill persons in custodial institutions and giving rise to the community mental health paradigm. Complementing both were advances in psychopharmacology, which would supplant the “talking cure” as the favored treatment modality for mental disorder. Taken together, these historical changes allowed for the emergence of a new biomedical science that transformed previously obscure psychic conflicts into objective entities to be precisely targeted with psychopharmaceutical drugs.

DSM-III and the Revolution in American Psychiatry

Writing in the late 1990s, the historian of medicine Edward Shorter observes that “if there is one central, intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry—treating mental illness as a genetically influenced disorder of brain chemistry—has been a smashing success” (1997: vii). At the time, Shorter’s conclusion regarding biological psychiatry’s triumph seemed wholly warranted. Epidemiological research findings pointed to the increasingly widespread prevalence of untreated psychiatric illness—particularly major depressive disorder—which helped to foster the conditions under which a market for a new class of psychopharmaceutical

drugs, known as selective serotonin reuptake inhibitors (SSRIs), could emerge (Healy 1997; Horowitz 2011; Kessler et al. 1994; Mojtabi 2008; Olfson et al. 2002).

The adoption of SSRIs, of which Prozac became the standard-bearer, is significant not only in that it heralded a paradigm shift in the use of drugs to treat mental illness, but because it indexes changing understandings of the nature of the underlying disorder targeted by those drugs. The prescription of psychopharmaceuticals was not an entirely novel development—indeed, forms of pharmacotherapy were fairly common in American psychiatry since at least the 1950s; rather, SSRIs posited a new mechanism of interaction between drug and brain that located disorder in neurochemical processes (Healy 2001).¹⁰ Prozac and other SSRIs were advertised as “smart drugs” that could directly regulate the levels of those neurotransmitters thought to have a causal relationship with the presence of disorder, and do so in a way that minimized the side effects associated with earlier classes of psychopharmaceuticals (Rose 2003). Nikolas Rose (2003:55) summarizes the psychiatric ethos of the era in the following manner:

The central presupposition, perhaps more significant than any individual drug, was that of specificity. This presupposition was actually three sided. First, it was premised on the neuroscientific belief that these drugs could, and ideally should have a specificity of target. Second, it was premised on the clinical belief that doctors or patients could specifically diagnose each array of changes in mood, will, desire, affect as a discrete condition. Third, it was based on the neuroscientific belief that specific configurations in neurotransmitter systems underlay specific moods, desires, and affect. The three presuppositions were then mapped onto one another.

¹⁰ The introduction of SSRIs as the primary treatment modality for major depressive disorder and other diagnoses is the culmination of the serotonin theory of depression, which postulates that disorder is rooted in neurotransmitter deficiencies. The earliest iterations of this hypothesis date to the 1960s (Coppens 1967; Schildkraut 1965). More recent research suggests that the pharmaceutical industry ignored the paucity of evidence for the serotonin hypothesis as it mounted advertising campaigns for the early SSRIs (Healy 2015; Lacasse & Leo 2005).

In this formulation, affective states have direct neurochemical correlates, and SSRIs represent a desirable advance in the treatment of psychiatric disorder because they can be tailored to intervene in specific illness processes at the molecular level. Psychiatrists are able to prescribe the appropriate drug because they can isolate discrete categories of disease through the careful interpretation of a patient's symptomatology. Perhaps more than anything else, it is this assumption that the objects of psychiatric knowledge are organic, biological forms of disorder that can be discerned and classified on the basis of symptom groups that functions as the lynchpin of contemporary psychiatric reason.

Despite the seemingly self-evident objectivity of the diagnostic categories derived from the contemporary biological model of psychiatric disorder, the prevailing system of classification is a fairly recent achievement and a radical departure from that which preceded it, if not a reflection of scientific progress. In histories of diagnosis and disease classification in American psychiatry, the 1980 publication of the DSM-III marks a decisive shift away from a tradition of psychodynamic practice and toward an empirical approach advocating diagnostic standardization from which the systems of classification familiar to contemporary practitioners are derived (Horwitz & Grob 2016; Horwitz & Wakefield 2007; Mayes & Horwitz 2005; Rose & Abi-Rached 2013; Shorter 1997; Wilson 1993; Young 1995). The reasons for the transformation of American psychiatry are many, but some of the most important of these overlapping factors include struggles between factions within the field for professional status, the need to create a nosology compatible with insurance reimbursement procedures and the demands of pharmaceutical manufacturers, and changes to federal government mental health policy.

For much of the twentieth century, American psychiatric practice was not particularly concerned with specific diagnostic entities. By midcentury, the field was largely organized around psychodynamic theories of mental illness that located the etiology of disorder in an individual's failure to adapt or adjust to environmental conditions and difficult life circumstances (Wilson 1993). This approach was reinforced by the experiences of World War II military psychiatrists who had observed many cases of what they viewed as mental maladaptation stemming from soldiers' combat stress responses and became convinced that a similar model could be applied to forms of disorder found in everyday civilian life (Grob 1991a). Symptoms were interpreted as "symbolic manifestations that only became meaningful through exploring the personal history of each individual. The focus of analytic explanations and treatment, therefore, was the total personality and life experiences of the person that provided the context for the interpretation of symptoms" (Mayes & Horwitz 2005:250).

Leading psychiatrists of the period such as Karl Menninger rejected the notion of discrete disease categories and instead viewed psychological distress as varying in severity but ultimately belonging to a single continuum of maladaptation (Menninger, Mayman & Pruyser 1963; Wilson 1993). Menninger went so far as to declare that "There is only one class of mental illness—namely, mental illness" (Menninger, Mayman & Pruyser 1963: 9). From this perspective, a vast expanse of disorders ranging from the most severe to the seemingly mundane came to fall under the psychiatric umbrella; however, it is toward the milder end of the spectrum of the continuum where psychiatric

expertise in its psychodynamic guise experienced the most significant growth (Hale 1995). Mayes and Horwitz (2005:250) summarize this transformation:

Between 1900 and about 1970, the focus of dynamic psychiatry broadened from the treatment of neuroses to more generalized patterns of maladaptive behavior, character, and personal problems. Its clients came to be people who were dissatisfied with themselves, their relationships, their careers, and their lives in general. Psychiatry had been transformed from a discipline that was concerned with insanity to one that was concerned with normality.

In a sense, the groundwork for the medicalization of everyday life that is often associated with more contemporary psychiatric logic was laid during the psychodynamic period (Grob 1987; Horwitz 2002).

The psychodynamic school of psychiatry did not entirely eschew nosology, and the first two iterations of the DSM—published in 1952 and 1968—were compatible with the perspective and concerns of its approach to mental illness.¹¹ The publication of the two earliest editions of the DSM offered something of a corrective to an earlier classificatory tradition that emerged from demographic data collection by the Bureau of the Census on institutionalized patient populations. Concern for the prevention of the sort of severe mental illness that prevailed among the institutionalized mentally-ill led the American Medico-Psychological Association and the Bureau of the Census to produce the *Statistical Manual for the Use of Institutions for the Insane* in 1918.¹² The manual was intended to facilitate the collection of epidemiological data on hospitalized patients

¹¹ DSM-I was heavily influenced by the work of Adolph Meyer, one of the most prominent American psychiatrists of the first half of the 20th century. While not part of the psychodynamic school, Meyer “saw diagnostic groups as representing quantitatively different reactions of human personality to a unitary set of causes: psychological, social, and biological...Because of its orientation toward psychological process, Meyer’s system was entirely consistent with psychodynamic premises” (Young 1995: 98)

¹² The American Medico-Psychological Association was the forerunner of the American Psychiatric Association.

and ten editions were published during the first half of the twentieth century (Horwitz & Grob 2016). Midcentury psychodynamic psychiatrists mainly practiced outside of large public hospitals, and their belief in a continuum of mental health that encompassed far milder types of disorder than the severe forms of psychopathology common among institutionalized patients meant that the nomenclature of this earlier manual was of little utility.¹³ In its place, leading psychiatrists drafted a new nosology that reflected the concerns of the dominant intellectual forces operating in their field by codifying psychodynamic concepts, ultimately resulting in the publication of the DSM-I (Grob 1991b).

Neither the of the first two editions of the DSM laid out a particularly detailed, comprehensive classificatory schema. Since visible symptoms functioned as indirect expressions of deep intra-psychoic conflict or failures of adaptation to environmental circumstances all of which existed on a continuum, it made little sense to distinguish between discrete disorders. While the DSM-I did draw a distinction between disorders of an organic nature and those that were presumed to stem from an individual's adjustment difficulties, the former encompassed conditions that were precipitated by impaired brain function and were limited to "syndromes associated with a variety of somatic conditions—infection; drug, poison or alcoholic intoxication; trauma; circulatory or metabolic disturbances; intercranial neoplasms; multiple sclerosis; and Huntington's chorea or other diseases of hereditary origin" (Grob 1991b:428). The latter category of disorder was further disaggregated into psychotic and neuropsychotic disorders that ran

¹³ Psychiatrists of the psychodynamic persuasion rising to prominence around the time of the publication of DSM-I practiced mainly in clinics, medical schools, and private settings (Grob 1991b).

the gamut from manic-depressive and paranoid reactions to a host of personality disorders. The second of these two overarching categories was predictably more expansive, and the diagnoses contained therein were rooted in psychodynamic theory rather than empirical observation. Describing the definition of depression operationalized in the manual, Horwitz and Grob (2016:528) observe that it “like the others in the DSM-I, focused solely on the psychodynamics (loss, guilt, ambivalence) that presumably lead to depressive conditions but contained no definitional criteria that would indicate the presence of a disorder.”

The contents of DSM-II, published some sixteen years after the first edition, were largely consistent with its predecessor. The effort to create an updated manual was motivated, in part, by a need to establish consistency between the contents of the DSM and the World Health Organization’s International Classification of Disease (ICD), which was being revised concurrently.¹⁴ While this collaborative process led the DSM-II committee to feel some pressure to reduce the “emphasis on disorders as reactions to precipitating life events, it did not eliminate this suggestion entirely, and it also retained, and indeed extended, the categories of neurosis,” categories that represented vestiges of classic psychoanalytic theory (Rose & Abi-Rached 2013:119). While some of the more empirically-oriented psychiatrists advising on the revision as consultants to the American Psychiatric Association’s Committee on Nomenclature and Statistics felt heartened by the convergence of DSM and ICD categories, the DSM-II did not meaningfully depart from

¹⁴ The revision of the International Classification of Disease in question here was the eighth (ICD-8).

its predecessor's disregard for discrete diagnostic entities. In any case, neither of these first two editions of the DSM had much bearing on clinical practice given that diagnostic specificity had little to do with the theoretical assumptions guiding the field and, importantly, because "the bulk of outpatients at the time paid for their own therapy, so that no private or public third parties required diagnoses to reimburse clinicians" (Horwitz & Grob 2016:528).

Even before the publication of the DSM-II in 1968, psychiatry began to face criticism from both inside and outside of the field that would evolve into a crisis of legitimacy by the 1970s. In the broader cultural milieu, critiques of the field emanating from the "anti-psychiatry" movement began to garner public attention. Activists associated with this movement voiced a range of concerns about psychiatry's social function and approach to knowledge production. Seminal works by "anti-psychiatry" thinkers questioned the fundamental reality of mental illness and suggested that it instead constituted an entirely normal attempt to cope with difficult social conditions; from this perspective, psychiatric conditions functioned as arbitrary labels used to police nonconformists (Laing 1967; Scheff 1966; Szasz 1961).¹⁵ The intellectual challenge that proved to be the most consequential, however, came from an emergent branch of psychiatry led by research psychiatrists working in academic settings who wished to reshape the discipline so that psychiatric knowledge production adhered more closely to the norms associated with conventional scientific inquiry. While the vision of these

¹⁵ The general critique of psychiatry as a form of social control was also reflected in popular cultural production, with perhaps the most notable example being the award-winning 1975 film *One Flew Over the Cuckoo's Nest*.

empiricists would ultimately triumph and become codified in the DSM-III, their ideas gathered strength not simply on merit, but because a number of parallel processes helped to create an environment in which those ideas could be positively received.

By the mid-1960s, psychiatry began to be impacted by the rise of Medicaid and private health insurance plans whose third-party payment policies introduced an intermediary between therapist and client. Psychodynamic practitioners had typically dealt with clients who paid out-of-pocket and were thus able to maintain a great deal of autonomy with respect to the nature of the services that they elected to provide. As insurers began to expand coverage for outpatient psychotherapy, they found that the prevailing psychodynamic model was a poor fit for reimbursement policies organized around the diagnosis of discrete disease entities (Horwitz 2002). In order to maximize return on investment, insurers demanded that reimbursed services demonstrate accountability in the form of improved patient health outcomes (Hale 1995; Wilson 1993). Studies intended to evaluate the clinical efficacy of existing psychodynamic therapeutic practices found little evidence of their effectiveness, leaving insurers concerned about the financial wisdom of providing coverage for what was often a very long-term form of treatment (Mayes & Horwitz 2005; Starr 1982). The lack of evidence supporting the psychodynamic approach introduced competition as non-physicians such as psychologists and social workers argued that they were also equipped to treat ill-defined mental disorders and could do so in a more cost-effective manner than psychiatrists (Abbott 1988). Mayes and Horwitz (2005:254) summarize insurer sentiment on the issue:

Those who provided psychiatrists' chief source of income were becoming increasingly skeptical of the product being delivered and unwilling to continue reimbursing for mental health treatment unless changes were made. Outpatient care in office settings, the primary venue for most psychotherapists, came under attack as ineffective, unaccountable, and financially wasteful. Both insurance companies and the federal government increasingly demanded diagnoses and treatments that were both demonstrably effective and financially accountable.

During the same period, government policy regarding the provision of mental health services shifted the locus of treatment for the severely mentally-ill away from large state-run institutions and into the community. This process of deinstitutionalizing long-term psychiatric patients and placing them in less restrictive community settings began to accelerate significantly in the mid-1960s along with the expansion of the American welfare state. According to Hale (1995), the number of individuals residing in mental institutions declined from 475,000 in 1965 to 138,000 in 1980, a reduction of nearly sixty percent. The Community Mental Health Centers Act of 1963 officially marked this shift toward community treatment by providing funding for the construction of community-based mental health clinics responsible for managing the outpatient treatment of severely mentally-ill individuals and addressing the incidence of more minor disorders so as to prevent the development of more serious symptoms (Gronfein 1985; Strand 2011).

Deinstitutionalization and the expansion of community-based mental health treatment increased demand for mental health professionals while also highlighting some of psychiatry's significant limitations. At the dawn of the era of deinstitutionalization, few psychiatrists were affiliated with state-run mental institutions and thus had little experience treating the sort of patients that populated them (Grob 1991a). The cohort of

formerly-institutionalized individuals often suffered from severe and chronic forms of mental illness frequently accompanied by co-occurring substance use disorders (Redlich & Kellert 1978). Psychiatrists discovered that therapeutic models associated with the psychodynamic tradition were poorly-suited to the severe and chronic types of disorders prevalent among the deinstitutionalized population. Furthermore, regardless of the appropriateness of psychodynamic approaches, the scarcity of psychiatrists relative to the increased demand created by deinstitutionalization limited practitioners' ability to see the course of their conventional long-term methods through, leading them to cede responsibility for treatment to other types of mental health professionals. In light of the limited efficacy of psychotherapy in this context, the method was frequently supplanted by pharmacotherapy, with medication often yielding superior treatment outcomes for challenging cases in the community (Strand 2011). The era of deinstitutionalization had revealed a fundamental mismatch between prevailing psychiatric methods and the demands of the day:

Psychiatrists, who had largely established themselves in outpatient practices that catered to urban, cosmopolitan intellectuals amenable to lengthy and expensive treatments grounded in psychoanalysis, were ill suited to deal with the conditions of schizophrenia and degenerative brain disorders common among formerly institutionalized patients. They also expressed little interest in treating alcoholic patients or those with drug addictions but often referred them to psychologists and social workers (Mayes & Horwitz 2015:255).

By the late 1960s, it was clear that the era of psychodynamic psychiatry was drawing to a close. The various challenges that I have outlined left psychiatry at a crossroads and exacerbated tensions between different schools of thought within the field itself. The boundaries of the disorders that psychiatrists attempted to address were ill-defined, and the evidence for the efficacy of its treatment modalities was, at best, limited.

For some, it seemed that the field's practitioners could only be differentiated from other types of mental health professionals with whom they were in competition by virtue of the medical training they possessed (Hackett 1977). In this climate, the concerns of formerly-marginal research psychiatrists came to the fore. This empirically-minded group of psychiatrists, who some viewed as "neo-Kraepelinians," argued forcefully for reforms to disease classification and diagnostic procedures firmly rooted in the mainstream conventions of scientific inquiry (Mayes and Horwitz 2005; Young 1995).¹⁶

The third revision of the DSM, which culminated in the publication of a landmark update to the manual in 1980, was driven by the concerns of prominent psychiatric researchers. In 1974, Columbia University psychiatrist Robert Spitzer—a convert to the empirical approach from the psychodynamic tradition—was appointed by the APA to chair the revision.¹⁷ Spitzer's Task Force on Nomenclature and Statistics was replete with adherents to positivist, empirically-oriented psychiatry (Guze 2000; Wilson 1993). While the official demand for a revision was once again associated with efforts to align DSM and ICD nomenclature, the scope of Spitzer and his colleagues' reform ideas extended far beyond that mandate (Mayes & Horwitz 2005). In light of the various challenges to the legitimacy of psychiatry, the empiricists sought to shore up the foundations of the field as a medical science. As the APA planned for the revision,

¹⁶ Emil Kraepelin was an influential German psychiatrist famous for attempting to create one of the first modern psychiatric nosologies. Kraepelin took a descriptive approach that stressed the importance of classifying disorders on the basis of observable symptoms and believed that research would eventually establish the biological origins of serious mental disorder (Shorter 1997; Young 1995).

¹⁷ Spitzer chaired the APA's Task Force on Nomenclature and Statistics, which coordinated the work of fourteen advisory committees and functioned as the main decision-making body on revision-related matters (Young 1995).

Spitzer observed that “the issue of defining the boundaries of mental and medical disorder cannot be ignored. Increasingly there is pressure for the medical profession and psychiatry in particular to define its area of prime responsibility” (Healy 1997:233). The group of psychiatrists tasked with revising DSM-II were determined to establish a nosology that differentiated disorders on the basis of symptoms while banishing traces of psychodynamic theories of etiology.

The intellectual origins of the DSM-III can be traced to the Feighner criteria developed by psychiatrists at Washington University with whom Spitzer had worked closely (Feighner et al. 1972; Horwitz & Grob 2016).¹⁸ The highly-influential Feighner criteria put forth fourteen distinct categories of disorder each accompanied by “a general clinical description together with a checklist of observable symptoms, with the stipulation that a certain number of these must be present to warrant a diagnosis, and a criterion concerning the time scale of the condition and implications of preexisting psychiatric conditions” (Rose & Abi-Rached 2013:120). The importance of the Feighner criteria was not so much the content of the categories of disorder, but the positivist manner in which those categories were constructed. Such criteria reflected a less-encompassing vision of psychiatric diagnosis that narrowed its objects of inquiry in accordance with a classical model of disease (Klerman 1978). Psychiatric disease entities should be mutually exclusive, reliably diagnoseable across clinical settings using measurable symptoms, and sundered from etiological assumptions of the sort found in psychodynamic practice. Research psychiatrists assumed that systematic classification following such principles

¹⁸ Washington University had served as the primary hub of psychiatric empiricism during the halcyon days of psychodynamic psychiatry (Horwitz & Grob 2016).

would yield data to which they could apply accepted epidemiological methods for validity testing (Feighner et al. 1972).

In order to operationalize the aforementioned principles, Spitzer and his colleagues needed a blank nosological canvas to work from, and as they began work on their revisions they were careful to highlight their atheoretical approach to the question of etiology. Previous iterations of the DSM were compatible with the psychodynamic embrace of unconscious and psychosocial causes of disorder, which, in the view of the empiricists guiding the revision process, was largely responsible for the diagnostic impasse from which psychiatry's crisis of legitimacy stemmed. From this perspective, so long as diagnosis was mired in subjective interpretations of amorphous conflicts playing out in the unconscious domain of the patient or fixated upon maladaptive responses to highly particular sets of circumstances, it would remain forever incapable of identifying its true object. For research psychiatrists, it followed from the lack of evidence in support of psychodynamic etiological formulations that the only responsible method for constructing a reliable nosology was to do away with causality altogether—unless the presumed biological origins of disorder could be identified—and rely solely on the observation of symptoms. While the “atheoretical” approach to etiology would prove a highly controversial issue at times during the revision process—particularly during a fiercely contentious debate over the future of the term neurosis—it ultimately carried the day.¹⁹ Wilson (1993:405) cites the minutes of the inaugural meeting of Task Force on Nomenclature and Statistics to describe the consensus of Spitzer's team on the issue:

¹⁹ One particularly controversial instance of the severing of etiology from disorder in the construction of the DSM-III was the attempt to remove any mention of the term neurosis, which Spitzer and his colleagues

It was the unanimous opinion of the Committee that etiology should be a classificatory principle only when it is clearly known, and that conventional speculations about etiology should be explained if they must appear...A diagnosis should be made if the criteria for that diagnosis are met...It is hoped that this will appreciate stimulation, among psychiatrists, of the distinction between the known and the assumed. In everyday practice, then, there will be fewer assignments to diagnostic categories on the basis of assumed correctness, and more diagnoses that force the clinician to admit what he does not know.

While this view was entirely consistent with the positivist approach to reforming psychiatric knowledge production, Spitzer was also aware that purging diagnosis of its unmeasurable psychodynamic elements would go some way toward placating the various actors outside of psychiatry who had cast doubt on the status of the field as a medical science (Healy 2000).²⁰

In its final form, DSM-III contained 265 distinct diagnoses—DSM-II enumerated 182—described over the course of nearly 500 pages. The increased number of diagnostic categories was presumed to have resulted from the introduction of a more rigorous approach to classification that was better-equipped to scope the specificity of distinct disorders. Final publication had been preceded by National Institute of Mental Health (NIMH)-sponsored field trials of the diagnostic categories, which, while yielding only moderately successful results, nonetheless conferred a certain legitimacy on the project (Grob 1994). Spitzer and his allies had succeeded in denuding the manual of psychodynamically-tinged references to etiology and, in their place, implemented a system

thought to be irredeemably tainted by its association with psychodynamic theory. This move was met with fierce opposition such that the approval of the revised manual seemed to be imperiled, and a compromise was struck to allow for DSM-II disorders defined as neuroses that were renamed in DSM-III to carry a parenthetical reference to neurosis; however, the DSM-III text explicitly states that the term should not imply the presence of any etiological process (Bayer & Spitzer 1985; Young 1995).

²⁰ More specifically, those responsible for drafting the document were concerned about crafting diagnoses in such a way that made them consistent with health insurance reimbursement policies and suitable for large-scale research endeavors dependent upon government funding (Healy 2000).

of classification that operationalized disease constructs on the basis of patterns discerned from symptomatology. In doing so, the field of psychiatry rejected the notion of a continuum of mental health that appeared in the various strains of psychodynamic theory in favor of a view of disorder that threw normality and pathology into stark relief by rigidly enforcing the criteria which needed to be met in order to confirm the presence or absence of discrete categories of disorder. The final approval of the DSM-III by the APA's Board of Trustees and subsequent publication marked nothing less than a complete reconsideration of psychiatry's epistemological underpinnings, moving the field "away from the fluid psychoanalytic understanding of mental illness toward a standardized nosology of fixed disease categories that was congruent with the model of specificity that dominated other medical specialties" (Horwitz & Grob 2016:530).

The advocates of psychiatric empiricism triumphantly framed the publication of DSM-III as the culmination of a battle between science and ideology within their field (Klerman et al. 1984; Sabshen 1990). The arrival of a new system of classification had released psychiatry from the grips of dogma and created a universal grammar that could be shared by all types of mental health professionals—with psychiatry, of course, positioned as the gatekeeper of knowledge production. Whereas previous iterations of the manual were irrelevant to the practices of many psychiatrists, DSM-III was quickly adopted as the authoritative text on mental disorder. Medical schools incorporated the manual into their curricula, venues for the publication of scholarly research demanded that authors reference its categories, and funding bodies expected research proposals to conform to its specifications (Young 1995). In addition, the specificity of DSM-III

diagnostic categories created a rationale for enhanced government-funding of mental health research programs targeting particular categories of disease while also opening the door for the pharmaceutical industry to develop psychopharmaceutical treatments with the potential to be tailored more precisely to unique disorders. The DSM-III also assuaged the concerns of both public and private insurers regarding the rather opaque nature of mental disorder and its treatment that had complicated reimbursement policies. Mayes and Horwitz (2005:265) summarize the vast impact of the revision:

The publication of the DSM-III in 1980 caused a revolution in psychiatry. It also triggered a paradigm shift in how society came to view mental health. Prior to the DSM-III, psychiatrists primarily targeted the underlying psychological causes of mental illness and disorder with psychotherapy. Alternative approaches, such as behavioral therapy, were subordinated to the dominance of psychodynamic theory and practice... With the DSM-III, they gradually shifted to primarily targeting the symptoms of mental illness and disorder with psychopharmacology, the use of drugs to treat mental illness. The direct and indirect institutional change the new manual produced extended far beyond psychiatry, because the DSM is used by clinicians, the courts, researchers, insurance companies, managed care organizations, and the government (NIMH, FDA, Medicaid, Medicare). As a classificatory scheme, it categorizes people as normal or disabled, healthy or sick. And as the definitive manual for measuring and defining illness and disorders, it operates as mental health care's official language for clinical research, financial reimbursement, and professional expertise. Few professional documents compare to the DSM in terms of affecting the welfare of so many people.

While the publication of the DSM-III may have gone a long way toward addressing the numerous threats to the field of psychiatry, its success was also related to the way in which it conferred "facticity" on its categories of disorder (Young 1995). In this view, facticity emerges not simply from the objective existence of a category of illness, but in the way that the category is historically-constituted using standardized diagnostic technologies and methods of verification commonly-accepted among researchers. In the case of DSM-III, Young (1995) contends that psychiatry was, for the first time, able to solidify the boundaries of mental disorder by fostering intellectual

conditions that allowed for the application of concepts of reliability and validity—roughly speaking, the consistency of diagnosis across practitioners and extent to which a disorder possesses intrinsic unity, respectively. The reliability of a diagnostic category is crucial to the vision of psychiatry promulgated in DSM-III not only as a technical issue but because of the way it helps to buttress objectivity:

Reliability is, by convention, a precondition for aggregating like cases for research purposes. The aggregation of large numbers of case is, in turn, a precondition for employing statistical technologies and generalizing findings beyond single research sites. It is these same technologies, together with their guarantees of reliability, that permit researchers to liberate cases from contexts and to decompose distinctively messy lives into uniform and universal constitutive elements. In this way, a technique's reliability is linked to its objectivity (Young 1995:102-103).

Validity has presented itself as a perpetually vexed question for psychiatry, but the point is that it, along with reliability, represent fundamental scientific concepts associated with the operationalization of constructs that the standardized definitional criteria for disorder advanced by DSM-III were amenable to. The challenge of actually establishing reliability and validity is a separate question; it is through the perceived ability to test these concepts in the pursuit of generalized, decontextualized biomedical knowledge that facticity gains its grip on the scientific imagination. Lakoff (2005:13) suggests that even though the authors of the DSM-III may not have intended for the document to be the final word on the nature of the disorders it delineated, their deployment of concepts like reliability and validity—and associated testing procedures—constituted a process of “professional normalization” through which consensus is established regarding the acceptable set of rules and norms for informing future refinement and revision of diagnostic standards.

The transformations to psychiatric diagnosis ushered in by the publication of the DSM-III have remained fundamentally intact. Two subsequent revisions (DSM-III-R in 1986 and DSM-IV in 1994) did not include substantive changes to the categorical system of classification, and despite the expression of deep misgivings from some quarters about the reigning paradigm ahead of the 2013 publication of the DSM-5, significant proposals for transforming diagnostic logic were rejected (Greenberg 2013; Horwitz & Grob 2016).²¹ One of the most consequential byproducts of the enduring legacy of disease specificity since DSM-III has been the reorientation of the search for the origins of disorder toward human biology. While the manual's approach to etiology was explicitly atheoretical—though, as I have discussed, the rationale for this strategy had everything to do with marginalizing psychodynamic theory—the endorsement of a classificatory structure that could be mapped to conventional medical models of disease at the very least gave tacit endorsement to the notion that discrete disorders had biological correlates. As it happens, Spitzer and a number of his colleagues did, in fact, demonstrate an explicit commitment to biological explanations for psychiatric disorders, and as the classificatory logic of the DSM-III reshaped psychiatry, proponents of a more biologically-oriented psychiatry were appointed to leadership positions in academic departments, government

²¹ During the revision of DSM-IV, the manual came under attack for its strict adherence to the principle of diagnostic specificity. Critics of the specificity principle contended that the distinctions between disorders were often arbitrary and perpetuated false corresponding belief in a distinct causal mechanism underpinning each category. If, as these critics suspected, there is significant overlap among disease categories, then the specificity model was impeding attempts to improve treatments. Finally, the binary assumptions regarding the presence or absence of mental illness built into the reigning paradigm were not sensitive enough to genetic variance in populations, the elaboration of which may lead to interesting scientific advances about the causal mechanisms behind various disorders (Whooley & Horwitz 2013). A dimensional approach to diagnosis was proposed, field-tested, and ultimately defeated with relative ease. According to Horwitz & Grob (2016:536), “The professional stakes of the document simply became too high to allow for anything other than tinkering around the edges of its categories of specific disorders. Despite the DSM-5 Task Force’s intention of introducing a new paradigm, the DSM-5 looks very much like its categorical predecessors.”

agencies, and on the boards of major scholarly journals (Rose & Abi-Rached 2013; Metzler 2003).

Rose (2007) identifies the decade from the mid-1980s to the mid-1990s as a turning point in biological psychiatry during which psychological space was mapped explicitly onto the brain. During this period a vast community of researchers spanning a variety of disciplines began to cohere and, through its output, produced an “apparatus of truth” that formulated theories of the somatic origins of psychopathology derived from the brain—represented as analogous to any other of the body’s organs—and its functions which “fuse cellular structures and molecular events” (ibid:189-190). Theories of psychopathology are produced through a delimited set of “truth technologies” encompassing

research involving correlations of psychiatric observations and diagnoses with assays of body fluids, cultures of tissues, scans of brain functions, DNA sequencing. There is the combination of genealogical, clinical, experimental, and statistical techniques characteristic of research in behavioral genetics...facts, observations, and explanations are only candidates for truth or falsity if their truthfulness is potentially ascertainable by one such authorized means. The new style of thought in biological psychiatry not only establishes what counts as an explanation, it establishes what there is to explain.

The mysteries of psychological interiority gradually gave way to a form of the “medical gaze” that aspired to the same sort of depth of vision that Foucault (1975) famously described as a core component of 19th century clinical medicine, except at this juncture it was trained directly on the structure of the brain.

The research advances in biological psychiatry that Rose describes increasingly came to be associated with neuroscience in the 1990s, and assumptions about the ability to map psychological space with fine precision in order to identify the anomalies that

shape disorder were pushed to their logical, reductive conclusion. Martin and others (Martin 2000, 2004; Tallis 2011) have analyzed developments in cognitive science and neuroscience in an attempt to outline the central tenets of neuroreductionism. In Martin's (2000:576) view the body that appears in neuroscientific accounts of behavior is "universal, unhistorical, unconscious of its own production, and possessed of many of the characteristics of modernist scientific accounts." Such a body is, in her analysis, the outcome of research in fields like computational neuroscience, where the brain is thought to "represent the world by means of networks of neurons" (ibid: 572). In the neuroreductionist perspective that Martin summarizes, cognition is governed by contained, autonomous neuronal networks; even where cognition is taken as an "emergent" property not fully explained through knowledge of molecular and cellular levels of the brain, it is assumed that such emergent phenomena will ultimately be reduced to lower-level brain activity into which the social learning characteristic of cultural practice will dissolve (ibid: 572). In the neuroreductionist account of behavior, then, environmental cues instruct the brain, but only in an extremely narrow fashion that remains largely independent of subjective reflection; indeed, environmental inputs are useful only to the extent that they allow brains to program the sorts of characteristics that might be considered adaptive in an evolutionary sense (e.g., rationality and capacity for moral reason).

Linking neuroreductionism with contemporary psychiatric practice, Rose (2000:487) argues that humans have come to understand themselves over the past half-

century or so as possessing a unique “somatic individuality.” Further elaborating on this concept, Rose (2007:188) contends that:

we human beings have become somatic individuals, people who increasingly come to understand ourselves, speak about ourselves, and act upon ourselves—and others—as beings shaped by our biology. And this somaticization is beginning to extend to the way in which we understand variations in our thoughts, wishes, emotions and behavior, that is to say, our minds. While our desires, moods, and discontents might previously have been mapped onto a psychological space, they are now mapped upon the body itself, or one particular organ of the body—the brain.

In recent times, the process of somaticization has extended its reach to thoughts, emotions, and behaviors which are now interpreted through the molecular lens of biological psychiatry. Molecular argumentation about the nature of mental illness brings into play a new vocabulary derived from an understanding of disorder emanating from anomalies in particular neurotransmitter systems, creating an explanatory framework in which psychiatrists are able frame diagnoses in terms of their relationship to serotonin, norepinephrine, receptor sites, and synapses (Rose & Abi-Rached 2013; Rose 2007). Deep interior space is thus made legible by way of cutting-edge research into neurochemical systems that deploys brain imaging technologies and compelling forms of visual simulation to ground its truth claims (e.g., functional Magnetic Resonance Imaging and Positron Emission Tomography) (Dumit 2003, 2004; Rose 2003, 2007). Given the sweep of the neuroreductive narrative in the contemporary moment, there is often a tendency to equate personhood with the health of the brain (Ortega & Vidal 2011). Rose & Abi-Rached (2014:21), however, point out that a more careful reading of this narrative indicates that it attempts to convey the message that not only do “our brains shape us, but also that we can and should act on our brains through our conscious decisions: reshaping our brains to reshape ourselves.” Such attempts to modify the self by altering brain

chemistry are consistent with psychiatry's primary treatment modality: psychopharmacology.

Psychopharmacology

As I have noted, large-scale custodial institutions began to fall out of favor as the preferred sites for the long-term care of the severely mentally-ill around the middle of the twentieth century. One of the key developments that allowed the deinstitutionalization movement to gain traction was the introduction of psychotropic drugs that facilitated the transfer of patients from institutional custody to community treatment. This early phase of modern psychopharmacology was not necessarily interpreted as a step toward the medicalization of psychiatry, and psychodynamic practitioners of the era gave consideration to the ways in which pharmaceutical consumption might alter patients' psychic makeup so as to make them more amenable to the dominant varieties of psychotherapy (Grob 1991; Hale 1995). Indeed, rather than undermining the authority of and shifting the emphasis away from psychodynamic therapeutic models, some of the most prominent early clinical drug researchers were also practicing psychotherapists who hoped that advances in psychopharmacology might, for the first time, help severely mentally-ill patients become suitable candidates for conventional therapies (Grob 1991). Nathan Kline (1959:454), perhaps the leading figure in early American psychopharmacology, suggested that "chlorpromazine and resperine [some of the first widely-used antipsychotic drugs] make it possible to quiet the schizophrenic sufficiently so that he can enter into psychoanalysis and tolerate the temporary threats of id

interpretations.” In the same way that dosages would eventually be regulated to efficiently modulate mood and behavior, Kline (ibid:454) viewed psychopharmacological intervention as a means of pacing therapeutic progress: “When the analysis loses its momentum, the dosage can be reduced until sufficient psychic pressure once again builds up. In this way the rate of analytic progress can be regulated by the analyst.”

The early convergence of psychodynamic psychiatry and the burgeoning field of psychopharmacology would prove to be brief, but it highlights the way in which the introduction of a new treatment modality interacts with prevailing forms of expertise to both determine appropriate use and set the agenda for subsequent knowledge production.

Lakoff (2005:10) argues that:

the effects that a given drug produces depend, at least in part, upon the milieu of expertise into which it enters. In this sense, these drugs are instruments whose function is shaped by the form of rationality in which they are deployed; they are the means to various possible ends. Tracing differences in their use and meaning provides a window into broader differences in regimes of health and forms of governance.

Pharmaceutical regulations implemented by the Food and Drug Administration (FDA) in 1962 gradually put an end to the dialogue between psychopharmacology and psychotherapy and aligned the former with the emergent expert discourse of empirical psychiatry (Marks 1997). In order to pass muster, the FDA regulations mandated that manufacturers needed to demonstrate that drugs produced specific, measurable effects in homogenous patient populations using randomized controlled trial methodology. Makers of psychiatric drugs found that this regulatory demand presented a particularly daunting challenge given the amorphous status of mental disorder and the notoriously unreliable diagnostic practices that accompanied it; however, the radical reforms to classification

and diagnosis that paved the way for DSM-III also allowed for compliance with the new regulatory regime (Lakoff 2005). As research psychiatrists furthered their project of recreating psychiatric disease categories through evidence-based practices, the standardized diagnostic criteria that they began to codify also helped to produce the sort of patient populations necessary for pharmaceutical testing. Emergent categories of mental disorder thus functioned as “boundary objects” that “inhabit several communities of practice and satisfy the informational habits of each of them. In working practice, they are objects that are able to both travel across borders and maintain some sort of constant identity” (Bowker & Star 1999:16). While psychopharmacology did not initially share a natural affinity with the ascendant biological view of psychiatric disorder, the empiricist model of disease classification and its attendant diagnostic practices helped to constitute new types of subjects that could be aggregated into patient populations useful both for solving dilemmas unique to psychiatry’s crisis of legitimacy and preparing new classes of drugs for mass consumption.

Over time, the merger of modern psychopharmacology with models of disease specificity fueled the idea that pharmacotherapy, beyond its utility in the stabilization of particularly troublesome patients, had the potential to target the origins of each variety of disorder at the neurochemical level. The potential for scientific advances set into motion a flurry of research and development activity in both the academy and industry that sought to isolate compounds the molecular structures of which might eventually allow for the fabrication of drugs to intervene in neurochemical anomalies. Rose (2007:200)

describes how new “technologies of psychiatric truth” took shape through large-scale psychopharmacological research efforts:

A whole experimental apparatus was brought into being for the development of drugs and the testing of hypotheses...New entities were brought into existence—receptor sites, membrane potentials, ion channels, synaptic vesicles and their migration, docking and discharge, receptor regulation, receptor blockade, receptor binding. These were first hypothetical, then demonstrated in the lab, then experimental entities in their own right, finally as realities that seem to be rendered visible by PET scans or other visualization techniques. New forces became involved, not just teams of research scientists...but also big grant-awarding agencies and, of course, the pharmaceutical companies. For these processes were not merely processes of discovery, but of intervention—the neurochemical brain becomes known in the very same process that creates interventions to manipulate its functioning.

This psychopharmacological research apparatus had, by the 1990s, given rise to and normalized a molecular style of reasoning that took for granted the unique relationship between the neurochemical basis of specific diagnostic categories and the mechanisms of action underlying new drug therapies targeting those categories.²² The complex interplay between nosology, neuroscientific research, and psychopharmacology created a new domain of neurochemical objects that could be interpreted as corresponding with DSM categories of disorder. These objects could seemingly be manipulated by pharmaceutical researchers to target the mechanisms of brain-based disorder with ever-increasing accuracy; disorder and treatment were mutually-constitutive.

The final decades of the twentieth century saw an exponential increase in psychopharmaceutical prescription rates in the United States that reflected the significant investments in research and development endeavors that sought to bring new, more sophisticated drugs into the market. As I have mentioned, this period saw the widespread

²² This occurred despite a significant amount of evidence calling into question the notion of drug specificity in the case of psychopharmaceuticals (Moncrieff & Cohen 2005; Healy 1997, 2001).

adoption by psychiatrists of pioneering classes of drugs (first, Selective Serotonin Reuptake Inhibitors (SSRIs), and more recently, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)) that were thought to represent the therapeutic culmination of cutting-edge research on the neurochemical correlates of psychiatric disorder. Prozac, the example par excellence of the SSRS drug class, “did not become an iconic drug because it was more effective than previous antidepressants. Its status was based on its claim to be the first drug whose molecule had been deliberately fabricated to disrupt one, and only one aspect of a single neurotransmitter” (Rose 2007:201). The introduction of new drugs was complemented by direct to consumer marketing campaigns that encouraged disease awareness and asked potential consumers to consider whether or not their everyday anxieties might actually be indicators of the presence of a treatable illness (Moynihan, Heath & Henry 2002).

Advances in modern psychopharmacology gave patients hope that drugs would not only help them to cope with symptoms and, to some extent, normalize everyday life, but also that the increased precision of psychopharmaceutical mechanisms might fundamentally restore or enhance human capacity. Rose (2007:222) contends that the purpose of consuming psychiatric drugs is not so much to cure, but to “modify the ways in which vicissitudes in the life of the recipient [of medication] are experienced, lived, and understood.” Pharmacotherapy now extends to the disordered individual the prospect of recovering one’s “true” self, a self that must, in part, be produced through an assemblage of medication compliance, mood hygiene, and participation in biosocial communities (Martin 2007; Rabinow 1996; Rose 2004). The location of disorder at the

neuromolecular level, more than any other psychiatric development, has altered understanding of human capacity and responsibility among those suffering from mental illness: it both promises a restoration of the self and demands adherence to particular forms of conduct in order to maintain a stable form of personhood. Rose (2007:223) observes that “the forms being taken by contemporary neurochemical selfhood, the blurring of boundaries between treatment, recovery, manipulation and enhancement...are intrinsic to the continuous task of monitoring, managing, and modulating our capacities that is the life’s work of the contemporary biological citizen.” For people coping with serious mental illness, molecular reasoning and its truth claims alter understandings of personhood by translating disturbing forms of experience into technical categories and raising questions about appropriate forms of self-conduct (particularly as they pertain to illness management and recovery), a point that I will return to later in this dissertation. As Lakoff (2005:3) puts it, “To ask about the site of disorder is to ask about ways of knowing—and working on—the human.”

Community Mental Health

I previously discussed the rise of community mental health in the context of the convergence between deinstitutionalization and the rethinking of psychiatry’s classificatory and diagnostic systems, noting that the United States had seen an extraordinary reduction of its institutionalized population in 1980 from its peak in the 1950s. As public outcry over the poor conditions in some of the nation’s large mental

hospitals intensified, mid-century policymakers and researchers in the newly-formed National Institute for Mental Health (NIMH) began to conceive of mental illness as a public health problem amenable to population-level interventions that might help some to avoid long-term hospitalization altogether. Around the same time, advances in psychopharmacology led to some of the first large-scale attempts to prescribe drugs—particularly chlorpromazine—that promised to facilitate the discharge of hospitalized psychiatric patients. A new consensus began to emerge around the idea that treating psychiatric patients in the community was not only more humane than custodial treatment in hospitals, but also likely to be more effective.

In the 1960s, an atmosphere conducive to social change helped to accelerate the move away from institutional treatment for psychiatric patients toward an emphasis on community-based care. Psychiatry became the target of activists who viewed it as a mechanism of social control, but the field—at least in its institutional form—also garnered attention from policymakers working to expand the social safety net. This attention led to the enactment of legislation, most significantly the Community Mental Health Centers Construction Act of 1963, which directed state and county hospitals to release patients who did not pose an immediate threat to themselves or others and advanced the notion that comprehensive mental health services should be provided by specialty community clinics (Grob 1994; Shorter 1997).

The legislation and its underlying philosophy were fundamentally byproducts of the sweeping changes to the American welfare state unfolding in the 1960s:

The creation of CMHCs came during a decade when mental health rhetoric and ideology paralleled newly enacted federal social and economic programs designed to eliminate poverty. Both grew out of the belief that the origins of most social problems could be found in a deficient environment... Faith in the redemptive qualities of modern psychiatry was fused with demands for social justice, for an end to structural barriers that impeded individuals from realizing their full potential, and for the realignment of mental health services at the community level. Community psychiatry was nothing less than a psychiatric revolution that would saturate a given geographical area with services that would provide both preventive and therapeutic services for all families (Grob 2016:8).

Unfortunately, the spirit of the legislation represented “a victory of ideology over reality,” and there was little in the way of substantive policy descriptions of the actual mechanisms by which the proposed community mental health model would assume the duty of care that rapidly downsizing mental hospitals had previously been tasked with (ibid:7). The future client base of the community mental health clinics was described in “global and protean terminology” and it was assumed, without any evidence of note, that “patients had a home in the community; that a sympathetic family would assume responsibility for the care of a released patient; that the organization of the household would not impede rehabilitation; and that the patient’s presence would not cause undue hardship for other family members” (ibid: 8).

By the 1990s, it became clear that many of those suffering from mental illness who would have been long-term inpatients prior to policies promoting deinstitutionalization were now often found living in communities without the necessary resources to meet their basic needs due to the impact of failed policies (Shorter 1997; Torrey 1997). While safety-net expansion in earlier decades afforded mentally-ill individuals basic subsidies to cover the costs of various types of treatment and housing—mainly through federal entitlement programs like Medicaid, Supplemental Security Income and Social Security Disability Income—community-based services frequently

lacked funding and coordination, posing significant obstacles to the management of psychiatric symptoms among the deinstitutionalized (Mechanic & Rochefort 1990). In addition, the 1970s saw the growth of a cohort of young adults experiencing the onset of severe psychiatric disorder outside of institutional settings for the first time; the social isolation, homelessness, scattered spatial distribution, and co-occurring disorders (substance use and mental illness) common in this population further strained existing community health resources (Brodwin 2013; Estroff 1981; Grob 2016). A diffuse network of professionals from fields with sometimes conflicting mandates such as social work, law enforcement, and medicine all had a hand in the lives of those with severe and persistent mental illness, but these actors had little awareness of one another's roles and procedures and found it challenging to communicate. Unlike the era of the total institution, no single entity bore responsibility for the well-being of those coping with severe and persistent mental illness (Grob 1994; Mechanic 1989).

In their race to transition from an era of confinement to one of enlightened community-based treatment, policymakers had not given due consideration to the varied supports that such a transformation would require (Bachrach 1990; Mechanic 1989). "In particular," observes Brodwin (2013:34), "reformers overlooked how housing, income support, and social connections affect the well-being of people with disabling symptoms. The stepwise process by which the state abandoned people with serious mental illness thus produced an entirely new cluster of clinical needs and social dilemmas." Federal funds filtered down into states and counties via entitlement programs where they were distributed to contracted providers of various sorts of housing and psychiatric services for

mentally-ill populations. These providers often found that reimbursement worked in their favor when the quantity of people served was emphasized over the quality of services. Providers were also often assessed on the housing and job placement rates of their clients, sometimes leading them to avoid potential clients with the most intractable problems (Tessler and Goldman 1982). The outcome of these circumstances was, ironically, the reproduction of the sort of neglect and substandard care that had been a crucial factor in the closing of large mental hospitals in the first place (Mechanic 1989; Mollica 1983).

In response to the less than desirable outcomes of deinstitutionalization that first became apparent in the late 1970s, federal policy began to shift toward an emphasis on rehabilitation and supportive services of indefinite duration. One of the clearest articulations of this new orientation appeared in the Community Support Program (CSP), an NIMH-designed comprehensive blueprint for community mental health service delivery that grew out of attempts to account for the failures of deinstitutionalization (Turner & TenHoor 1978). Broadly speaking, the CSP endorsed a holistic model of community support that sought to transcend the narrow focus on mental health treatment and called for the integration of multiple systems of care. Under this model, community health treatment would be more carefully aligned with related social and rehabilitative services including primary health care, crisis response, employment readiness, housing, entitlements, peer and family assistance, and substance abuse treatment (Turner 1977). CSP was intended to aid the redesign of state and local community mental health programs through federal grant-making, but it had the misfortune of emerging alongside Reagan-era fiscal austerity, which limited funding of its type. Still, CSP

established a broad outline for reorganization of service delivery that was implemented in various programmatic iterations by local agencies over the next few decades (Brodwin 2013). The narrow focus on treatment that had prevailed in visions of community psychiatry to that point made way for a new emphasis on systems integration, continuity of care, rehabilitation, and recovery that still sets the agenda for popular community mental health models today.

While the CSP functioned as a kind of high-level directive, it was up to states and local governments to test model programs that incorporated its central tenets and then to scale up those programs deemed most effective. The trajectory of this process moves from the ideal state outlined in the CSP and then:

diffuses downward to the level of particular mental health agencies, where frontline workers translated ideals into workable programs on the ground. Individual clinicians used real-time, trial-and-error learning to figure out how to keep clients stable outside the hospital. In the third step, the results of their experimentation were scaled-up, inserted into disciplinary discourses, and repackaged as manuals and templates generalizable to other settings...the standardized and transposable model for community services was legitimized by academic research, and it had broad effects in mental health policy and state law (Brodwin 2013:39).

Brodwin (2013) describes how Assertive Community Treatment (ACT)—the dominant model of coordinated service provision in contemporary community mental health—and similar community mental health initiatives have engaged in a process of model experimentation followed by collaboration with researchers to deliver services in a standardized way such that outcomes can be measured to determine whether or not evidence of effectiveness exists. Once an evidence base is built around findings derived from randomized controlled trials and quasi-experimental research designs, model programs can be removed from the highly particular worlds of social work practice in

which they are tested and deployed in heterogenous settings across the country and, in the case of ACT, the world.

Brodwin (2013) argues that the evidence-based movement in program design dovetailed nicely with the changes to classification and diagnosis that accompanied the DSM-III revolution in psychiatry. Just as research psychiatrists found that they could stabilize discrete categories of disorder through standardized, thoroughly-researched diagnostic practices, so too could researchers evaluating the effectiveness of community mental health interventions apply a similar data-driven, empirical approach:

The DSM-III aimed to rationalize psychiatric research as a scientific enterprise by providing stable and mutually exclusive categories for disease. With these stable categories in hand, all researchers could be confident they meant the same thing by *schizophrenia* or *depression*. The Madison group [prominent early ACT researchers] applied the same logic to mental health services. They measured outcomes in a way that invited further refinement and testing, with validated and reliable instruments that quantified community adjustment, self-esteem, family burden, and so forth. With these outcome measures in hand, researchers across the country could replicate the program and test it against other modes of treatment (ibid:42).

Like the question of diagnostic specificity, the matter of developing model community mental health programs becomes a technical issue requiring the application of certain forms of expertise to gather evidence within particular parameters. Once sufficient evidence of effectiveness is gathered, then a successful program can be replicated in a variety of settings assuming fidelity to standards and protocol is maintained.

The preference for proven community mental health models allowed for the diffusion of a fairly unified set of community psychiatry practices that have been implemented by most public health and human service agencies and their various partners. While earlier clinically-oriented models mainly assumed chronicity—and, accordingly, emphasized stabilization and avoidance of rehospitalization—contemporary

community mental health practices often find their philosophical grounding in the concept of recovery.²³ This notion of recovery is deeply rooted in core American concepts of the individual. Those dealing with psychiatric illness are active “consumers” of services who should feel empowered, autonomous, and independent as they become responsible for making choices about their future that will positively transform their lives (Myers 2015). In recovery-oriented models, it is expected that services will not only stabilize symptoms, but also allow the individual to “return to the life one might have been expected to lead if one had never become ill—or possibly even a better life” (ibid:4).

Given the challenges faced by those coping with severe mental illness, recovery is understood to be a potentially fraught process that, while not necessarily linear, assumes gradual growth and personal transformation (Crowley 2000; Ralph 2000). Some influential proponents have suggested that not only is recovery a process, it is

a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again... The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (Deegan 1988:15).

While mental health providers should draw from a core set of evidence-based interventions, the specific services provided should reflect goals established by the consumer (Drake et al. 2001).²⁴ Service provision should be a collaborative process that

²³ Recovery was endorsed as a fundamental pillar of community mental health in 2003 by George W. Bush’s President’s New Freedom Commission on Mental Health. Little detail was provided as to how the concept should be operationalized in policy (Grob 2016).

²⁴ Key evidence-based practices include “prescription of medications within specific parameters, training in self-management of illness, assertive community treatment, family psychoeducation, supported employment, and integrated treatment for co-occurring substance use disorders” (Drake et al. 2001).

fosters a sense of agency so that the recovering consumer can integrate—or reintegrate, in the case of those cycling in and out of short-term hospital stays—into a community of one’s choosing in a way that is meaningful to them. The vision is ultimately one of a productive, self-reliant citizen working and participating in a community of their choosing rather than one of the chronically-ill patient (Myers 2015; Solomon & Stanhope 2004).

This recovery model is largely consistent with what Mol (2008) calls the “logic of choice,” in which a premium is placed upon patients’ ability to exercise autonomy in decision-making about their care. Mol observes that such an approach can have serious drawbacks for individuals dealing with chronic symptoms because it creates a set of circumstances in which people expect to achieve a relative degree of “normality” and can then come to experience inevitable symptom relapses as moral failings.²⁵ Similarly, Brodwin’s (2013) ethnography of ACT details the conflicts that emerge between the goals and needs of clients and the standardized procedures that overburdened case managers must carry out as they relate to medication management, adherence to treatment plans, and the provision of billable services. In the contemporary community psychiatry landscape, various types of case managers (typically mental health professionals with the least professional prestige) act as representatives of multiple forms of expert knowledge and authority but have less room to maneuver relative to past eras as

²⁵ Mol contrasts this model with a “logic of care” in which there is acceptance of the fact that individuals are not always completely capable of making independent choices and an acknowledgement of continued disability that might yield different types of supportive relationships between patient and provider (Mol 2008).

they attempt to meet the needs of severely mentally-ill clients in the community.

Brodwin (ibid:53) writes:

When mental health from psychiatry and social work scaled up their nascent programs, they standardized and rationalized the roles of all clinical personnel. Case managers were inserted into a particular slot on the ACT team...manuals and (especially) state codes meticulously define case managers' activities in line with bureaucratic needs for surveillance. The guidelines substitute algorithms and explicit lists in place of judgments based on accumulated clinical experience...Over the years, their [case managers] job has become hedged in by organizational and technocratic restrictions...By design, they have the most exposure to and closest relation with clients, but the least authority over decisions about diagnosis, medication, and hospitalization.

In this critique of the contemporary community health paradigm, expert forms of knowledge allow for the formation and widespread implementation of coherent programs, but those programs structure relationships between staff and clients in ways that sometimes conflict with the forms of individual autonomy that they hope will propel the recovery process.

The emphasis on individualized recovery in contemporary community health models also reflects the fraught historical relationship between psychiatry and difference in the non-institutional spaces that the former has been projected upon. Raz (2011, 2013) contends that psychiatry's conceptualizations of the role of community in psychological wellbeing were anchored by white, middle-class assumptions that became visible in mental health experts' contributions to policies associated with the War on Poverty. In this context, mental health experts argued for the foundational role of the theory of cultural deprivation in the formulation of social policy.²⁶ Deprivation theorists encouraged policymakers to understand poverty in terms of deficient family structures and deviant social habits in troubled neighborhood environments. Cultural deprivation

²⁶ Raz discusses the contributions of psychiatrists and other mental health experts to the development of major anti-poverty programs like Head Start.

understood poverty not simply as an economic condition, but as “a distinct socio-cultural pathology that caused academic and even intellectual disadvantage and social disability,” outcomes which reproduced themselves over time (2013:37). Theorists of cultural deprivation and poverty invoked a colorblind discourse that hinged upon the category of “low-income” people living in urban centers in their discussion of interventions focused on individual deficits and shortcomings, thereby eliding the overtly racial dimension of their work. As was the case with famous contemporaneous policy and social science investigations into the nature of poverty, mental health specialists saw individual rather than structural/institutional pathology at the root of poverty and fashioned policy recommendations accordingly.²⁷ Psychiatrists working on cultural deprivation issues implicitly signaled their endorsement of a model of community as the embodiment of white middle class values and gendered vision of labor as they described the deficits of low-income groups:

Liberal-minded experts and politicians expressed confidence that they could effectively identify and provide what the poor needed. These perceived missing components often reflected a moralizing psychological interpretation of the personal failings believed to be common among low-income and particularly minority groups. Children were unloved or unstimulated; mothers were deficient both in their homemaking abilities and in their capacity to understand and care for their children; fathers lacked self-esteem and positive masculine role models (ibid:170).

The concept of community is, as I have noted, under-theorized in community mental health literature, and the unfounded early optimism regarding the positive social supports inherent to the concept may well have been grounded in the sorts of naturalized assumptions about how community is lived that I have described here; such assumptions allowed for the shortcomings of deinstitutionalization for marginalized groups to be

²⁷ The work of the cultural deprivation theorists is part of a broader genre of work that informed policy debates by explaining poverty as an outcome of various pathological social and cultural characteristics of racial Others (Lewis 1969; Moynihan 1965).

framed in terms of individual deficits and pathology rather than the social determinants of health.

While contemporary community recovery models aim to empower people and address their needs in a holistic fashion, they often fail to meaningfully incorporate the challenges faced by people struggling both with mental illness and social inequalities. The individual locus of control at the core of recovery models does not address the challenges and constraints faced by those whose everyday lives are impacted by deeply unequal social arrangements. Mills (2015) suggests that the “psychiatrization of poverty” is increasingly translating the political, systemic origins of difficulties faced by people living in marginalized communities into biomedical categories amenable technical solutions. For Mills, the question is not so much whether poverty causes mental illness or vice-versa, but, rather, why it seems that those living in poverty are increasingly likely to be diagnosed with a psychiatric disorder. Hansen, Bourgois, and Drucker (2014) argue that the late twentieth century retrenchment of the American welfare state restricted access to key income support benefits and made the presence of psychiatric diagnoses one of the key eligibility criteria justifying receipt of such benefits. This shift toward the medicalization of welfare is an emergent mechanism for the pathologization of marginalized groups who, characterized as predisposed to psychiatric illness, must frequently comply with mental health screening and the psychotropic drug consumption requirements in order to remain eligible for benefits (Hansen, Bourgois, & Drucker, 2014; Schram, 2000). The sort of independent, self-directed course of recovery that informs a number of community mental health models becomes complicated in instances

where forms of difference are medicalized and constraints associated with marginality mediate people's engagement with mental health services and psychiatric knowledge. Choice and autonomy as fundamental characteristics of the recovering individual must be considered in light of submission to pathology as a means of accessing resources as one considers the implementation of community mental health models across varied settings.

Service provision at IRTS facilities reflects many of the practices and tensions that I have outlined here. IRTS sits in the space between psychiatric hospitalization and independent living; it offers a place in the community (often, in fact, the very geographic community that clients will ultimately reside in) for those in recovery and provides a structured experience as they transition toward living on their own. Under the roof of an IRTS, clients engage in therapeutic activities that use evidence-based best practices (e.g., Illness Management and Recovery) and regularly check in with counselors to discuss and revise goal-oriented treatment plans. Clients also often interact with peer support specialists and other staff who act as conduits to additional services (e.g., assistance with applications for various benefits, housing, ACT, education, and employment) that will lay the groundwork for their reintegration into various communities. Despite the fact that IRTS clients are not completely independent, supervision is minimal, and they are permitted to come and go as they please, to some extent. The ethos of recovery permeates the content of therapeutic programming, but the liminal space-time of IRTS causes many clients to pose questions that hint at their ambivalence toward the issue of managing serious mental illness in the community. As they reflected on their impending departure from IRTS facilities, participants outlined a structure of community

encompassing legal issues (upcoming criminal proceedings or the restrictions imposed by civil commitment), social life (embeddedness in harmful social networks and estrangement from social support, absence of relatedness), continued access to professional care, and structural conditions (poverty, underemployment) that conflicted with or challenged the forms of personhood—often incorporating components of the philosophy of recovery—they were attempting to enact.

Conclusion

In this chapter, I have outlined the historical processes that converged to produce contemporary psychiatric reason and its accompanying forms of knowledge production, treatment modalities, and means of service provision. Today, psychiatry understands mental disorder to be comprised of objective categories of disease that stem from neurochemical anomalies. The preferred—and often only—form of treatment available to those coping with psychiatric illness is pharmacotherapy, which involves the use of drugs that have been fabricated with the express purpose of intervening in neurochemical processes specific to the diagnosis of the patient. For all but the most severe cases, treatment occurs in community settings where, in addition to drug treatment, individuals come to rely on a diffuse network of mental health professionals and social service agencies to achieve stability and maintain independence.

This arrangement has its origins in the resolution of a mid-twentieth century crisis of legitimacy in the field of psychiatry that involved a fundamental rethinking of what mental illness is and how it can be diagnosed. The resulting system of classification

emphasized the correlation between observable symptoms and discrete disorders and largely set aside etiological concerns where they were not directly linked to human biology. Significant resources were directed toward large-scale research efforts that brought together an array of experts to refine this understanding of mental illness and develop psychopharmaceuticals intended to target specific disorders with increasing precision. These transformations were accompanied by the dismantling of traditional custodial settings and the projection of psychiatric reason onto quotidian community experience. I will now turn to these community settings to examine how psychiatric experience is enacted in small-scale treatment facilities where young adult clients of mental health service providers contend with the implications of diagnosis and illness management for the formation of personhood.

Chapter III. The Work of Recovery

Introduction

In this chapter, I describe the processes through which IRTS clients become enmeshed in what I call the “work of recovery.” The work of recovery refers to the way in which selves are reconstructed in treatment and rehabilitation settings after psychiatric emergencies through diagnostic processes, educational activities that promote particular forms of self-management, and psychopharmaceutical consumption; this is a collaborative process through which IRTS clients and staff reckon with symptomatology in an attempt to lay the groundwork for the emergence of a reconfigured personhood. IRTS rehabilitation offers participants the opportunity to make sense of unsettling symptoms by mapping those symptoms to diagnostic categories, which function as a kind of gateway for the reconsideration of the self in terms of chronic mental illness rooted in neurobiology. I argue that successful recuperation of the self involves acceptance of an ethical imperative to indefinitely and independently manage symptoms in a way that will optimize one’s ability to productively participate in community life. At the same time, I emphasize the heterogeneity of participant responses to and interpretations of the lessons of rehabilitation. I argue that the everyday demands of clinical practice in IRTS settings lead to diagnostic approaches that sometimes conflict with client histories of illness and explanatory models, leading to an impasse at which clients who do not accept conventional psychiatric readings of experience are deemed to be lacking in insight and thus become poor candidates for self-fashioning projects.

My theoretical approach to psychiatric self-fashioning attempts to reconcile two often divergent positions. I draw upon a subjectification framework that emphasizes the way in which psychiatric rehabilitation functions as a kind of political technology comprised of an array of techniques for relating to and acting upon the self; the practice of these techniques is an effect of power and a medium of governance through which participants occupy certain psychiatric subject positions. The use of subjectification is inspired by a conceptual framework associated with Foucault and other post-structuralist thinkers who have theorized the ways in which the modern subject produces itself through agentive, intentional forms of social action that function as enactments of dominant rationalities; such rationalities are, in practice, modes of governance that operate through illusory appeals to freedom and choice (Butler 1997; Cruikshank 1994; Dean 1994; Foucault 1977, 1978, 1982; Foucault et al 1991; Rose 1996, 1999b).

My research suggests that the application of a subjectification framework to questions of health resonates deeply with elements of the work of recovery. As IRTS clients begin to participate in group-based mental health education and rehabilitation they are introduced to a variety of “technologies of the self” through which they are encouraged to regularly monitor affective states and take responsibility for intervening in abnormal processes; adoption of practices intended to shape conduct in a way that optimizes mental health is framed as a crucial step in paving the way toward recovery (Foucault et al. 1988). Such incitements to act upon the self—endorsed by most of the IRTS clients I met—are consistent with Rose’s (2007:23) contention that contemporary

biological citizenship compels individuals to constantly track indicators of well-being and independently implement changes in order to boost human capacity:

The new psychiatric and pharmaceutical technologies for the government of the soul oblige the individual to engage in constant risk management, to monitor and evaluate mood, emotion, and cognition according to a finer and more continuous process of self-scrutiny. The person, educated by disease awareness campaigns, understanding him- or herself at least in part in neurochemical terms, in conscientious alliance with health care professionals, and by means of niche-marketed pharmaceuticals, is to take control of these modulations in the name of maximizing his or her potential, recovering his or herself, shaping the self in fashioning a life.

While the subjectification framework allows for a useful theorization of the operation of power in the fostering of psychiatric subject positions, it takes a fundamentally anti-humanist position that is often too totalizing to account for the complexities of people's lived experience in everyday settings such as IRTS.

To account for the indeterminacy of lived experience, I derive the concept of the work of recovery from Obeyesekere's (1985) notion of "the work of culture," which he uses to describe the methods through which affective states become meaningful against a particular cultural backdrop. Obeyesekere (ibid:147) understands the work of culture to be "the process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols." Using a case study that highlights the peculiarity of the concept of depression in the context of Buddhist existentialism, Obeyesekere emphasizes the interpretive malleability of affect (or symptoms, as the biomedical perspective would have it). He suggests that the raw materials of difficult human experience—whether one wishes to assign them to the category of affect, emotion, or symptom—need to undergo a process of symbolic transformation in order to become legible to a specific set of social actors. Furthermore,

Obeyesekere underscores the contingency of this process of transformation, even within highly-distinct cultural worlds; participating in this sort of labor implies failure and the occasional inability to render affects meaningful.

The work of culture is evident in the trajectories of the lives of the young adults that I met at IRTS facilities. Many of these individuals had taken up residence in an IRTS facility in the aftermath of the first instance of an acute psychiatric emergency. Events of this type are frequently so extreme in nature as to culminate in a kind of unmaking of the self as strange, unfamiliar symptoms overwhelm existing explanatory models, leaving the individual unmoored and frightened by their inability to comprehend experience. In the wake of such events, the self is remade through a process of stabilization, diagnosis, and rehabilitation that relies upon forms of psychiatric expertise to translate symptoms into disorders. While formal diagnosis merges symptoms with categories of disorder, a host of supporting rehabilitative activities deploy psychiatric knowledge in ways that allow clients to craft meaningful narratives out of past experience and consider the implications of disordered subjectivity for the types of futures that they seek to inhabit. At the same time, as Obeyesekere suggests, the work of culture is often incomplete or failed; diagnoses are frequently contested or reshaped in accordance with alternative interpretive frameworks that highlight components of life histories that clients feel clinicians have neglected or misunderstood.

I bring the two aforementioned approaches together as I describe the ways in which the work of recovery deploys projects of psychiatric self-fashioning to reconfigure lives in the wake of emergency and produces possibilities for new forms of personhood that are intended to guide participants' transition back to their communities. First, I begin with the story of Andrew, a participant whose experience encompasses the key features of the work of recovery. After recounting Andrew's story, I draw out each of these features in greater detail, beginning with a description of the ways in which severe psychiatric symptoms challenge participants' interpretive capacities and ultimately leave selfhood unmoored. Next, I turn to the ways in which IRTS staff produce diagnostic assessments and how clients make sense of diagnoses; diagnosis is a fluid, trans-institutional process that sometimes diverges from psychiatric reason in ways that clash disruptively with participant understandings of illness. From there, I discuss the rehabilitative activities that unfold at IRTS and describe the ways in which clients are encouraged to draw upon dominant psychiatric conceptual frameworks to develop knowledge of the chronically-ill self and then monitor and act upon that self indefinitely. Anchoring these activities is extensive use of pharmacotherapy, which, as a means of addressing the dominant psychiatric metaphor of chemical imbalance, both enables practices of self-governance by stabilizing symptoms and also compels their indefinite enactment as a component of psychiatric personhood due to the fact that chronic disorder leaves the client at perpetual risk of relapse.

Andrew

I want to begin by recounting the story of a participant, Andrew, whose experience reflects many of the themes central to the work of recovery: how young adults understand mental illness, use what they learn at IRTS to reframe unsettling memories of the past, conceive of the self, and imagine possibilities for the future. My interview with Andrew took place in a small city about an hour south of Minneapolis. On a rainy mid-summer afternoon, I made my way down the city's thoroughfare and through a small business district, passing a diner and a locally-owned hardware store before quickly transitioning into a quiet residential area with a housing stock comprised of well-maintained Victorian homes. Like so many of the other sites where community-based mental health care services are provided, the IRTS facility where Andrew was residing blended seamlessly—to the outsider, at least—into the surrounding community.

I arrived at my destination, a large Victorian, and followed the front walkway up to a wraparound porch where several young men sat on a bench smoking. I told them that I was looking for Andrew, and they suggested that I let myself in the front door. Upon entering, I found myself in the living room where a few more residents lounged in front of a television broadcasting a daytime talk show. After I introduced myself, one of the residents disappeared in search of the supervisor, and I was soon greeted by the director of the facility. She showed me into her small office just off the living room

where I would conduct the interview and excused herself to go and let Andrew know that I had arrived.

After a few minutes, a young man wearing a bright yellow tee-shirt bearing the M & M logo and sporting a goatee entered the room and introduced himself as Andrew. We shook hands and settled into chairs on either side of a desk for the interview. Like many of the young adults I met, Andrew defied common stereotypes about how people battling severe mental illness present themselves. Andrew was well-groomed in appearance and able to articulate thoughtful, cogent responses to my many questions throughout the duration of our hour-and-a half conversation. In addition, he was good-natured and exhibited a keen sense of humor with regard to his circumstances and the difficulties that his symptoms had caused him.

Andrew was raised in and around the community where I met him. After high school he joined the National Guard, where he first began to experience the symptoms that would result in his initial psychiatric diagnosis, schizoaffective disorder. Andrew excelled during National Guard basic training but, before long, began to be troubled by dramatic mood swings. After these symptoms became overwhelming, he was hospitalized and his condition stabilized. Thinking that the episodes of unusually depressed or elevated mood that he was experiencing were a normal response to the stress of basic training, Andrew quickly resumed his duties only to relapse again, leading to discharge and a diagnosis of bipolar disorder. At the time of the interview, Andrew was

receiving temporary retirement pay from the National Guard—about a quarter of normal his normal salary—and was eligible for this amount for up to five years, along with other benefits.

After his stint in the National Guard, Andrew returned home and entered what he called “a downward spiral.” During this period, Andrew stopped taking the medications that had been prescribed by National Guard physicians and subsequently experienced a series of unfortunate events that included alcohol abuse, being kicked out of his mother’s house, defacing his father’s tombstone, accumulating a significant amount debt, and living out of his car for an extended period of time. He described some of the events of this period to me, including a “manic episode” that would lead to an arrest and civil commitment:

Mainly it was behaviors that were uncharacteristic behaviors including poor decision-making, not well thought out plans at all. Frivolous expenditures causing a huge amount of debt, and finally I had a major manic episode where I was found naked downtown. It was early in the morning so it wasn’t that I was necessarily flashing a number of people but it was still indecent exposure and I just was not thinking straight.

Reflecting on this period, Andrew remembers feeling as though he was on top of the world and that all of the decisions he was making were perfectly rational. The cumulative impact of these actions finally led to about a month of inpatient treatment at a psychiatric hospital after which Andrew transitioned into the IRTS program. After being evaluated by staff in the psychiatric hospital, Andrew’s diagnosis was modified to bipolar disorder with psychotic features.

Andrew's symptoms were stabilized, and he moved from the hospital to the community-based treatment facility where I met him. During this phase of his recovery, Andrew began to participate in illness management and recovery groups. In group discussions and activities facilitated by mental health professionals and in more informal conversations with other residents, Andrew arrived at a better understanding of mental disorder and its implications for his sense of self. During our discussion, Andrew drew a sharp distinction between *having* a disorder and *being* disordered. In addition, he carefully explained the implications of having a disorder for how he might forge an identity as he reestablishes social relationships during the process of rejoining his community:

I *have* a disorder, I'm *not* the disorder; that's the biggest lesson that needed to be learned when I was diagnosed...If I understand my illness I feel that I can better explain my illness to somebody else. Explain why I acted weird when I acted weird and explain that not all of the time I spent with my old friends was necessarily me in a manic stage. I would fluctuate, and so you enjoyed a good portion of me; the stuff that you didn't like, that was mainly my manic stage. With me understanding it, it's a confidence thing as well as, uh, an understanding. I feel that I need to understand my own illness so that I can recognize, okay, you know, I'm kind of feeling this, this way. I feel like I'm maybe I'm talking too much or in a rapid rate, or my brain is just flying through thoughts; or maybe on the other side, it's like I feel really slow; I feel disconnected; I feel, you know, backed in a corner watching myself out in the middle of the room. So those are the highs and lows, and I think that by actually getting a document that describes what bipolar type whatever it is, it'll help me understand it to where I'm more comfortable saying 'you know what, I have to tell you something pretty big about me, and this is it. You can still be my friend, and I'm not gonna wig out or anything like that. Put it out there and let the decision be made by them. I feel that there's a good chance that bipolar's something I'll have to deal with the rest of my life, and I'm comfortable with that.

When I interviewed him, Andrew observed that he occasionally experienced spells of sadness derived from a sense of loss; he felt as though he no longer had close friendships and that his actions had left him estranged from many of the people and places that were familiar to him. He did, however, find social support in kinship relations, particularly through his mother and brother. During treatment, Andrew was

able to renew his relationship with his mother, who provided him with the type of encouragement necessary that he needed to begin rebuilding self-confidence. Andrew also mentioned that his brother, who would soon be returning from National Guard duty, would act as a close confidant. Despite the fact that his community-based treatment was occurring in his hometown, Andrew noted that he had yet to make an attempt to reach out to old friends. Andrew reported feeling anxious about doing so because he was unsure how they would react to the news of his psychiatric diagnosis. He wondered whether he might experience the harmful effects of stigma now that he understood himself to be afflicted with a chronic condition that others might not fully comprehend.

Still, despite the various challenges that lay ahead, Andrew maintained a largely positive tone as our conversation began to focus more specifically on the topic of life beyond recovery. During his time at the IRTS facility, Andrew felt that he had been able to develop the sorts of self-monitoring and communication skills that would allow him to remain accountable for his actions and responsible for his psychological wellbeing. For example, he learned to recognize the onset of troublesome symptoms and how to appropriately convey his concern about their appearance to others. Andrew also mentioned techniques he could use to manage minor symptoms and emphasized the importance of quickly accessing the appropriate help resources if things began to get out of hand. In addition, like nearly all of the young adults I interviewed, Andrew was consuming a “cocktail” of psychopharmaceuticals that would need to be continuously monitored and adjusted according to the frequency and severity of his symptoms. Andrew thought that he might receive occasional medication reminders and check-ups

from a community support team but predicted that his long-term wellbeing would largely be conditional on compliance with the pharmaceutical regimen that his doctor had prescribed for him. Reinforcing the conceptualization of mental disorder as a chronic condition to be managed rather than cured, Andrew expected that he would likely be in need of a “tune-up” at various points in the future; this might involve hospitalization or a return to an IRTS.

Beyond the individual strategies that Andrew felt responsible for implementing during the reentry process, he also hoped to build a strong relationship with his case manager, who he expected to play a prominent role in his upcoming search for housing, employment, and transportation. In addition, he felt that he would be able to continue his relationship with IRTS staff and noted that he would feel comfortable seeking additional help from them with housing or employment if need be. Andrew also mentioned that the IRTS staff would likely be happy to help him continue to develop illness management skills as he began to better understand how everyday stressors might trigger certain symptoms.

Andrew seemed to have spent a good deal of time considering the possibilities for his short-term future. Though he was unsure of where he would be living next, Andrew mentioned that a family at his church had offered to open their home to him for a while so long as he abided by their rules. In addition, Andrew was entertaining subsidized low-income housing options and could also move in with his mother, though he worried that

doing so might place a heavy financial burden on her. To meet housing costs, Andrew planned to look into his eligibility for Veteran's Administration benefits that would allow him to save on rent and put more money from work toward repaying his debts.

Andrew was able to work and was interested in seeking employment somewhere in town. Before attempting to manage the stress associated with full-time employment, Andrew wanted to check the local job advertisements for a part-time position that would allow him to slowly become accustomed to the demands of work again. I asked him about where he thought he might begin looking for a job, and Andrew mentioned that he is intrigued by the idea of working as a waiter because he feels the tips would be good. At the same time, Andrew knew that he would eventually yearn for a more stable nine-to-five type of job, which he would use a job placement agency to search for.

In addition to finding a job, Andrew looked forward to having a place to live. Andrew suggested that finding a permanent home would make him feel more rooted, which in turn will give him more confidence to reconnect with old friends; concerns about stigma were currently preventing him from rekindling relationships. He noted that none of his friends have much money and felt that it would be nice to be able to treat them to coffee or ice cream as he attempts to convey his recent experiences in treatment and rehabilitation to them. Andrew also hoped to regain and maintain the high level of physical fitness he had attained before he began dealing the symptoms of bipolar disorder. Still, Andrew felt that many of the short-term possibilities before him were

contingent on the outcomes of upcoming legal proceedings related to incidents that occurred prior to his hospitalization; the potential outcome of his case seemed unclear and this uncertainty engendered a great deal of anxiety.

Andrew identified several modest long-term goals, the most important of which was returning to school. He described a longstanding interest in engineering and told me that he was thinking about eventually enrolling in some community college courses with the long-term goal of obtaining a bachelor's degree. Looking further down the road, Andrew imagined himself owning his own home—something affordable that would not stretch his budget too much. He thought that new friendships would likely emerge from whatever type of work he ends up doing, and he hoped that he would have the means to take a small vacation with people close to him each year.

Andrew expected that the most challenging thing about moving back into the community would be dealing with the realization that the weight of his responsibilities is entirely back on his own shoulders. During his time at the IRTS facility, many things have seemed remote and simply out of his hands. Still, Andrew remained hopeful, and if things become difficult or overwhelming he will rely on his small but supportive social network to keep him on track.

Andrew's story provides a glimpse into a life course trajectory that shares many characteristics with the narratives provided by other research participants. A seemingly

high-functioning young person, Andrew is unexpectedly beset with symptoms that begin to impede everyday life. The severity of his symptoms gradually increases and his problems culminate in displays of erratic behavior that lead to homelessness, legal trouble and hospitalization. Referred to an IRTS by the hospital, Andrew begins to learn more about psychiatric diagnoses through illness management and recovery groups and acquires the recommended coping and self-management skills.

The outcome of knowledge cultivation informed by psychiatric reason for Andrew is the ability to imbue his symptoms with an objective quality that allows him to articulate a notion of personhood that embraces the classic distinction between being and having a disorder. Furthermore, Andrew's understanding of his constellation of symptoms as unified in a distinct disorder allows him to bracket certain symptom-driven aspects of behavior as separate from his true self; this bracketing informs his approach to the relational dimensions of disorder as he describes how he might deploy diagnosis as a means of explaining past actions in attempts to reestablish friendships. In addition to altering notions of what it might mean to relate to others, Andrew also highlights the way in which psychiatric knowledge incites individual action by organizing sensory experiences into signs of a symptomatic self that requires an intervention, often in the form of modifications to pharmacotherapy.

The Unmaking of the Self

The onset of severe psychiatric symptoms challenges the stability of the self by exposing individuals to forms of inner experience that defy recognition and attempts at description, which often leads to extreme social isolation (Karp 1996). Most young adults who arrive at IRTS facilities have little familiarity with—or even access to—dominant psychiatric discourses and expert opinion, thus the various categories of disease that populate the DSM and the sets of symptoms that they encompass are not always readily available as tools for making sense of troubling episodes. While some clients have been dealing with symptoms intermittently for extended periods of time prior to arriving at an IRTS facility, it is typically the case that those experiences cannot be reframed and aligned with the relevant classificatory system until later on in the work of recovery.

There are several influential accounts of the entanglements of suffering and agency that are helpful for considering the possibilities of how one might experience new and unfamiliar forms of pain that are instructive here. Scarry's (1985) discussion of pain as the unmaking of the everyday world resonates with participant accounts of mental anguish that feature in instances of both acute panic and protracted withdrawal from sociality that manifest as characteristics of a variety of forms of mental illness. For Scarry, the material onslaught of pain and suffering defies linguistic description, thus shattering the everyday experience of the world insofar as the individual is unable to imbue suffering with meaning that can be grasped by another; pain in this formulation is always pre-objective. This problem is compounded in moments of severe psychic anguish recounted by my participants where symptoms present with undeniable

immediacy due to the combination of their severity and incomprehensibility; all-encompassing suffering seems to occur without warning or cause and cannot be adequately represented to others. Building on Scarry's argument, Good (1994:30) adds:

language is not only inadequate when the intensity of pain can only be expressed only in cries and the contorted body; it is perhaps more typically inadequate as a sufferer seeks a name for his pain, an individual name that accurately represents that pain, describes it with such clarity that its origins and contours are expressed, a representation possessing enough power that the pain can be controlled.

Scarry suggests that, ultimately, the absence of adequate representational tools for private experiences of suffering may raise the specter of doubt over the veracity of the experience given the challenges of confirming the validity of pain in the eyes of an observer. For those coping with the onset of psychiatric symptoms, the diagnostic processes that are eventually employed by staff at treatment and rehabilitation facilities involve this impasse around meaning.

In his critique of secular conceptions of human agency, Asad (2003) observes that the modern subject is thought to assume a certain passivity in the face of the experience of pain. Pain, observes Asad (ibid:79), is typically conceived of as negating the possibility for intentional human action:

When we say that someone is suffering, we commonly suppose that he or she is not an agent. To suffer (physical or mental pain, humiliation, deprivation) is, so we usually think, to be in a passive state—to be an object not a subject. One readily allows that pain may be a cause for action (seeking to end the suffering, say), but one does not normally think of it as action itself. Pain is something that happens to the body or that afflicts the mind.

While Asad concedes that the failure to communicate one's pain to another can in some circumstances render it unshareable, he takes issue with Scarry's contention that resistance to language is the fundamental essence of pain, proposing instead that pain

may also possess a relational quality that can transform it from a seemingly passive experience to an active one:

There is always an irreproducible excess in pain. I argue that that is not all pain is. Sufferers are also social persons (animals) and their suffering is partly constituted by the way they inhabit, or are constrained to inhabit, their relationships with others... There are varieties of incommensurable experiences that we collect together under the label “pain” (or “suffering”) as though it were, like agency, a single thing, an ultimate vindication of corporeal reality. But as a social relationship pain is more than an experience. It is part of what creates the conditions of action and experience (ibid:85).

In Asad’s view, pain can be rendered incommunicable in particular instances, but he contends that it is productive to understand what pain is and how it is experienced as “modes of living a relationship” (ibid:84). To the extent that the self is unmade through the onset of severe psychiatric symptoms, the process of remaking that constitutes the work of recovery depends not only on linguistic representation, but also a means of inhabiting a variety of relationships—with mental health professionals, with a biosocial community of peers, and so on. Beyond linguistic representation of affective states, recognition of suffering requires an audience willing to respond to claims of pain in ways that validate them. At an even more foundational level, social relationships at different scales are generative of symptoms that may, for the sufferer, initially seem to belong to an inaccessible realm of inner experience, an insight that I will explore further in the next chapter. Both Scarry and Asad’s influential commentaries are useful for understanding the onset of wrenching psychiatric symptoms. Scarry’s reading of pain hints at the incapacitating inability to objectify forms of suffering expressed by my participants, while Asad’s invitation to consider the experience of pain as an active form of living a relationship comes into play as individuals begin to gain access to the tools necessary for making symptoms intelligible.

The onset of symptoms typically took several forms among my participants. In a number of instances, a pattern of troubling behavior began to gradually take shape and eventually culminated in events characterized by complete social withdrawal or unusual social interaction that raised deep concern in others. Such was the case with Andrew, whose bipolar symptoms initially went unrecognized and increased in severity over time to the point where, in retrospect, he was unable to recognize himself in the symptomatic figure of his narrative. In a similar vein, a young woman named Erin talked with me about the slow descent into paranoia that first-episode psychosis had induced. Feeling overwhelmed with fear, Erin was barely unable to venture out of her home or engage in social interactions of any sort and was eventually admitted to a hospital. Erin described this period of her life in the following manner: “Well, I needed something because I was pretty bad and I just sat in my house. I wouldn’t go out unless I absolutely had to. I’d be in my own world, and I had all the curtains drawn. I was very isolated, and I was afraid go out anywhere.” Another participant experienced the symptoms of schizophrenia for over a year before he gained access to a mental health provider after treatment that was ostensibly intended to address methamphetamine use brought his mental health challenges to the fore:

I went into a psychosis, and after that I was like symptoms all the time for about a year. Didn’t really tell anybody; I just figured everybody knew. And...delusions of people thinking they can hear what I’m thinking. And paranoia like that... I was experiencing all these new symptoms that I hadn’t experienced before...like counting letters and certain letters stick in my head, like KGQC and G, all those letters. Any word that starts with those letters, like if I’m thinking it with my mouth open I’ll think that I’m saying it; even with my mouth closed I thought I was saying it. Like sometimes those words can be bad and you can get in trouble for saying those words, you know. And I was very paranoid about that so I stayed home a lot.

In other cases, symptoms occurred with an immediacy that was terrifying and caused some participants to feel as though they caught in potentially life-threatening situations. Anne, a mother of two young children who struggles with depression and an anxiety disorder, gave a nightmarish account of a series of panic attacks that unfolded without warning:

I came to [IRTS] at the end of March, March twenty-sixth. Previous to that a couple months before that I was having little panic attacks. I wasn't exactly sure what they were; I just thought there was something physically wrong with me. And then on the twenty-third through the twenty-sixth it was just like a complete mess. I didn't know what was wrong with me; my heart was racing; I felt like I was on fire. I felt like I was having a heart attack, dying and I didn't know why. I went to the emergency room three times that weekend and then finally on Monday I went to the mental health unit and just told them that I needed some help.

Adam, who, when I met him, had just spent several weeks in what he called a “transition home” before coming to IRTS, initially had resorted to hospitalization after he began hearing voices that overwhelmed his ability to function: “I started hearing voices...I was hearing voices and finally they got so much, so loud and so commanding that I had to go get help and I finally went to the hospital to get help. They finally gave me the medicine that gets rid of the voices.”

The sorts of illness experiences that I have described are applicable to the lives of most of my participants, though there are several other routes to an IRTS. Of these, I most frequently encountered young adults who were cycling through the process of symptom onset, hospitalization, and discharge to community treatment for a second or third time. In such cases, clients typically had become what mental health professionals would call “non-compliant” with pharmacotherapy. For example, a participant named Andrea who had been hospitalized several times over the previous several years for what

she described as difficulties associated with psychosis, post-traumatic stress disorder, and bipolar disorder observed that her current residence in an IRTS resulted from a sense that she might be able to succeed without medication. As I spoke with Andrea about how she had come to the IRTS that I visited her at, she said “Well, I have psychosis where I hear audio and I was off my meds. ‘Cause you know I could do it by myself and everything; well, that didn’t work, and in the process I got my daughter taken away and then sent here.” While most of the young adults I met were receiving intensive treatment rehabilitative services for the first time, a small subset also had experiences similar to Andrea’s involving difficulty managing medication after an initial diagnosis that resulted in multiple hospital stays over several years prior to their recent arrival at an IRTS.

Whether the symptoms of illness appeared out of the blue like the pangs of a panic attack, gradually grew overwhelming like the auditory hallucinations sometimes associated with schizophrenia can, or brought basic motivation to a standstill as major depression is known to, the incidence of symptoms that would later necessitate hospitalization and rehabilitative care was often looked back upon by participants nearing the end of their time at IRTS as a rupture in or sudden loss the self. In the case of the sudden onset of severe symptoms, participants had a sense of their everyday world slipping away from them, while others were unable to fully grasp the manifestation of symptoms until their troubling circumstances diminished their ability to participate in social life entirely. These difficult experiences typically result in short-term inpatient psychiatric care and stabilization at a regional treatment center or community behavioral

health hospital.²⁸ Often, this is the first step in a process of reckoning with the self through the encounter with psychiatry, a process that gathers speed in the IRTS setting.

Piecing Together Diagnosis

As I argued in the previous chapter, the defining characteristic of the contemporary psychiatric paradigm is, perhaps, its emphasis on diagnostic specificity. The assumed correspondence between symptom clusters and underlying pathology allows psychiatry to systematically define its objects, develop pharmacological and rehabilitative treatments that target specific disorders, and facilitate access to services by satisfying administrative and bureaucratic requirements for insurance reimbursement and social welfare benefits. Diagnostic specificity, then, becomes a kind of “connective tissue” providing coherence to the notion of mental disorder as it becomes embedded in the rationalities of various sorts of institutions and their respective logics (Lakoff 2005).

In addition to the fact that the operationalization of diagnosis is a key component of various commercial, professional, and bureaucratic rationalities, it, of course, also has undeniable implications for the self. Martin (2007:136) characterizes DSM diagnostic

²⁸ At the time of data collection, the Minnesota Department of Human Service operated several Regional Treatment Centers throughout the state; currently, Anoka-Metro Regional Treatment Center is the only facility of this sort. Outside of the Twin Cities metro area, the Community Behavioral Health Hospitals function as regional centers for short-term inpatient psychiatric care intended to stabilize patients and plan appropriate aftercare. Anoka-Metro Regional Treatment Center provides similar services for the metro area, but also has much larger patient population as well as the capacity to treat highly-complex patients.

categories as “text atoms” that condense “the detailed contexts of daily life in which people experience moods of all sorts.” The concept of a text atom is borrowed from Silverstein and Urban (1996:1), who observe that transforming “something into a text is to seem to give it a decontextualized structure and meaning, that is, a form and meaning that are imaginable apart from the spatiotemporal and other frames in which they can be said to occur.” In this decontextualized form, diagnostic categories often act as one of the key vehicles through which IRTS clients encounter “received-facts” regarding the nature of mental illness (Dumit 2003). The notion of “received facts” speaks to the “activity of translation that has taken place in order for the results of a scientific or medical project to reach us” (Dumit 2003:39). The process of consuming received-facts—always contingent on the social and cultural milieu in which they are mediated—lays the ground work for the crafting of an “objective self” which reflects the “set of acts that concerns our brains and our bodies” and consists of “taken-for-granted notions, theories, and tendencies regarding human bodies, brains, and kinds considered as objective, referential, extrinsic, and objects of science and medicine” (ibid:39). Objective selves are actively fashioned, always bound up in a process of making and remaking that depends on the translation of received facts.

IRTS clients whose understandings of their place in local worlds have been undone by severe mental illness find that diagnosis is an incontrovertible fact of their lives. By virtue of the demands of the very rationalities that I have just made mention of, diagnosis must come into play at various points in time as a prerequisite for treatment and rehabilitation. At the same time, diagnosis opens up possibilities for interpreting,

reframing, and narrating experience. Rose (2013:2) makes the case for the primacy of disease categories at the level of the self:

Diagnosis, especially categorical diagnosis—the allocation of a name to an experience of illness—has crucial social and cultural characteristics that make it difficult to abandon altogether. Diagnosis is deeply embedded in our contemporary notion of medical care. There is an expectation that a visit to the doctor will result in a diagnosis that, among other consequences, legitimates the ailment. And when a diagnosis is given, it reframes the symptoms into a pattern that is recognizable to both doctor and patient. For the doctor, this enables the patients' history to be organized into a narrative which provides a shape for the past and an orientation to the future – it is performative. For the patient, who may be experiencing symptoms that are often diffuse and transient, who may be struggling with behaviours that can be seen as merely personal inadequacies, diagnosis reframes these troubles into an illness. The diagnosis enables a story to be created about it – what has led to it, what it is, how it will be treated, what the outcome might be, how it can be spoken about with family, friends, employers and others... Of course, sometimes those diagnosed do not always find their diagnosis a relief, and do not wish to align their own understanding of their condition with that provided by medical authority... For some, a psychiatric diagnosis seems a denial of their own account of the causes of their troubles... and psychiatric diagnosis may generate stigma, not just 'in the community' but also in wards, clinics, day hospitals... The diagnosis shapes the way in which care staff interpret speech, conduct, and distress... In short, diagnosis is a transformative moment for the person diagnosed when they embark on a 'moral career' as a mental patient, with the changes of self perception and treatment by others that this entails.

Rose's perceptive reading of diagnosis captures many of the nuances involved in assigning a category to a person. He highlights the work of translation that allows the symptomatic person a degree of agency insofar as he or she becomes objectified in a way that allows for the possibility of decision-making regarding a course of treatment. Furthermore, an entirely new narrative trajectory becomes available to the diagnosed. Whatever the nature of the experiences that preceded the diagnostic encounter, the patient can now reinterpret them in a way that helps to provide coherence to an unsettling past and casts the future as a time pregnant with possibility rather than freighted with uncertainty. Rose recognizes that these sorts of outcomes of diagnosis are potentially productive of a certain sort of sociality in that they provide the afflicted with a biomedically-legitimated story that can circulate among the members of one's kinship and broader social network in a way that reincorporates the mentally-ill person. At the

same time, Rose points to the fact that diagnostic categories can inhibit interpretive possibilities that are not aligned with the biomedical model and, in doing so, leave the subject without a legitimated narrative and thus open to stigma and differential treatment.

A key component of the client intake process at an IRTS facility is the completion of a diagnostic assessment (DA). In addition to simply enumerating a potential client's psychiatric diagnosis, the DA is a written report that encompasses the following: 1) nature, severity and impact of behavioral difficulties; 2) functional impairment; 3) subjective distress; and 4) strengths and resources (Minnesota Health Care Programs Provider Manual 2018). This report is part of an ensemble of assessments and evaluations that help mental health professionals (typically the lead counselor and an intake specialist) at an IRTS to determine both whether or not the potential client meets various administrative criteria for admission common to all licensed IRTS and if the individual in question is a good fit given the characteristics of the clients currently in residence at a given facility. In addition to the DA, the intake process includes a Functional Assessment and a Level of Care Utilization of System assessment; the former instrument assesses an individual's level of functioning across a variety of domains (e.g., symptoms, housing, interpersonal skills, independent living capacity), while the latter is intended to determine mental health resource needs (i.e., do they demonstrate need for IRTS, or would, say, Assertive Community Treatment suffice?). Taken together, mental health professionals understand these intake tools as mandatory elements of a

bureaucratic framework that governs their ability to provide services to particular individuals, but also as an opportunity to form a holistic view of potential clients.²⁹

Initially, I assumed that there would often be a good deal of correspondence between the diagnosis received by a client at the referring hospital and the diagnosis derived from the IRTS DA; however, there is often significant variation between the diagnostic practices employed at inpatient hospitalization settings and those that are associated with a DA. Mental health professionals in IRTS settings usually have access to at least partial medical records for potential clients when conducting an intake, but rather than mapping their diagnoses onto an individual's medical history, their descriptions of the DA process indicate that it is often the diagnosis that they consider to have the most immediacy that is foregrounded in their report. A lead counselor at an IRTS facility described his approach to the DA in the following terms:

They [potential clients] do have diagnoses when they come from the hospital. Like my current client who's coming tomorrow, they're [the referring hospital] like 'he has depression, anxiety, TBI [traumatic brain injury], fetal alcohol syndrome, cannabis use disorder, and schizophrenia.' Well, I'm obviously not going to diagnose him with every single one of those, right (laughs)? So, I'm gonna go through—I had a meeting with him yesterday—where is he at now; which piece is he at. Otherwise you end up over-diagnosing, even though he might have all of those diagnoses. We have to have the top five—major depressive, schizophrenia, bipolar, and PTSD—one of those to be able to admit. Most of them have had several admissions [to a hospital], and then there's like history of all these different diagnoses and why they were admitted to the hospital. I usually got some past stuff, but I want more current. But I also want to know what's happened in the past...Do they have a history of violence in any way? Do they have a criminal record? Do they use drugs? I want to know some of that, but I want to know the recent pattern.

²⁹ The Minnesota Department of Human Services is responsible for licensing and setting out requirements for admission to IRTS facilities. IRTS facilities provide the most intensive levels of care outside of a hospital and thus are typically more expensive for insurers than other community-based mental health services, hence a higher threshold for admission.

In this narrative, the counselor acknowledges that the client may have a somewhat complicated psychiatric history, but the “recent pattern” is the primary area of concern. From a clinical point of view, this approach is logical; in the most basic sense, the goal of IRTS rehabilitation is to address the most salient symptoms and “deficits” currently troubling a person. At the same time, this example demonstrates the complexity of psychiatric “received facts” and the way in which their mobilization in local worlds is sometimes at odds with dominant understandings of mental disorder enshrined in systems of classification. On the one hand, contemporary psychiatric reason relies upon a conceptualization of disorder as underpinned by various sorts of neuropathological processes; disorders are natural entities inherent to the human, not objects that are to be selectively chosen and discarded. In practice, however, IRTS clinicians find it expedient to employ a kind of diagnostic fluidity in light of the time-sensitive nature of the rehabilitation activities that they oversee and the need for restoring a certain level of functioning for clients preparing for uncertain community living situations. For the community mental health practitioner, there is a way in which this kind of diagnostic selectivity can be reconciled with psychiatric reason insofar as diagnoses are largely considered to be context-free entities; client medical history is important to the extent that it impacts the present manifestation of symptoms, so, in many community mental health settings, historical diagnoses, despite acknowledgement of their facticity, must be subordinated to the most current diagnostic entity threatening client stability.

The example of the DA, then, highlights the notion of diagnosis as an ongoing, contingent process that often subsumes the specific judgment of any one mental health

professional at a particular moment in time. Individual acts of diagnosis certainly do assign categories that have the effect of “making up people,” particularly as those diagnoses are codified in medical records, but the import of the realities that these various pronouncements produce is variable depending on the way that they are taken up in different articulations of psychiatric practice (Hacking 1986).³⁰ The diagnosis that emerges from a DA responds not only to the client’s current symptoms, but also to the norms and standards that guide professional mental health practice and its expected outcomes in the IRTS setting. Thus, as Godderis (2011:139) argues, “‘diagnosis’ does not happen at a particular instant in time, such as when a psychiatrist makes a pronouncement, but rather is an institutional process that occurs over a period of time and in a variety of locations.”

Viewed as an institutional process, diagnosis can be understood as facilitating “the movement of results of institutional decision-making and procedures from generalized discourses back into people’s everyday lives” (ibid: 139). Diagnosis as institutional process depends on relations between various knowledge-producing sites that are knit together by virtue of their responsibility for addressing embodied experiences of the sort that fall under the purview of psychiatry. Such relations “create, and rely on, textually based realities to produce, re-produce and stabilize institutions because texts have the capacity to preserve meaning in the absence of local context” (ibid:139). As a node in a network of psychiatric institutions, IRTS, due to its mandate

³⁰ Hacking (1986; 2007) suggests that the introduction of categories and their attendant properties that accompany systems of classification produced through the process of human scientific inquiry may, in effect, make up new forms of people.

and the associated administrative criteria that its mental health professionals must adhere to, both relies upon the diagnostic knowledge produced by other psychiatric institutions and imposes its own order upon that knowledge in order to foreground categories that allow mental health professionals to engage clients in a way that is consistent with the mission of promoting stability and some degree of independence for severely mentally-ill individuals living in community settings.

Upon determining which diagnosis (or diagnoses) should take precedence in the DA, IRTS clinicians must then make decisions about what diagnostic information to convey to clients. These decisions involve a mental health professional's assessment of the extent to which a client may be willing to accept a particular diagnostic category and also reflects a concern for managing conceptions of psychiatric disorder as a thing that one has rather than an identity that negatively defines oneself. Many of the tensions that IRTS mental health professionals face around the issue of communicating diagnosis are highlighted in the following excerpt of a discussion that I had with a licensed professional clinical counselor:

With clients I don't usually tell them their diagnosis unless it's something they have awareness of and they want to go into because your diagnosis isn't who you are, and it feels labeling to them. And then they focus on that instead of on the symptoms part, which is the more important part. The diagnosis, at the end of the day, is a billing code, but, yes, they do also meet the criteria. On the one hand, though, when they do agree with it and they have insight about it, it makes them feel less alone. Because 'I'm crazy' is what you hear all the time and 'no one else has this,' and then you give them something written and concrete and suddenly they don't feel so ostracized and horrible about it. Then they can see the separateness of it, because it's not them; they don't look it up and see a picture of them. And then there are some who are in complete denial, and part of that is the psychosis piece because that is part of the diagnosis, is the delusion just not having any kind of awareness at all, especially if they're paranoid, they think that we're the bad guys. So I think it can be helpful, but sometimes it isn't...But if they're at that place where they're like 'I know I have this', then we teach them about the pieces of the symptoms and what they can do to combat them.

These comments reveal several concerns regarding diagnosis that are widespread among mental health professionals in IRTS settings. First, concerns about stigma deflect communication about diagnosis between practitioner and client. Severe mental illness is frequently entangled with processes of stigmatization due to the way in which symptoms call into question an individual's autonomy, rationality, and self-reliance (Barrett 1988; Jenkins & Carpenter-Song 2007). Clinicians expressed an acute awareness of the ways in which diagnosis had the potential to ostracize clients, particularly younger clients who often had limited experience of diagnosis and treatment. In such cases, mental health practitioners often felt that directly employing diagnostic labels might deflect a client's attention away from symptomatology, the management of which should be the real aim of rehabilitation and recovery work.

At the same time, while a diagnosis functions in part as “just a billing code” that facilitates the provision of services, the fact that clients meet diagnostic criteria lends objectivity to categories that may in turn provide a useful framework for client-clinician interaction. Such instances recall the key diagnostic lesson of Andrew's story, the classic distinction between being and having a disorder (Estroff 1981; 1995). In Andrew's case—as it was for others—the acceptance of a diagnostic category called forth the “having” framework and the separation of disorder from self embedded in it. Weiner (2011:461) underscores the importance of this distinction for the practice of biomedicine:

the managing self of biomedical discourse is predicated on a distinct notion of authentic selfhood as something that is and must be delineated and distanced from the disease. According to this logic, there exists a subtle but actual boundary between the real person—who is characterized by

coherence and stability, or continuity across time—and disease manifestations that may take the appearance of personhood and “fool” the untrained patient.

Clients like Andrew begin to participate in the work of recovery by accepting the premise of symptoms as valid signs of underlying neuropathology represented in the form of diagnosis. Acceptance of diagnosis then facilitates a process of translation through which past experiences of symptoms and the painful life events that often accompanied them are reframed so that the client comes to understand that the actions of the symptomatic self are distorted; they do not reflect the intentions of the authentic self, which can subsequently emerge from the process of recovery and its various treatment modalities. This work of translation provides the individual with both an explanatory model and, to some degree, absolves her or him of responsibility for undesirable past actions, actions which may also come to be understood as uncharacteristic because they emerged from unmanaged disorder. Recall Andrew’s comments:

I have a disorder, I’m not the disorder; that’s the biggest lesson that needed to be learned when I was diagnosed...If I understand my illness I feel that I can better explain my illness to somebody else. Explain why I acted weird when I acted weird and explain that not all of the time I spent with my old friends was necessarily me in a manic stage. I would fluctuate, and so you enjoyed a good portion of me; the stuff that you didn’t like, that was mainly my manic stage.

While acceptance of a diagnosis may be the ideal platform from which IRTS staff can move forward with its rehabilitation and recovery process, sharing diagnostic categories with a client, as the counselor I mention above observed, is not always a viable strategy. How, then, do IRTS counselors and other mental professionals make decisions about whether or not a client is a good candidate for interventions that directly invoke his or her diagnosis? In discussions of this matter, mental health professionals often referred

to a client's "awareness" or "insight," words—particularly the latter—that I quickly discovered were not being used colloquially and had significant meaning for clinical mental health practice in community settings and beyond. Landi et al (2016) suggest that insight includes at least three components: the awareness of suffering from an illness, an understanding of the cause and source of this suffering, and an acknowledgment of the need for treatment. Summarizing some of the key questions raised by the operationalization of the concept of insight in psychiatry, Markova (2005:x) writes:

It is a question that encompasses many facets. From one perspective, it addresses in a practical way the degree of understanding patients have about their conditions. In turn, this raises important issues relating to clinician-patient communication and carries implications for the management of the individual patient. From another perspective, however, the question of patients' insight reaches to the core of our understanding of mental disorders themselves. It forces us to consider, for example, how mental functions might act and interact in health and illness. Can mental disorders have selective effects on mental function? To what extent can mental dysfunction in one area affect mental function or capacity in another area? The question of insight from yet a different perspective is wider still and focuses enquiry on the nature of self in relation to mental illness. Here, questions arise concerning the sorts of factors that may contribute to self-knowledge and to what degree these might differ in the 'healthy' individual and the person with mental illness.

Beyond the basic definition of the concept, Markova indicates that the level of insight goes some way toward structuring the communicative practices between clinician and client, as well as the course of treatment. Additionally, Markova suggests that differences in type of disorder may pose unique challenges to an individual's capacity for insight. Finally, Markova links the notion of insight to the concept of the self by raising the question of how access to insight as a proxy for self-knowledge more generally might vary across normal and pathological selves.

The questions Markova raises figure directly into mental health professionals' work at IRTS, as the comments of the counselor that I discussed above indicate. From

the practitioner's point of view, communication about diagnosis is premised on a clinical judgment regarding the presence of insight, with some forms of disorder—particularly schizophrenia—posing severe challenges to the development of a self-reflective awareness necessary for parsing the distinction between self and disorder. Another mental health professional offered her perspective on this issue:

When I do an intake I ask, 'hey do you have a diagnosis and do you know what it is?' Sometimes they say 'I have this' [diagnosis]...and 'Do you agree with that?' to kind of see where they are with their awareness of it. Some of them are like 'no' because some people are here unwillingly; they're on commitment [court-ordered treatment] or they don't remember their psychotic break, and they're like 'no, this is BS'. And then some of them go 'ok, this is my sixth round, so now I get it'.

In this example, one glimpses the clinical dance that occurs around the evaluation of diagnostic insight. Some clients reject diagnostic categories due to symptoms that are likely related to schizophrenia (“psychotic break”), and we are also reminded that IRTS services are entangled with coercive legal practices that exercise judicial authority to force an individual to submit to treatment, which may both stem from a client's lack of insight and engender additional resentment of diagnostic pronouncements.³¹ Finally, this practitioner points to the important idea that insight can be learned, that it is not necessarily a quality inherent in the individual or a function of a specific disease category; insight can be cultivated, though sometimes self-knowledge must develop over time, perhaps only after several visits to an IRTS or another type of treatment setting.

³¹ I met a number of clients who were admitted to an IRTS by way of civil commitment. Under Minnesota law, a mentally-ill person may be ordered into treatment when they refuse to obtain help voluntarily or when there is evidence that such a person is a harm to them self or others.

In IRTS settings, then, assessments of insight function as a means of defining a subject position that is made amenable to rehabilitative practices. Blackman (2007:8) argues that in treatment settings the concept of insight is:

taken to be a measure of how well a person has adjusted to their experiences and is able to view them as signs of mental disorder. This subject position is one that allows distinctions to be made between those who take up an active relationship to their illness and those who are considered recalcitrant. The recalcitrant are those who are viewed as more likely to be non-compliant with drug regimes, and therefore more aligned with danger and risk.

Recognition of this subject position hinges upon an individual's willingness to accept an injunction to locate their experiences of symptoms within the framework of biological psychiatry. Crucially, acceptance of this injunction implies acknowledgment of a diagnosis and its implications and signals compliance with recovery models emphasizing certain techniques of self-management (particularly as they relate to the consumption of psychopharmaceuticals) that distinguish the responsible from the risky. In Andrew's story, we saw a prime example of how the embrace of this injunction can entail an entirely new orientation toward self-cultivation that is consistent with the contemporary paradigm of psychiatric reason; however, from the perspective of an IRTS mental health professional, evaluations of client insight suggest varying degrees of readiness for further exploration of diagnostic categories and their implications for recovery. Counselors and other staff often fear that lack of insight will derail the work of recovery entirely, and thus, in light of the time-bound nature of their practice, seek to redirect attention toward symptom management; while this strategy may not be ideal, it nonetheless allows clinicians to engage clients of questionable insight in standardized rehabilitation practices by other means.

Clients tend to have significantly more knowledge of diagnosis than discussions with mental health professionals would suggest, and many of the young adults that I met offered diagnostic interpretations that clashed with the normative assumptions embedded in the recovery model. While a number of clients accepted the biopsychiatric injunction and its accompanying being/having distinction, others described a more conditional acceptance that acknowledged the accuracy of a diagnosis while rebutting its context-free status by linking the diagnosis to significant life course events and the social circumstances in which they unfolded. Still others rejected diagnoses altogether, offering alternative explanations for their debilitating symptoms and expressing frustration that clinicians tended not to validate these interpretations and/or provide venues within which counternarratives could be explored; very few, however, altogether contested the notion that they were suffering from some form of illness that needed to be addressed.

While the exigencies of IRTS practice necessitate a focus on those diagnoses that staff deem most urgent, clients—even those accessing mental health services for the first time—tend to arrive at IRTS after emergencies that cause them to be exposed to a number of psychiatric evaluations. Because of this, clients often develop their own strategies for reading diagnoses and are acutely aware of the way in which diagnostic histories can inform the way in which mental health professionals attempt to manage their illness experiences in the present, for better or worse. A key theme that emerges here has to do with the way in which, over time, diagnoses cohere in a medical history

that can then be read by professionals across institutions to allow for the rendering of “form-made persons” (Jacob 2007). Hull (2012:259) argues:

Insane or reasonable persons are produced and diverted into regimes of rehabilitation or punishment through the ritualistic production of intake documents... Discursive logics, concepts, norms, and social relationships can account for classification schemes, the criteria for bureaucratic determinations of what sort of person or thing fits within them. But documents are what mediate between these schemes of classification and particular people, places, and things.

While diagnostic assessments of various sorts may follow standardized procedures, they come to form a history that is read and interpreted by different social actors as clients travel across treatment/rehabilitative settings; these situational interpretations sometimes exert an influence over which clients have frustratingly little control. Clients may not be knowledgeable about the specific documents that impact their treatment, but they are sensitive to the way in which diagnostic histories seem to travel along with them.

Conversations with a number of clients revealed ambivalent attitudes toward the way in which diagnostic histories structured clinical interactions at IRTS in the present. Early on in my research, I met Rebecca, a young person recovering from a suicide attempt and receiving treatment stipulated by a civil commitment order. As our discussion turned toward her mood, Rebecca expressed dissatisfaction with the indeterminacy of diagnosis as well as the way in which diagnostic categories travel:

I: What about the mental health side of things, how do you feel about that or how are you feeling?
R: I'm feeling pretty good, I just don't agree with most of my diagnosis, I have major depression and poly-substance abuse and I also have borderline and bi-polar, and I don't agree with those two; they put borderline 'cause I like to cut.
I: Have you talked to your counselors here about why you disagree or how you disagree with those two?
R: Yeah
I: What is their response?

R: They tell me what everyone else tells me: it's 'cause I've cut since I was five. It's still a mental illness when I cut.
I: But you disagree?
R: I have my own reasons for why I cut.
I: So how does it make you feel to be labeled with those things?
R: Makes me feel kind of stupid.
I: Can you say more about that?
R: Like you know, when I go somewhere they always know what my diagnosis is or they read my past, or they'll lose something and it just gets all over the place and it gets screwed up. And every place I go to says a different diagnosis, and I move onto the next one and the diagnosis is something else and then I have this whole file of different things they've diagnosed me with.
I: It sounds like from Anoka [regional treatment center] to here the diagnosis had stayed the same?
R: The same.
I: But you feel like, sounds like you feel like it's something that follows you around?
R: Yeah

Rebecca's frustration seems to stem from her disagreement with the category assigned to the action of cutting, an action which she has engaged in for years and seems to have fashioned an alternative explanatory model for. In addition, Rebecca describes diagnostic fluidity across institutions as a phenomenon that makes her feel "stupid," and results in an ever-accumulating "file" full of diagnoses that fails to encompass the totality of experience. As our conversation continued, Rebecca observed that these processes made her reticent about participating fully in rehabilitative activities such as groups, where she largely remained quiet and omitted certain diagnoses when discussing her symptoms with others.

Derek, an introverted young man whose experience of major depression and suicidal ideation had led to a hospitalization and subsequent discharge to the IRTS where I met him, discussed his dissatisfaction with what he viewed as a misdiagnosis. While Derek understood himself to be depressed, he had grown deeply dissatisfied during his time in IRTS because he felt that he had been mischaracterized as having a substance use

disorder. Derek freely admits that he often resorted to drinking as a coping mechanism, but he felt that his concerns about depression had become increasingly overshadowed for no apparent reason by a clinical emphasis on chemical dependency.

I: Do you feel like there's been some change during the time that you have spent here?

R: No, I actually...well in regards to them getting new meds yeah, but in actually getting the help I need, I think that's been going downhill, at least for the past month.

I: And what would you attribute that to?

R: Well I'm always compared to being a chemical dependency and a person that's like addicted to alcohol; they always assume that about myself, which is not true at all. I don't...I never do drugs or...I do drink, but I'm a social drinker. They don't classify myself as depression and so they always give...I think they just classify me wrong here which is blocking me off from what I really, where any kind of help I might need.

I: So who do you feel is classifying you wrong, other residents or...?

R: Residents definitely yes, but staff too. That's why, I mean I don't...I used to talk to 'em when I first got here but that kind of changed; I don't really talk to them anymore. It's a trust thing.

I: So you feel like that they maybe see some alcohol dependency issues with you that you don't necessarily feel like are there?

R: Yep. Exactly.

Later in the conversation, Derek described how his relationship to the counseling staff at his facility had changed from the time when he was admitted and feeling optimistic about the opportunity to address his struggles with depression to the period just prior to discharge when I met him.

I: What changed? What do you think changed your relationship to the staff?

R: I feel like every time I talk to them something bad will happen. I just talked to Sharon [a counselor] about this after group. I feel like...ok, yesterday I said I was addicted to drugs and alcohol—which isn't true—I just said that 'cause I feel like that's how people identify me here. So I was, say that and then tell Sharon I just felt like that in regards to staff they were just not listening to me, or they just classify you as something else and that's the way you're going to have to live by. And I just can't talk to staff anymore, or as much as I used to.

While Derek is unable to pinpoint exactly where things went wrong, my conversation with him indicates that his openness about using alcohol as a means of self-medication was documented during one of the many diagnostic assessments that clients are invariably asked to complete at various points during their journeys through hospitals and treatment centers. Admission of alcohol use would likely be incorporated into an IRTS

treatment plan as an issue to be addressed during the client's stay. In any case, Derek felt that his optimism about the opportunity to address major depression—a diagnosis that he felt comfortable with—had been severely dampened and that clinical interactions were too frequently organized around management of substance use, so much so that he found himself inhabiting an identity that was inconsistent with his experience because it seemed to better meet the expectations of staff and peers.

Seth, a client with a history of schizophrenia and methamphetamine use that had caused a pattern of recurring hospitalization and treatment over the past three years, discussed his experience of shifting diagnoses over time with me. Seth's multiple and time-variable diagnoses are typical of someone with a more extensive institutional history, and his deep familiarity with these diagnoses is evident in his remarks:

I: What was the, if you don't mind me asking, what was the original diagnosis that you got when you first...when you were 17 and has that changed over time?

R: Yeah, I started out with meth-induced psychosis, then when I turned 18 and went to Fergus [Fergus Falls state hospital] they chose paranoid schizophrenia; same symptoms, God knows why, it's like the same thing pretty much, though. When I got to CBHH [community behavioral health hospital] they diagnosed me with meth-induced psychosis and OCD [obsessive-compulsive disorder]. And then I went to Wilmar [state hospital] and they diagnosed me with schizo-affective disorder with OCD, and that's what it is right now.

I: Was there ever a CD [chemical dependency] diagnosis to go along with that?

R: Poly-substance dependence, I think

I: Has that stayed the same sort of all the way through?

R: Yeah

I: Did you receive that somewhere along the line?

R: Matters more on who I was honest to and who I wasn't.

I: How do you feel about that personally? With issues of mental health, chemical dependency? Do you feel one is primary or they fit together in some way for you?

R: For me, I think that mental health is more important 'cause when your mental health starts skipping I start using drugs just to cope with the symptoms.

I: And had that been the case when you were much younger before you were 17, or did you experience...

R: I was doing a lot of drugs back then.

I: And were you also experiencing mental health issues too?

R: Yeah, that's why I was using drugs, 'cause I couldn't handle not telling anybody what's going on.

I: And then by the time you were 17, it just kind of reached a boiling point for you?

R: I had a break down, when I was about 18, really close to my 18th birthday.

I: Can I ask you, if you don't mind, about the changing diagnosis you've received, what do you think about that, do you think they describe the ways you've been feeling, or what do you think about all the different changes in the diagnosis?

R: They're all so close, like you got schizophrenia and meth-induced psychosis, the only difference is psychosis is drug-induced, so it only happens in one night, which I think happens, so personally if I was diagnosing myself I'd rather have meth-induced psychosis because it happened in one night, this change did not occur like I was experiencing symptoms for a period of time, and then it just kept getting worse, one night all of a sudden, boom, it just happened; I was on meth, that's why it happened, so I think it's meth-induced psychosis, but then you got the paranoid schizophrenia thing cause meth-induced psychosis is supposed to go away after a while and people say why hasn't it gone away and you know I don't know, and then paranoid schizophrenia is just the same thing pretty much, but yeah, I mean schizo-affective disorder is about the same; it's not as bad as schizophrenia; it doesn't have as bad a stigma on it, so that's not so bad. But I agree with the OCD, that's one they never diagnosed me with which they should have a long time ago.

I: So generally, with all the changes in diagnosis, do you think that's something that's happened with this, maybe the doctors you encounter don't know enough about you or....

R: I think it's like if you were experiencing bad symptoms, then you must be a schizophrenic you know, but maybe my symptoms are just really bad right now, you know. But if your symptoms are okay, you could be schizo-affective, and then the OCD should have been diagnosed a long time ago; I don't see why my doctor never saw that. I was telling him the same thing I was telling everybody else. And then finally I got the OCD, so that was just terrible doctoring.

Seth's acknowledgement of the way in which symptom severity can mediate diagnosis is, in some ways, consistent with the emphasis on recent symptoms that conditions diagnostic practice in some IRTS settings; however, in his view, misreading severity can cause mental health professionals to assign diagnoses that are different in kind to their predecessors when it may not be appropriate to do so. In addition, Seth's narrative indicates that such revisions to diagnostic categories have serious ramifications from the client point of view because they may carry different meanings with respect to stigmatization. While Seth finds the nature of diagnosis to be highly-contingent (and perhaps arbitrary, to some degree), his comments suggest that he believes the categories themselves to be coherent. Thus, while the logic he follows would suggest that clinicians' attempts to differentiate between methamphetamine-induced and paranoid schizophrenia may be problematic, these categories seem to demarcate objective modes of experience, one of which may be preferable to the other because its causal origins are

distinct, located beyond the self, and give rise to symptoms that are expected to abate, perhaps permanently.

In instances where the onset of symptoms was very recent or a client had little experience with mental health professionals until the events that precipitated their IRTS admission, there were fewer opportunities to build a diagnostic/treatment history, and clients in this group were typically more inclined to find relief in a diagnostic category. While such clients tended to offer less ambiguous examples of acceptance of the biopsychiatric injunction, they also highlighted difficult social circumstances that were associated with the onset of symptoms, even if the relationship between the two factors could not be fully disentangled. An IRTS client named Susan was admitted to the hospital for unfamiliar symptoms three times in quick succession over the course of several months, and I spoke to her as she was preparing to discharge and enroll in a local community college:

I: If you think back to December, what was going on in your life that made you initially go into the hospital?

R: Honestly, it's kind of a big blur for me, like this whole last year has been. But I know that it's been going on for a long time, but it's just working four jobs and wearing myself down was kind of what made me crumble back in November, which was when I got really sick, and that's when all the stuff happened. Ended up in the hospital because of it.

I: What did they do for you in the hospital?

R: Well, the first time it was for suicidal ideation, so basically it was just there to stabilize me, that's when they got me on meds. That's about it.

I: You don't have to answer these next questions, it's totally about your comfort level, but do you mind if I ask you about your diagnosis?

R: No, that's fine.

I: Currently what is your diagnosis?

R: Borderline personality disorder, major depression, dysthymia.

I: Dysthymia, that has to do with major depression, right?

R: Mmhmm, well, it's like a low mood constantly.

I: How do you, I mean have you educated yourself or know a lot about these diagnoses and do you feel that they speak to what you feel like inside?

R: I've read on some of them, I'm reading a book right now about a girl with borderline and I mean it's like reading my own life story, when she talks about the way she feels about things and

how she reacts to those things. As for the dysthymia, I've always just been kind of a low person, not like sad all the time, but just kind of low key. I'm not real excitable unless something really really good happens. And then major depression, I don't so much think that I have that diagnosis anymore, I think it was more when I first went to the hospital and I had been on meds and been sick for so long and it finally hit.

In this example, Susan, with the assistance of some health education resources available at her IRTS, developed a deep identification with her personality disorder and was also able to imagine dysthymia as an enduring feature of her individual history. While the diagnosis of major depression strikes her as more of a singular episode, the other categories seem to come to life as characteristics or traits. At the same time, their emergence and need for recognition is the culmination of challenging life circumstances. Due to what Susan described to me as fairly precarious socioeconomic situation, she had been overworking herself in the months prior to her hospitalization, and despite the fact that she had begun to experience increasingly acute symptoms, she was without health insurance and could not afford to schedule a check-up appointment. There is little debate over the nature of disorder in Susan's case, though the manifestation of overwhelming symptoms is linked to the social arrangements that ground her everyday life.

Finally, there are those clients, few in number, who IRTS clinicians would consider to be sorely lacking in insight. These young adults raised doubt over the extent to which their patterns of behavior constitute mental illness and were reticent about interpreting symptomatology in a conventional fashion. Brittany, who was looking forward to leaving IRTS and completing her period of civil commitment talked with me about her experience hearing voices:

I: And what do you think about the diagnosis?

R: At first I was really scared. They told me it was the worst one, but I have schizophrena-form, so I only have some types of it. I'm not sure which ones, but I ruled out bipolar disorder so I'm a little bit of bipolar I guess. I don't feel I have bipolar, but my mom says everybody has bipolar and she's a nurse; that's what she says [laughs]. So that made me feel a little better.

I: Is it useful to have those terms and diagnoses?

R: It is. I don't like that they're called mental illnesses. I don't feel like I have a mental illness, but I do since I experience voices.

I: What do you mean you don't feel like you have a mental illness?

R: Well it is a mental illness, and they tell me I have a mental illness, so I guess I have a mental illness even though I feel totally normal and I feel the same way I did 6 months ago, only I hear voices, and that's it.

I: So you feel like you're the same person?

R: Yeah, I am. There was a weird, confusing time period in my life that they [voices] were telling me weird things, but now they're great. I love to hear them. And they're surprised to hear that I like to hear them.

I: The voices?

R: Yeah, cause a lot of them tell people to do things like kill themselves or hurt other people and mine have never done that.

I: They tell you kind of good things?

R: Oh, yeah. They'll tell me to do my homework, and if I go to the casino they'll help me cheat and funny stuff like that. I don't think it's serious.

Brittany is reluctant to label her experiences with voices as mental illness, but it is clear that she feels compelled to characterize them as such. Brittany went on to tell me that she likes who she has become and is frustrated about being forced to take medication, which does not seem to aid her in any way. Such an orientation toward diagnosis is unsettling for clinicians and suggests a reversal of the very principles of psychiatric subjectivity that they attempt to impart through the work of recovery. In this view, Brittany becomes an at-risk client who is likely to struggle to abide by the forms of self-management necessary for minimizing symptoms and participating productively in everyday life.

For mental health professionals, the decision about the extent to which a diagnosis should be discussed with a client is dependent on a particular client's insight, or their awareness of the fact that they are suffering from a psychiatric disorder that is largely biological in origin. IRTS clinicians fear that by sharing too much diagnostic information

they run the risk of alienating clients who may resist labels and their associated stigma. However, as I have attempted to demonstrate, clients are typically quite familiar with their diagnostic history and are quick to offer their own interpretations of the various categories that have been applied to their symptoms over time. Diagnosis is processual rather than singular; it encompasses a variety of encounters with various mental health professionals across knowledge-producing sites where categories reflect symptom presentation, medical history, and institutional objectives. At IRTS, as we have seen, diagnosis is present-oriented; clinicians use standardized assessments to hone in on those categories that best reflect the symptoms that are currently troubling the client rather than attempting to grapple with an individual's entire psychiatric history. This approach reflects the demands of clinical practice in this unique community rehabilitation setting, where the goal is to quickly equip clients with the sorts of skills and knowledge that will allow them to cope with symptoms and function more independently in the near future.

Mental Health Education and Self-Management

At IRTS facilities, much of the work of recovery occurs in group settings where mental health professionals lead client groups focused on psychoeducation and life skills topics. Mental health professionals typically employ an illness management and recovery (IMR) model, which encompasses a broad set of evidence-based practices. The illness management component of the model emphasizes the minimization of symptoms and prevention of relapse, while recovery focuses on boosting self-esteem and self-efficacy

with the ultimate goal of fostering the sorts of skills that will help individuals achieve meaningful personal goals (Substance Abuse and Mental Health Services Administration 2009). One of the key assumptions underlying this model has to do with the largely chronic nature of the psychiatric illnesses that it seeks to address; in most cases, it is not realistic for clients to expect complete remission of their symptoms, though this is somewhat dependent on the nature of their disorder. At the same time, the recovery component of the treatment model emphasizes client autonomy and independence in the definition and pursuit of short and long-term life goals. The Federal government's Substance Abuse and Mental Health Administration summarizes the role of the individual in a programmatic statement on the evolving concept of recovery:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals. Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness" (National Recovery Statement 2004).

This formulation valorizes the status of the person as a rationally-choosing, self-determining actor but also suggests that this status is always at risk of being compromised by the reemergence of symptoms which the consumer must be prepared to assume responsibility for.

As IRTS mental health professionals engage clients in the fashioning of a recovering self, education and skill-based components of mental health rehabilitation

invoke both the individualizing and collectivizing projects of what Rose and Novas (2005) call “biological citizenship.” Rose (2007: 134) argues that:

Biological images, explanations, values and judgements thus get entangled with other languages of self-description and other criteria of judgment within a more generalized “regime of the self” as a prudent yet enterprising individual, actively shaping his or her life course through acts of choice.

Ethical stances are inherent in forms of biological citizenship as identity becomes intertwined with “more general norms of enterprising, self-actualizing, responsible personhood; knowledge of the biological self demands biological responsibility, particularly the responsibility to optimize” (Rose 1999:18).

In IRTS settings, educational and skills-based programming function as spaces where dominant psychiatric concepts concerning diagnosis, symptom management, and pharmacotherapy circulate and are reflected upon by clients. My research suggests that this circulation of ideas offers clients the opportunity to begin to identify with dominant categories while recovery strategies encourage the development of what I call the activist self; that is, an approach to illness management that demands active, ongoing self-surveillance and the deployment of a variety of techniques and strategies for symptom prevention and management. At the same time, rehabilitative projects involve the deliberate formation of biosocial groupings through which clients are, to some extent, able to normalize the isolating sense of difference that often accompanies a psychiatric diagnosis by virtue of the fact that they imagine themselves as belonging to and integrated into a collective. In this case, the presence of disorder in others is reflected back onto the self, helping to concretize the notion of oneself as having a mental illness.

Everyday life at an IRTS is organized around group activities. An IRTS clinical director described how participation in groups unfolds over the course of a day:

We have a check-in every day at 9:30, so the counselors and the clients go to check-in. It's super informal; everyone introduces themselves, and we put on the board what all of the groups are for the day; and then the Clients can say 'I'm [client name], and I'm gonna go to IMR group today, and I'm gonna go to DBT skills group today, and I have an appointment with my doctor this afternoon.' It's kind of like some accountability, get them out of bed, get them started with the day. And then we typically have groups then at 10 am and 11 am, and then lunch from 12 to 1, and then any variety of groups in the afternoon—like a one o'clock, two o'clock, three o'clock group. So, there's certain groups that we're required to provide... We have IMR that's required for all of our clients. All of our clients are also required right now to go to coping skills group, and they go to health and wellness group. They go to IMR three times a week. Then we have some other groups. We have a community resource group that our case manager runs. We have some other evidence-based groups that our peer support specialist facilitates. And dual recovery [mental illness and substance use]... So those are like the elective groups. Everyone goes to three sessions of IMR, coping skills, and health and wellness, and then they're able to work with their counselor on customizing some of those elective groups, too. So, I'd say each client goes to a couple of groups a day.

As is evident from these remarks, a client's day is largely structured around mandatory groups, and many choose to participate in elective groups as well. Groups are often led by IRTS counseling staff, but peer support specialists—individuals who have undergone treatment for psychiatric disorder themselves—and case managers—a role that usually involves connecting clients with an array of resources beyond IRTS—facilitate activities and discussion as well.

Group sessions—particularly IMR—involve discussion of client illness experiences in terms of disease categories and include advice on how to cope with and communicate about chronic symptoms. In these groups, activities include reading directly from the DSM, filling out worksheets that assess mood and behavioral traits, and developing strategies for symptom management that concretize mental illness as an

objective disease. One counselor explained how diagnoses are discussed in a broad manner in groups and cause clients to pose questions of themselves:

And they do talk about it [diagnosis] in the groups, like the illness and management and recovery groups, they do talk about it, but it's blanket because of HIPAA [health care privacy regulations], too; we don't say you have this and you have that, but we talk about it, and they'll be like 'Oh, I have that [symptom] sometimes, does that mean I have this [diagnosis]?' and so we say, 'oh, let's look at it.'

Adam, a young man plagued by schizophrenia and the commanding voices that sometimes accompany it described some of the means by which he has gained insight into his own condition, as well as those diagnoses that his peers at the IRTS facility deal with:

In the mental illness groups they talk about my specific mental illness, so I learn more about it... We got the book out, I forgot what it's called...the DSM...we got that book out and read what everybody's mental illness was. I read all about mine. It explains a lot better in detail how it works...It just clicks with me and starts making more sense in trying to overcome the mental illness... From what I've read in the DSM, in that book, yeah, it seems pretty much right on; I've read the descriptions and everything and that seems, yeah, they got me.

Another man, struggling with major depression and borderline personality disorder described one of the means by which he has gained insight into his diagnosis: "I've read on some of them [diagnostic categories]. I'm reading a book right now about a guy with borderline, and I mean it's like reading my own life story, when he talks about the way he feels about things and how he reacts to those things." Alice, who felt relieved at having recently been diagnosed with paranoid schizophrenia after her physicians had struggled for some time to match her symptoms to a category, discussed her experience at IRTS:

So I went and I tried to learn everything I could about it [the diagnosis], 'cause finally something was fitting. I didn't want to have it, and so much stigma around it and I know, I've taken a lot of psychology classes so I know, but it was through being here I learned a lot about it, and I mean I live it.

A client who had recently come to an IRTS to stabilize symptoms that arose after he stopped taking his medication noted how group work had brought a sense of stability to his understanding of diagnostic categories:

I: And you mentioned that your diagnosis was schizophrenia, but it sounds like you're talking about there's kind of co-occurring things for you?

R: Yep. Like they had, a while ago they had me diagnosed with ADHD, then they ruled that out. And then they had me diagnosed with a mood disorder, and then they ruled that out and just slapped on schizophrenia like probably four years ago, I'm thinking, I've had this diagnosis now. And now that we've gone through some of the groups, like today we did the diagnosis group one, and then we were talking about schizophrenia all the, the whole time, and the symptoms and all that. I'm pretty sure that's what I've got 'cause all the symptoms are in...that category is something I have in each category of symptoms.

Group sessions survey the dimensions of diagnostic categories using authoritative texts and other materials, providing a framework within which clients can locate the specifics of their embodied experience. Diagnoses begin to “fit” as they are presented to clients as objective entities backed by expert knowledge codified in manuals and other documents, and mental health professionals act as guides as individuals attempt grapple with the ways in which a category matches their experience.

The process of grasping one's own illness also entails the recognition of a broader biosocial community to which the individual belongs. Cheryl, an upbeat woman that I spoke with on the day before she was set to leave treatment sketched out her complex diagnostic history before observing that “It's weird, 'cause when I wasn't diagnosed you looked at people with mental illnesses like ‘wow look at that one,’ and now it's like I am that one.” Similarly, another participant observed how the treatment and rehabilitation process had awakened her to the high prevalence of mental illness and offered a new perspective on inhabiting the world:

I think I've seen the world from a completely different view...I think there's a lot more lonely people out there in the world besides me; there's a lot more depressed people, a lot more than I thought...I'm just more understanding towards it [mental illness], and I don't know, I just understand a lot of illnesses more cause we talked about it in so many places, you know. We talked about it here, about like all...bi-polar, schizophrenia, depression, so I've learned more about, instead of just depression. I've learned more about other diagnoses too and other problems people have, so it makes me more understanding.

In addition, clients develop bonds with one another beyond the group setting based on shared diagnoses, which enable them to discuss common experiences and delve into one another's symptomatology more informally. The interview excerpt below provides an example of this process:

I: And you mentioned that you like the group where you talk about mental illness, so I'm just wondering if there's anything else you've picked up during your time here that you feel will be particularly helpful once you leave?

R: Not right off hand that I can remember right now. I like learning about other people's mental illness too, trying to compare it to mine, seeing how bad they have it off, you know.

I: Is that something you were a lot less aware of before?

R: Yeah, the types, like the bi-polar one, two and three, I think it is or whatever. We're learning about that and the whole manic and depressive, couple other ones, major depression I was interested in.

I: I'm just sort of wondering how that helps you when you're comparing illnesses. Helps you know there are other people out there dealing with it?

R: Yeah it helps me know better I'm not the worst one off or I can relate with them you know, oh you hear voices too and talk to them about it after group. I've talked to a few people about it. It's interesting to see what they hear, what goes on in their head, what they think about...

I: So you've talked quite a bit at times with other residents?

R: Yeah, I have, about their mental illness, about my mental illness, and comparing and contrasting the two of them; how they're similar yet they're so far different.

I: And that seems like it's been productive?

R: It's been very productive when they feel like talking about it.

I: Do you think there are people that you'll try and keep in touch with once you leave?

R: Yes, I'm gonna try to keep in touch with my roommate after I leave, we're pretty close. Some long nights talking.

I: When you have one of those long nights what kind of issues come up?

R: Just history, like one time this happened, one time I went to this store and I couldn't handle it so I turned around and walked out and stuff like that.

An IRTS mental health professional explained how such bonds can be beneficial for rehabilitation, observing that "A lot of it is just really about being social. They are so afraid of others, and they're so isolated that just being here with fifteen other people that struggle with mental illness is, you know, such a huge part of their treatment."

Following from the educational aspects of IMR are a set of self-management practices that Martin (2007) describes as belonging to the category of “mood hygiene.” Mood hygiene speaks to the myriad techniques and practices that an individual may put to use in order to monitor and manage their symptoms. The category is meant to be rather expansive and encompasses journaling, mood charts, the reframing of cognitions, and so on. Martin (2007:179-180) describes the role of mood hygiene in psychiatric self-management:

To govern themselves, individuals would need to collect information about their subjectivity in any number of forms, from written reports to drawings, from charts to statistics... Today, a person who keeps a mood chart is translating inside, subjective experience into outside, socially visible forms. The practices of introspection and record keeping we have come to take for granted build a strong identity at the individual level, both general (I am a self-regulating calculating, rational person) and specific (these are my mood patterns, and this is how I respond to my specific medications).

Mood hygiene thus refers to the inscription or stabilizing of seemingly uncontrollable, ephemeral phenomena so as to make them subject to transformation (Latour 1987; Poovey 1998; Rose 1996). The forms of knowledge derived from mood hygiene practices thus constitute a way of knowing the self that enables further self-regulation and modulation as means of coping with mental illness on an everyday basis.

IRTS staff use group sessions to provide high level education about diagnostic categories and then complement it with the introduction of mood hygiene practices that both reinforce the notion of a disordered self and promote ways of acting upon the self that will allow clients to succeed in the world beyond IRTS. Other forms of self-monitoring and self-evaluation must come into play to complement the use of

pharmacotherapy as mental health professionals prepare clients for their transition to independent living. One IRTS resident summed up this point on the day prior to her discharge when described how she had completed an anxiety and depression workbook during her time at the facility:

It has a lot of CDs and worksheets about how you rate your mood, how you rate your anxiety and depression and interpersonal skills, like how to deal with other people, how other people should see you, and stuff like that...I've kept all the worksheets that we've worked on, and I really just think that working through the worksheets again when I get home will help a lot.

She went on to add:

I was able to learn a lot. And we just talk a lot about anxiety and depression and ways to cope with it like self-talk and keep breathing and journaling and stuff like that...the deep breathing I use when I feel an attack [panic attack] coming on...The self-talk and my journaling kind of go together. I have two journals, one for negative things, I just write down my negative thoughts and I don't reread 'em. And then I have my positive journal that I write down quotes from the bible, positive self-talk and that one I read over and over when I tend to feel depressed or anxious.

Here one can see quite plainly how an activist orientation toward inner processes is seen as way to manage potential hardship in the post-IRTS future. Jane, whose symptoms had been stabilized at a state hospital prior to her admission to an IRTS, described the knowledge and skills that she had gained from IMR group participation:

I: What about these programs that you've talked about? Do you feel like you're going to be able to translate them into the community when you leave? Like, what you learned here, is it applicable?
R: Yeah, definitely. We do one group that's Mind over Mood. I don't know if you've ever heard of it before, but it's basically just changing your thoughts, change your actions and going through thought logs where you put a situation down, you rate the mood, you put down your automatic thoughts, what you think right away, evidence that supports it, trying to find a balance in thinking there. And then we do IM and R which helps us learn about the medications or stress tolerance and things like that.
I: And those are skills that when you leave here you think that...
R: Mmhmm, definitely.
I: So you would say that probably groups are the most helpful?
R: Yep, 'cause I think those are the two major groups here anyways, 'cause IM and R is usually two days a week.

Such well-defined plans for practicing mood management were not always present among respondents, but most understood mood hygiene to be a continuous, evolving process involving the documentation and assessment of symptoms and one's responses to them; as a participant in this process, one acts upon potentially risky affective states using medication in tandem with a variety of other techniques.

The concept of hygiene is expansive, and in some instances, it can be employed by mental health professionals to promote regulation of and control over aspects of everyday life that clients may not immediately associate with symptom management. A peer support specialist talked with me about the various groups that he facilitates or is involved in and the topics that are typically covered:

Teaching people coping skills is a big one. Independent living skills...I mean, in the beginning one of the goals is just getting people acclimated to this so that they can work on skills. We have coping skills group, and all the other groups have coping skills laced into them. We do a lot of stuff like journaling, light therapy is something that I'll bring up with people, sleep hygiene. It [sleep hygiene] has something to do with like making sure you're not getting caffeine, nicotine, or alcohol right before you got to bed. Part of it is getting enough light when you first wake up and circadian rhythm type stuff. At its core it's like keeping the same sleep schedule every night and making sure you get enough sleep each night. That's kind of another category we'll do, the health and wellness type stuff. One really good one that I like to do with people that have trauma histories or experience reality different from others...there's this one where there's like five things you can see, five things you can hear, and five things you can touch or feel. There was one person with the most significant trauma of any person I've ever met...and when she'd start thinking about the traumatic stuff it would just bring her right back out.

In this account, we see how the respective orientations of IMR, coping skills groups, and independent living skills groups interact to subject a host of biological and sensory processes to scrutiny; the presence of psychiatric disorder in all of its varieties calls for an equally complex set of interventions aimed at the body and interior experience. Given the short duration of an IRTS stay and the harsh fact that most clients will soon be faced

with challenging living arrangements, staff attempt to combine health education with skill-building in the hope of engendering forms of conduct that will minimize the impact of symptoms on everyday functioning. As a counselor I spoke with observed, there is little room for psychotherapy; IRTS rehabilitation is concerned with an activist orientation toward the symptomatic self that is enacted through practice:

We do psych rehab, so it's pretty concrete stuff. I'll ask them, if you come here, what do you want to work on? What do you want to do? 'Oh, I need to learn coping skills because I have anxiety, and I can't go to the store because I'm scared.' Ok, so, that's what you're going to work on. Like, what are some skills and then you go to group, and you learn about coping skills. Your counselor helps you figure out which ones are most beneficial and helpful for you and then you practice those in the moment...Just, like, working towards that, but a lot of it is just interacting with the counselor and they do a lot in the groups with their peers...And education about illness management and recovery. We sometimes take them out, and if they want to learn how to use the bus, we take them out on the bus; the counselor goes with them and practices with them. There's a lot they can do; it's just that they need that knowledge and that confidence about what to do when they become symptomatic...It's not talk therapy; it's more doing. What can you do? Because that's what they need more than anything.

As I indicated earlier, the efficacy of the various technologies of the self that permeate rehabilitative curricula in community mental health settings hinges upon an understanding of psychiatric disorder as chronic. Beginning with diagnosis, the work of recovery reveals disease entities through the use of an array of objectifying strategies and techniques that make categories tangible for clients; however, it is the expectation that symptoms—perhaps severe—will crop up again that compels clients to move back and forth between the accumulation of self-knowledge and active cultivation of a particular kind of self. While symptoms are not wholly uncontrollable, they do possess a degree of unpredictability, and the impact of their onset on the lives of clients can be minimized through the various means of governing habits and behavior. In interview after interview, the young adults I met conveyed the idea that mental illness was something that they expected to be dealing with for rest of their lives. Anne, the woman who had

experienced the very sudden onset of panic attacks, expressed a guarded optimism about her recovery, noting that she will always have a disorder, but is beginning to gain some mastery over it:

I think that I'll probably always have depression. I think it will always be there, waiting to come back. The anxiety I think is just a lot from my depression and my negative thinking. I think that I can control the anxiety if I try hard enough, if I keep going with the positive, stay away from the negative, I feel like I can control it versus when I first came in the anxiety attacks would last like an hour or two, sometimes longer, now it's about fifteen-twenty minutes and they are not nearly as...I don't know the word I'm looking for...intense as they were before... It's just, it's like you can't hold on to a thought to save your life, and that's what it was like in the beginning and now I am able to hold on to thoughts, I'm able to open up my journal and read the positive things, I'm able to read passages from the bible, I'm able to calm myself down.

Other clients shared Anne's positive outlook but understood that the chronic nature of psychiatric disorder meant that recovery was not a process likely to unfold in a linear fashion; there may yet be hospitalizations and treatment stints awaiting clients in the future. Andrew acknowledged the intractability of mental illness as we discussed his plans for the future: "I'll probably be struggling with it [mental illness] for the rest of my life, and who knows, I might need to go in for a tune-up every once in a while."

Andrew's words convey an understanding of psychiatric disorder as an organic, lifelong affliction. Furthermore, the mechanistic "tune-up" metaphor suggests that the mentally-ill self can be re-optimized or recalibrated through ongoing treatment in the future.

While IRTS staff work diligently to impart knowledge and skills that promote an activist vision of a self constantly attending and readjusting to the demands of affective states, self-management alone will not sustain clients of an increasingly overburdened community mental health system as they struggle to lead meaningful, independent lives. In such circumstances, the primary means of addressing and managing chronic psychiatric disorder is pharmacotherapy.

Drugs for Life

Dumit (2002:124-125) has argued that over the past quarter century, a new paradigm of health has emerged in the United States that privileges the assumption of people as inherently ill over previous notions of “inherent health,” which assume, with some exceptions, that illnesses are temporary disturbances to the body—“a robust system whose normal destiny is to return to health.” Those dealing with mental illness under the inherent illness paradigm find that normalcy is a rarely asymptomatic state ultimately fraught “with vulnerability and precariousness, requiring a constant vigilance for further warning signs” (ibid:125). The trajectory of mental illness within this framework begins with a “body that is destined to become ill” and then interprets the “past as genetic dispositions which can be identified; the present location within imbalances; and the future as an ongoing negotiation with therapy that returns and maintains the body within normal tolerance” (ibid:126). Ultimately, Dumit (2012) argues that the contemporary “mass health” paradigm functions to produce new forms of and lower thresholds for risk at the population level, which facilitates increasingly common lifelong pharmaceutical interventions.

Dumit’s model of an inherently-ill citizenry whose various risks fuel the ever-expanding need for pharmaceutical consumption exists in a symbiotic relationship with the preventive population-level interventions that comprise public health policy in what Biehl (2007) calls the “pharmaceuticalization of public health.” This conceptualization

of the relationship between illness and pharmaceutical use contrasts sharply with some prominent earlier accounts of the potential of psychopharmacology to liberate the individual. For example, Kramer's (1993) influential concept of "cosmetic psychopharmacology" seized upon the triumphalism surrounding the ascendancy of SSRI drugs (Prozac being the standard-bearer) in the 1990s to suggest that such antidepressants could be used to enhance the personalities and capacities of people without clinical diagnoses in a manner analogous to cosmetic surgery. Martin (2006) suggests that the varying uses of and values attached to pharmaceuticals may reflect class hierarchies, with cosmetic psychopharmacology the province of affluent professionals who look to enhance personality traits valued in their social milieu; among people of this strata, visiting a "psychopharmacologist" is a socially-acceptable act through which drugs are matched to desirable moods and traits. Martin contrasts this manifestation of psychopharmacology with the experiences of Medicaid-enrolled participants in her fieldwork who were limited to infrequent, short-duration medication management visits to healthcare providers.

The inherent illness model holds sway at IRTS and other contemporary community mental health settings where the contradiction of "recovery without cure" informs treatment and rehabilitation (Jenkins & Carpenter-Song 2005). Jenkins (2015: 63-64) characterizes pharmacotherapy as "the interiorization of the clinic" in which the consumption of psychotropic drugs represents

the incorporation of clinical ideology as transmitted by doctors, other service providers, and the myriad social actors who claim moral and working knowledge of mental illness and its treatment. In this context the medication is a kind of benefactor... This effect is possible because, though

unimaginable a few decades ago, the primary referent in psychiatric and psychological language for therapy has moved from “psychotherapy” to “pharmacotherapy” as the latter has become preeminent in terms of sheer frequency of “treatments” actually offered.

As I have argued earlier, health education provided at IRTS attempts to foster a sense of the self as perpetually at risk and in need of constant surveillance and management. For clients, compliance with medication regimens is both a means of gaining the stability necessary to act upon themselves as well as a self-management technique in its own right—perhaps the key such technique given that compliance signals a readiness for independent, rational decision-making in the eyes of clinicians. As Jenkins suggests, the logic and values of biological psychiatry are condensed in psychotropic drugs. Drugs are the primary therapeutic tool from the mental health professional’s perspective, and adherence to a pharmacotherapy plan is necessary for client stability in the short-term and is the foundation for client achievement of long-term recovery goals.

Most IRTS clients consume pharmaceutical “cocktails” comprised of a dizzying array of psychotropic drugs of various indications, and in the majority of cases they understand medication as something that will be vital to their functioning for the foreseeable future. The questions I posed to clients regarding medication were usually met with responses that enumerated the prescribed anti-psychotics, anti-depressants, and anxiolytics, occasionally accompanied by precise dosages. I quickly became familiar with a seemingly endless list of branded pharmaceuticals and their generic equivalents:

I: Are you currently taking medication?

R: Yeah.

I: Can I ask you what types of medication?

R: I’m on Effexor 300, Abilify, Lithium 600 twice a day, and Klonopin, 25mg three times a day; and then I get Trazodone at night, 400.

In this case, we find a serotonin-norepinephrine reuptake inhibitor class of antidepressant/anxiolytic (Effexor), an anti-psychotic (Abilify), Lithium to address bipolar disorder, a benzodiazepine usually prescribed for anxiety (Klonopin), and an antidepressant used to address sleep issues (Trazodone). For clients with multiple diagnoses, it was not uncommon to encounter such a lengthy list of drugs the dosages of which were regularly adjusted to manage side effects and therapeutic effect. While IRTS staff monitor clients' use of psychotropics, adjustments to dosages and changes to prescriptions typically occur off-site during occasional medication management check-ins with a psychiatrist.

Clients, when they are generally satisfied with medication, overwhelmingly view it as a preventive measure; ideas about cosmetic enhancement are rare among the young people that I met, and, generally-speaking, medication was largely deemed useful to the extent that it kept symptoms at bay. While clients did not always directly engage the master symbol of "chemical imbalance" in discussions about the purpose and efficacy of medication, it was clear that acceptance of pharmacotherapy follows from an understanding of mental illness as a chronic disease. Several client comments illustrate this perspective:

You'll be dealing with mental health the rest of your life, it's a disease. So is chemical dependency, but it's a manageable disease.

I don't really think alcoholism is a disease; I think it's a choice. But some people, I don't think they choose to be sad but all of a sudden they have a chemical imbalance in the brain

The health education groups I previously discussed included modules that emphasized the importance of remaining on a drug even if one felt that their symptoms had improved markedly, returning the person to a state of “normalcy.” An IRTS clinical director described the role of nurses in health education, noting “There’s a lot of medication stuff the nurse will do. If they [clients] have issues with compliance, we’re going to teach them about their meds and what they are and what they’re for instead of just giving them to them and they don’t know anything about them.” The importance of compliance is repeatedly impressed upon clients, one of whom observed: “Well I learned that it’s good to take your meds every day, and that it’s not ok if you don’t. You could also go through like seizures and crap like that not taking your meds.”

Jenkins (2015) suggests that characterizing and comprehending mental illness in biochemical terms—or at least as an organic disease—is central to the work of recovery as a kind of symbolic mechanism for shaping the experience of illness and rendering certain treatment modalities acceptable among patients. In this view, chemical imbalance “performs an essential ‘work of culture’ to signal the neurobiological mechanism of illness and suggest the psychopharmacological strategy for its treatment” (ibid: 39). At the same time, the notion of chemical imbalance is imprecise, thus opening the experiences arising from the consumption of psychotropic drugs to a variety of interpretations involving normality, the impact of side effects, and the ways in which drugs can induce unexpected affective states.

For those clients most satisfied with pharmacotherapy, the alleviation of symptoms accompanying medication brought a sense of normality and calmness:

I: What kind of medications are you taking?

R: I take Abilify.

I: And you find that to be helpful?

R: Mmhmm, very.

I: In what ways does that work for you?

R: It doesn't make me tired like most antipsychotics that make you drowsy or whatever, this one doesn't. It just basically makes you feel normal, perfectly normal.

I: You don't really experience many any side effects with that?

R: Nope.

I: How do you feel about those diagnoses?

R: As long as I'm on my meds, I'm just fine and I'm just normal. But if I'm off my meds then that's when you can see it and tell it and everything. So as long as I'm medicated I'm fine.

Beyond a sense of normality, some clients who benefitted from medication experienced something akin to the unleashing of potential:

I: Was it difficult for you before to be consistent with the medication in terms of taking it regularly?

R: Yeah, when I was at the hospital it was difficult for me because I didn't think the meds would help me, or I didn't think they were right on top of what I was diagnosed with, but they really did help.

I: How did you begin to see that change? When did you realize you felt like it was helping you?

R: Within two weeks of being in the hospital and taking the meds I was more calm and more relaxed and my body started to shape out more, 'cause I was really skinny and like really unhealthy. I felt like I was dead. Now I feel more energized and more alive than ever.

Normality was typically interpreted by clients mainly as the absence of symptoms, and while some clients noted increased stability, energy, and calmness, such improvements did not seem to be linked to ideas about medication fundamentally altering human capacity as other ethnographic work on pharmaceuticals has found.³²

³² For example, see Martin (2007) for a discussion of the way in which marketing campaigns imbue pharmaceuticals with magical properties and person-like traits that are tailored to desirable characteristics that drugs are thought to bring out in consumers.

Other clients described a far more ambivalent relationship to medication in which they experienced effects but feared that drugs might be depriving them of their capacity to experience emotions, or that drug side effects were inhibiting any potential benefits that might be gained from their use. Cheryl, who was looking forward to leaving IRTS and resuming her studies, talked with me about her experience taking Celexa, an anti-depressant:

- I: And so do you feel like those medications have been useful for you?
R: Kind of, they just more make me less aware I think, like more numb to what's actually happening. I think I don't get depressed as easy, but things that would usually make me depressed, don't actually, I just gotta sit there and think about it instead of cry or something. So it makes me more numb.
I: So it doesn't necessarily elevate your mood or make you feel...
R: I haven't really noticed it, they just prescribed me to it since I've been in the hospital, so like three months ago when I first went into the hospital they prescribed it to me and so far I haven't really noticed being more happy or anything.
I: Do you think it's something that you'll try and keep taking more long term or...?
R: Yeah, they just upped my dose yesterday, so I'm hoping eventually I'll start feeling a little bit better so we'll see how that works.
I: And then some of the issues that you were just mentioning that you don't feel like the medication can help you address exactly, just maybe makes you not think about them as much?
R: Yeah, it kind of just hides the feelings, hides what's actually going on.
I: So have you been able to address the actual concerns in any of the group settings here or...
R: I've talked about it with my psychiatrist, that's how he upped my dose.
I: And how often have you visited with him?
R: Just like once every month, like when I first came here I saw him and I just a couple days ago. When I was in the hospital I saw a psychiatrist every day, so...
I: But here it's more of a check-in kind of thing?
R: Uh-huh

Anne, who was balancing an anti-depressant and an anti-psychotic, had mixed feelings about the effect of her medications:

- I: In terms of the medication do you see that as a long-term solution? How do you view that?
R: Medication is a little tricky for me because I do believe that I have made just a huge difference in my life with the medication. The Lexapro I believe that I should probably be on for quite a while. The Seroquel I'm not too sure about it. The medication in general kind of just scares me in general; the side effects, my mind kind of starts to wander with the side effects. I would kind of like to get off the Seroquel, but then again it helps me sleep at night. I would kind of just like to get off the Seroquel and find something less habit forming at night for me. But then again when my insurance runs out, I'm not exactly sure what's going to come of the medications.

In these two examples, we see how some clients' experience of medications either differs from expectations or causes the individual to weigh benefits against side effects. For Cheryl, medication fails as an adjunct to other illness management techniques because it introduces a numb affective state that she feels hinders her ability to engage effectively with emotional responses. While in Anne's case, the considerable benefits of an antidepressant are offset to some extent by the side effects associated with Seroquel. Both cases illustrate the challenges that those coping with severe mental illness face as they attempt to negotiate medication management. Clients are prescribed complex psychopharmacological cocktails yet have fairly infrequent contact with psychiatrists; they may also face financial challenges associated with gaps in insurance coverage that make long-term pharmacotherapy planning difficult. Both examples highlight shortcomings inherent in psychiatric reason; despite claims about the specificity of drug mechanisms, medically-complex clients find it difficult to match diagnoses to medications and are drawn into an ongoing pharmaceutical experiment in which drugs are mixed and matched and dosages constantly recalibrated—all of which have unpredictable effects on the person.

Finally, there are a relatively small number of clients who feel that drugs are ineffectual and inappropriate to their circumstances. Such clients are typically—though not exclusively—those who mental health professionals might suggest are lacking in insight and awareness. These clients also tend to be under civil commitment, meaning that adherence to treatment recommendations—including any associated pharmaceutical regimens—is mandated by a court, thus also serving as a precondition for the lifting of

commitment restrictions. While the contradictions of recovery without cure may trouble such clients less given their disinclination to fully accept psychiatric explanations for their symptoms, the limitations on autonomy and choice manifest in their commitment orders nonetheless undermine IRTS emphasis on person-centered rehabilitation. Here I'll return to Brittany, who was diagnosed with schizophrenia, placed on civil commitment, and ordered into treatment:

I: Do you feel like medication for you is a long-term solution for your problem?

R: I don't know. I hate taking meds. I hate taking pills and having to remember things and having to depend on things, so I can see myself doing what I can to get off of them.

I: And when you say doing what you can to get off of them, would that mean getting better?

R: Just learning how to manage my illness and learning skills to cope with it.

I: Do you think it's just you being you ?

R: It is, not it is me and I guess I didn't really, I never knew I became, but I like who I've become. I like hearing voices, I think they're great. They don't put me on medication and they don't think it's great even though I say I don't want them to go away; they think I hear good voices because of medication and it's not like that.

I: It's not?

R: No, medication has done nothing for me at all.

I: Do you think it gets rid of the voices?

R: No, not at all; it doesn't do anything.

I: Really?

R: Yeah

I: So are you just going to be on it cause you know you're going to be watched [on commitment]?

R: Yeah, pretty much. I might still take them but I don't really think I need them. I don't think they're [the voices] going to go away and they're not gonna change so I don't really see the point of me taking medication, it does nothing for me, it does nothing for my mood, I was always a happy person, so they have me on anti-depressants and stuff, when I was in the hospital I was sad cause I wasn't in the free world anymore, so then they said I was depressed and I'm like, of course; I just lost my job, I'm stuck in the hospital, I can't see my friends, I can't see my family, of course I'm a little low.

For Brittany, pharmacotherapy is a means of satisfying the requirements of civil commitment; with respect to her symptoms, consuming drugs seems to interrupt what she views as a positive relationship with the voices she hears. Mental health professionals explain the positive nature of Brittany's auditory hallucinations as an outcome of medication rather than a phenomenon that occurs in spite of it, as she would have it. In such instances, the limits of community health treatment and rehabilitation models are

clear. The question for mental health professionals is how to reorient Brittany toward those models so that she is able to satisfy civil commitment requirements and be discharged from the IRTS, while also equipping her with the necessary illness management skills. For her part, Brittany is unwilling to be interpellated through acceptance of an illness narrative involving a particular diagnostic category and accompanying pharmaceutical intervention that would signal willingness to inhabit a recognizable “institutional identity” (Carr 2009); however she acknowledges that alternatives to medication may involve particular non-pharmaceutical techniques for managing the self.

Conclusion

In this chapter, I examined the ways in which IRTS facilities engage clients in what I call the work of recovery, which encompasses diagnosis, illness management/education activities, and pharmacotherapy. As young adults are faced with the onset of severe, often unrecognizable symptoms, they typically lack an interpretive framework through which unfamiliar affective states can be assigned meaning, challenging the very core of the self. In the wake of such crises, my research participants were hospitalized, stabilized, and referred to IRTS facilities to continue their rehabilitation and recovery. Mental health professionals in IRTS settings conduct diagnostic assessments of clients that isolate areas of concern that have the most immediate relevance to a person’s ability to live independently; this process is entangled with evaluations carried out in other institutional settings and highlights the contingent

nature of diagnostic pronouncements. While clinicians are concerned that sharing too much diagnostic information with clients may lead to labeling and self-stigmatization, it is often the case that clients are aware of their various diagnoses and sometimes craft explanatory frameworks that clash with authoritative explanations by disrupting their decontextualized application. Psychiatric reason offers clinicians few tools to deal with client perspectives on diagnosis that diverge from the disease model, and such perspectives signal that a client may perhaps be lacking in insight and less likely to embrace the recovery process.

Everyday life at IRTS facilities is organized around group sessions that utilize evidence-based rehabilitation practices to address illness management and recovery, as well as health education topics and independent living skills. IRTS staff seek to empower clients to act as agents in their own recovery and make choices that will help them to work toward meaningful life goals. At the same time, the principle of recovery without cure pervades group content; while clients may successfully manage symptoms to minimize their impact on everyday life, the prospect of serious relapse always looms large. In light of this conundrum, clients are introduced to an array of “mood hygiene” strategies that facilitate the self-monitoring of disease characteristics, which in turn both solidifies diagnostic categories and produces knowledge that can be acted upon. Through these processes, an activist vision of the self emerges: the independent, recovered individual who successfully integrates into a community of their choosing is one who embraces the ethical imperative to responsibly and vigilantly engage certain techniques of self-governance.

The concept of the activist self is ultimately anchored by pharmacotherapy, which assumes that the chronic risk associated with mental illness requires long term management using the most advanced psychiatric drugs to act upon specific illnesses; compliance with a pharmaceutical regimen both enables and is a function of the activist self. Compliance with pharmacotherapy also acts as an “interiorization of the clinic” in that it signals acceptance of the various assumptions of psychiatric reason that are condensed into drugs. While pharmacotherapy establishes a clear path to “normality” for some, others find that they are compelled to consume drug cocktails— either as a matter of ethical choice or via legal mandate—despite the fact that their outcomes can be unpredictable or unexpected in ways that challenge individuals’ sense of wellbeing. Pharmacotherapy and the various technologies of the self that follow from diagnosis and are at the core of rehabilitation are intended to help clients develop the skills that will allow them to function independently in their communities. I will now turn to the concept of community in order to examine how clients’ social circumstances interact with the recovery model to produce particular ways of living with mental illness.

Chapter IV. Structural Vulnerability, Relatedness and Personhood in the Community

Introduction

In this chapter, I examine participants' lived experience of the transition out of IRTS facilities and into a variety of community living arrangements. As clients move through treatment and rehabilitation programs, they are introduced to a vision of recovery that emphasizes the responsibility of the self-determining individual for managing symptoms in a way that will facilitate productive participation in everyday community life. From the recovery perspective, continuous self-monitoring and self-governance using techniques derived from psychiatric reason lay the groundwork for the realization of personhood, which comes into view as individuals independently pursue and reach meaningful goals (e.g., in the realm of employment, education, etc.). In practice, however, the possibilities for personhood emerge at the uneasy intersection of structural conditions that affect participants' ability to access fundamental resources and the complicated forms of relations through which people orient themselves in local worlds.

As they re-enter various communities, most participants occupy positions of "structural vulnerability" (Bourgois et al. 2017; Quesada et al. 2011) due to their rather precarious socioeconomic status, which limits access to desired forms of care and resources that would support the long-term management of symptoms. At the same time, I argue that the autonomous individual at the center of recovery discourse is, in reality,

enmeshed in a complex, unique network of relations and local processes that must be negotiated as one attempts to establish meaningful ways of living with mental illness. Participants leverage relatedness as they pursue activities and forms of care that address fundamental needs in their lives but also find that the obligations inherent in their connections to others sometimes make demands of them that challenge their ability to realize something like recovery. The possibilities for being a person, then, depend upon what is at stake between participants and others in the particular intersubjective, relational configurations that constitute the local world of community, and what is at stake is often partially an outcome of structural constraints.

Participants' marginal social position leads to an undermining of the empowered subject of psychiatric recovery by implicating them in an unpredictable temporality of waiting stemming from the need to gain approval for various benefits and other forms of assistance; this sort of aid guarantees that one's basic needs are met before moving forward with the pursuit of recovery goals. In addition, many individuals are subject to the coercive forms of legal power inherent in civil commitment orders, which include mandatory mental health treatment and surveillance activities for a specified period of time beyond IRTS. Against this backdrop, participants grapple with symptoms using limited resources while responding to numerous social pressures and challenges; consider the risks involved in communicating their diagnosis and presenting a version of the self to others; and, quite often, hope for the ordinary—a job, a welcoming place to call home, the ability to forge meaningful connections with others. Psychiatric personhood is an ongoing, unfinished project; structural conditions undermine the autonomous, self-

determining ideal of personhood endorsed in recovery models, but this does not mean that participants fail to negotiate the frequently contradictory messages of choice and constraint as they reinterpret their local worlds through the lens of diagnosis. I attempt to convey the substance of these efforts here.

I open this chapter with a discussion of how anthropological literatures concerning local ecologies of care and structural violence can be used to help flesh out participants' lived experience of community. Next, I use the stories of two participants—Derek and Anthony—to illuminate the experience of transitioning from IRTS to community settings; these two individuals were selected because they function as “typical” cases, and their stories condense a number of key issues common among participants. In the remaining sections, I elaborate upon the key issues and ideas that emerge in the aforementioned stories and weave in examples from participant interviews as I do so; these key issues and ideas are 1) the temporality of waiting; 2) coercion; 3) involvement in work and education; and 4) manifestations of relatedness in local worlds.

Community, Local Ecologies of Care, and Structural Violence

For IRTS clients, the presence of symptoms undermines the assumption of normative personhood; those who experience the onset of severe mental illness are presumed to have lost, at least temporarily, the capacity for rationality that anchors conceptions of the person. In response, clinicians first use the notion of insight to gauge clients' ability to rationally comprehend the nature of their illness and then introduce

various technologies of the self that can be tailored to the unique needs of the individual. Clients' willingness to adopt an ethical stance toward the self via the adoption of particular therapeutic practices is not necessarily an end in and of itself; rather, the reestablishment of personhood depends on the ongoing, indefinite demonstration of this activist orientation toward inner processes as the client makes his or her way in the world beyond IRTS. The personhood deficit—insofar as the model form of American personhood is understood to be highly egocentric, autonomous, and derived from interior stability—that plagues those who grapple with psychiatric illness is to be remedied by ethical self-governance that relegates symptoms to the background and ultimately allows the person to emerge recognizable as a productive and responsible employee, student, friend, relative, citizen—a member of a community.

The concept of community generally functions as an unmarked category in the community mental health paradigm. Early iterations of the community mental health model invoked community as a means of highlighting the shortcomings of institutionalization for severely mentally-ill populations, to draw attention to what those populations lacked by virtue of long-term institutionalization. As I have discussed, proponents of community models assumed that the formerly-institutionalized would transition into stable living arrangements, which were to include adequate housing and an acceptable measure of social support; from this stable foundation, community health infrastructure would be built to ensure the wide availability of accessible, person-centered services. Over time, the initial assumptions underlying community models proved to be

mistaken, but the lure of community and its seemingly hospitable nature for those struggling with mental illness have remained constant.

Much of the durability of the category of community has to do with its seemingly natural, unequivocal goodness. Across the political spectrum, invocations of the keyword of community hint at an ideal state of social relatedness in which cohesion, cooperation, empathy, and sense of belonging prevail (DeFilippis et al. 2006; Joseph 2002). The tendency to romanticize community becomes all the more compelling as public support for health and social services dwindles in the neoliberal age, leaving communities and their accompanying resources as the safety net of last resort for those who might otherwise fall through the cracks (DeFilippis 2004; Jessop 2002). This is not to say that professionals working in the field of community mental health do not consider the context of a given client's community; rather, it is the case that dominant understandings of the course of psychiatric illness in tandem with expectations about how the afflicted should go about directing that course cause mental health professionals to bracket social circumstances.

While mental health professionals acknowledge social context as a factor in the community recovery process, the biopsychiatric model ultimately suggests that disorder is an organic, individual matter. Clients should be equipped with the necessary tools to promote wellbeing, but beyond a point, the responsibility for preventing or minimizing

the impact of relapse lies with the individual. Hopper (2008:4), for example, contends that models of recovery elide structural forms of difference and inequality:

Race, gender and class tend to fade away into unexamined background realities, underscoring (intentionally? inadvertently?) the defining centrality of psychiatric disability in these lives. Material deprivation is largely ignored, though poverty and shabby housing bulk large in the lives of many persons with severe mental illness. Vital contextual features – the enabling resources, rules and connections that make prized prospects like a decent job feasible – are either disregarded or casually remarked, as though their provision were unproblematic or of lesser concern to individual reclamation projects.

As I have argued, well-intentioned proponents of recovery philosophies aim to empower those struggling with psychiatric illness by casting them as self-determining consumers in need of the freedom to choose the future that they wish to inhabit; however, this sort of idealized, autonomy-driven model necessarily rests upon a vision of community in which individual choice is unconstrained rather than bound up in complex, often unequal social arrangements.

In light of the unreflective way in which sacrosanct status seems to be ascribed to community in mental health discourse, I want to flesh out the contours of ordinary life in those local worlds that the category refers to from the perspective of my participants. As I do so, I draw upon anthropological literature related to what Das & Das (2007) call the “local ecologies of care,” those everyday lifeworlds and their accompanying material circumstances within which illness experience resides. Such local ecologies act as a “relational testing ground” or an “experiment with life” in which the individual negotiates health with the constituent members of a particular social world and “recasts illness categories, kinship textures, and patterns of social exclusion and inclusion” (Biehl 2004). Important recent scholarship has examined the workings of these local ecologies in

settings where public funding for health services has been slashed and the responsibility for managing illness is increasingly shifted onto already overburdened families (Biehl 2004, 2005; Das 2015; Das & Das 2007; Garcia 2008, 2010; Han 2011, 2012). This emerging body of literature highlights the ways in which domestic economies and the relations that constitute families and households become a key site of negotiation over the care of those struggling with mental illness and other health issues; these negotiations invariably draw upon broader networks of human and material resources to support their efforts.

Focusing on local networks of relations beyond IRTS moves the analysis away from the unitary psychiatric subject posited in mental health treatment and recovery discourses and draws attention to the ways in which the clinical project of self-making and the form of personhood it seeks to engender fare in the realm of everyday lived experience. Such an approach can help us to contextualize the limits of the autonomous, self-determining individual posited in recovery models and understand how the various considerations and constraints that weigh upon young adults as they seek to make their way in the post-IRTS world shape the possibilities available to them. Han (2012:232), for example, describes the complex networks of relations in which mentally-ill persons and their caregivers are situated:

Individuals are enmeshed in multiple relations that may be in play simultaneously, and these relations themselves may be composed of different elements, for example, blood and the everyday labors of caring. In this density of relations and elements, responsibility cannot be understood solely in terms of the willful autonomous subject. Rather, it might be understood as responsiveness, and this responsiveness must be understood in concrete circumstances.

Han's use of responsiveness is intended to circumvent the naïve emphasis on individual responsibility that pervades ideas about recovery and the ways in which people cope with illness in societies oriented toward market fundamentalism. When individuals "fail" in recovery it is not necessarily due to some moral shortcoming inherent to the self or the network of relations; rather, it may be that the pressures associated with the sets of demands that people are asked to respond to—on an intimate, relational level; in terms of the structural requirements that accompany recovery; and in terms of the broader cultural imaginary of recovery in which dominant ideas about the form of personhood one should aim to actualize—are overwhelming.

The approaches of Han and other scholars that I have referenced offer productive analytic frameworks for understanding how illness and subjectivity are embedded in the density of everyday relations, and, in turn, how these relations interact with different sorts of political-economic arrangements. Part of the reason that these accounts foreground the domestic economy when examining health outcomes is that they rely upon ethnographic fieldwork in settings where publicly-funded health services for low-income people have been almost entirely decimated, thus positioning the kinship network and the household as the de facto safety net. In such dire circumstances, the extraordinary strain that caring for the severely mentally-ill can place on an already-fragile domestic economy produces a kind of "social psychosis" in which those grappling with psychiatric diagnosis can be deemed unproductive through medical and political technologies, stripped of personhood, abandoned, and ultimately excluded from reality in a form of "social death" (Biehl 2005). In his account of the rise of zones of social abandonment in Brazil where the mentally-ill

and other undesirable subjects are discarded, Biehl (2005:21-22) describes the conditions in which social exclusion is produced:

As economic indebtedness, ever present in the hinterland, transforms communities and revives paternalistic politics, for larger segments of the population, citizenship is increasingly articulated in the sphere of consumer culture. An actual redistribution of resources, power, and responsibility is taking place locally in light of these large-scale changes. Overburdened families and individuals are suffused with the materials, patterns, and paradoxes of these processes, which they are, by and large, left to negotiate alone. The family, as this ethnography illustrates, is increasingly the medical agent of the state, providing and at times triaging care, and medication has become a key instrument for such deliberate action...Increasing calls for the decentralization of services and the individualization of treatment...coincide with dramatic cuts in funding for health care infrastructure and with the proliferation of pharmaceutical treatments. In engaging with these new regimes of public health and in allocating their own overstretched and meager resources, families learn to act as proxy psychiatrists...Families can dispose of their unwanted and unproductive members, sometimes without sanction, on the basis of individuals' noncompliance with their treatment protocols...Such possibilities and the foreclosures of certain forms of human life run parallel with gender discrimination, market exploitation, and a managerial-style state that is increasingly distant from the people it governs.

Biehl's arguments about the convergence of political-economic transformation, the biomedicalization of mental health, and the shifting of the responsibility for the management of illness onto families speaks to global processes of neoliberalization that have unfolded across the world over the last generation. While these conclusions regarding the restructuring of health systems, the pharmaceuticalization of psychiatry, and the increasingly heavy burden of care placed on poor families certainly have analogues in my own research setting, there are important contextual differences that I would like to highlight before proceeding.

Young adults' recovery and transition from IRTS to community living play out against a backdrop of relatedness and the sorts of interpersonal exchanges that both allow for and foreclose the emergence of particular forms of personhood. As these processes unfold, most participants occupy a position of structural vulnerability within the context

of access to health care services in contemporary America. Structural vulnerability (Bourgeois et al. 2017; Quesada et al. 2011) has been conceived of as an extension and refinement of the concept of structural violence, which Galtung (1969, 1975) introduced to refer to the abstract violence that limits the realization of human potential for people living in unequal social orders. Within anthropology, the concept of structural violence has been famously rearticulated in a materialist fashion by Farmer (1996, 2003, 2004) to encompass the ways in which social inequalities systematically place dominated groups at greater risk of various types of harm and disease; this socially-patterned exposure to forms of distress is complemented by erasures of historical memory that naturalize and individualize the uneven distribution of suffering. Quesada, Hart and Bourgeois (2011:340) mobilize the concept of structural vulnerability to make the effects of structural violence more explicit and to highlight a subordinate position that people occupy within a social hierarchy:

The more neutral term ‘vulnerability’ may be useful, consequently, to extend the economic, material and political insights of structural violence to encompass more explicitly (and to project to a wider audience) not only politico-economic but also cultural and idiosyncratic sources of physical and psychodynamic distress. These include (1) social hierarchies buttressed by symbolic taxonomies of worthiness; (2) historically distinctive discourses of normativity and ethics; and (3) the intersection of individual medical pathology and biography with social exclusion. In our conceptualization, structural vulnerability is a positionality. The vulnerability of an individual is produced by his or her location in a hierarchical social order and its diverse networks of power relationships and effects. Individuals are structurally vulnerable when they are subject to structural violence in its broadest conceptualization. This includes the interface of their personal attributes—such as appearance, affect, cognitive status – with cultural values and institutional structures.

In this description, the concept ties together the kinds of symbolic violence (Bourdieu 2002) that normalize the conditions that give rise to participants’ psychiatric diagnoses, the discursive frameworks through which they learn to occupy particular subject positions and modes of personhood, and the unique individual histories and circumstances through which illness experiences are lived and interpreted.

Structural vulnerability is most evident in relation to participants' class status, with most coming from low-income backgrounds and qualifying for a mixture of benefits, including Medical Assistance (MA or Medicaid, subsidized health care), Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) disability benefits (supplemental income assistance), and Electronic Benefit Transfer (EBT, referred to as "food stamps" by participants). Structural vulnerability as it relates to socioeconomic status has significant implications for the treatment and management of severe mental illness. In post-welfare reform America, mental health diagnoses constitute one of the few means by which low-income people—including the majority of my participants—are able to access relatively stable basic income support, particularly via SSI/SSDI (Hansen, Bourgois & Drucker 2014). The use of psychiatric diagnosis as a key criterion in determining eligibility for basic benefits represents the biomedicalization of poverty that is intertwined with the rise of a "disability economy" through which the state manages undesirable and unproductive populations that it has largely expelled from the social order (Knight 2013). Knight (2013:102-103) contends that against this backdrop mental health diagnostic practices and the subsequent assimilation of individuals into the disability economy constitute "pivotal bureaucratic events designed to manage material suffering that reference ideological and political debates in the United States about health care access equity and the entitlement rights of the poor."

Discharge from IRTS to the community was typically accompanied by a round of applications for benefits—participants were typically enrolled in MA but many were still in the process of applying for other types of assistance—that would help to sustain them during the period of community reintegration and beyond. Rather than the extreme dehumanization and abandonment of severely mentally-ill people that has been documented in recent ethnographic literature, I found that the most socially-excluded and vulnerable of my participants—for whom there was almost a complete absence of social support and independent ability to navigate community living—were absorbed into the disability economy via human services organizations functioning as the source of care of last resort. In these cases, young people with nowhere to go and no means to make it on their own sought assistance from human service organizations that integrated and coordinated various types of social services (e.g., case management, housing, education, employment readiness, therapy) that were, in the past, distributed across multiple provider groups; these services were paid for through a combination of MA and other benefits, or were otherwise subsidized by the state via human service provider contracts with local government entities.

For those participants almost completely lacking in options, the human services apparatus constituted community; such participants lived in a state of indefinite quasi-independence in which they formed bonds with mental health professionals who helped them set goals and plan and coordinate everyday activities. In some cases, IRTS facilities were managed by human service organizations that also offered an array of other services, allowing participants to move from IRTS to a supported housing environment

maintained by mental health professionals working for different units of the same organization. Participants who were not forced to wholly depend on the disability economy nonetheless typically relied upon benefits and the assistance of human services agencies for particular tasks as an adjunct to whatever system of support that they had in place; for example, human services organizations often provide case management guidance for those looking to find an appropriate housing setting in the community, and SSI might be used to help pay the rent or, in cases where a participant returns home, contribute to household expenses. For the state, this method of managing low-income, mentally-ill populations represents a form of cost-effective outsourcing in which local governments distribute funding to various licensed providers who receive reimbursement for a vast range of activities delivered via their centralized, integrated service delivery model. As we have seen in the example of IRTS rehabilitation and will see again in the process of transitioning to the community, participants implicated in the disability economy are often subjected to a form of symbolic violence through which the solutions to their problems come to be understood through the lens of self-management and individual responsibility for attainment of normative goals in the community.

I now return to the question of life in the community after IRTS. As I have indicated, participants typically occupy a structurally vulnerable position with respect to their socioeconomic status and rely on various benefits to help them to meet basic needs and make their way in the world. Many participants attempt to attenuate the effects of vulnerability on their ability to manage symptoms by reviving existing networks of relations or attempting to establish new forms of relatedness; however, the fact of

relatedness does not necessarily imply support, and embeddedness in various networks may sometimes be accompanied by stressors and other complications arising from interpersonal interactions involving illness management.

Departures

In this section, I detail the trajectories of the lives of several participants from the time of my initial meeting with them on cusp of their IRTS discharge to the subsequent circumstances that I found them living in roughly three months after our first conversation. I have chosen two participants who represent opposite poles of the post-IRTS continuum of transition; on the one hand, Derek's story illuminates the consequences of extreme social isolation and withdrawal for life after IRTS, while on the other, Anthony's experience foregrounds the complex negotiation of socioeconomic challenges and interpersonal struggle that are common even among those who seemingly have adequate social support. Derek and Anthony function as "typical" cases that are generally representative of the larger cohort of participants, whose trajectories cluster around either of the experiential poles. The stories draw out the context of transition for two different sorts of clients and shed light on the overlapping layers of inner experience, relatedness, and socioeconomic milieu in the course of recovery from severe mental illness.

Derek

I first encountered Derek at an IRTS in an exurb northeast of the Twin Cities, and we met again roughly three months after his discharge at a small suburban library in an adjacent city. Arriving at an IRTS in the wake of a suicide attempt, Derek was eager to address the depressive symptoms that recently overwhelmed his capacity for coping. He had never before spent time in a psychiatric treatment or rehabilitation setting, and the thought of having a host of mental health resources at his fingertips excited him; however, by the time that I met Derek, he had come to see his attempts to confront the specter of depression as thwarted by a misinterpretation of his diagnostic assessment that privileged alcohol use over his mental health concerns (I describe these challenges in more detail in the previous chapter). It seemed that Derek couldn't escape this misclassification, and he noted how he had ultimately given in to this inaccurate illness characterization in order to meet the expectations of IRTS staff, going so far as to pretend in group sessions that he suffered from a history of alcohol and drug abuse.

A deeply lonely and shy person, Derek struggled to relate to and trust his peers, with the exception of one resident with whom he bonded over shared experiences during the early part of his time at the facility. He spoke about how he had always felt like an outsider throughout his life and noted that some issues related to sexual identity that he was working through at the time of our discussion only compounded his sense of difference and alienation. While Derek felt that he had derived some benefit from the medications—Effexor and Zyprexa—that he grew accustomed to taking while living at the IRTS, his experience in this rehabilitation setting left him, on the whole, disappointed.

Derek depicts himself as a kind of profoundly socially-isolated drifter incapable of maintaining existing social ties—to the extent that these exist, they are largely kin relations—and rarely able to form meaningful new ones. His relationship to sociality is tenuous at best, and he described his tendency for extreme withdrawal from others:

I kind of am the person that will just kind of vanish off; like if something happens for us to split ways, I will never contact anybody; I will just kind of disappear from them. Like from my family they don't know where I am 'cause I just left. I will leave and not keep in contact with people, just kind of vanish from people's lives. I'm just too used to doing that. I mean, I don't do it to be mean, it's just how I am...It's like every four to six years I meet one friend cause the world really doesn't pay attention to me. I've always had an issue of meeting people and having friendships and actually keeping it for a long period of time. So, I mean, like now I don't have any.

As we discussed his difficulties establishing a sense of social belonging, Derek noted that the only extant relationship in his life involved his mother, though his communication with her was infrequent at best. As he reflected on the topic of social isolation, Derek traced the origins of his depression to an injurious relationship with his father that developed after his parents divorced:

I: So, outside of your mom, there really aren't many people that you keep in touch with too regularly?

R: I don't keep in touch with anybody besides my mom. Which kind of makes me depressed, which actually started depression before like when I was fourteen; that's the original how it originally started. Then it kind of just expanded from there.

I: Can you say a little bit more about that? How it started?

R: I was fourteen and living with dad, which was depressing enough as is because he was always very hard on me all the time. I was always the one getting teased, and no one wanted be friends with me. I never made, actually, I never made friends in high school at all.

I: In terms of your family life, how do you see that, your relationship to your family changing or developing in the next few months or after you leave here? You said your mother's getting married, that maybe you seem to like her fiancé. In general, your relationship with your family—how do you see that playing a part in life?

R: Well my mom might get a little bit better. But my dad, I just don't even go there. I don't want to deal with that. I just think that relationship will always be bad. I mean I'm not looking forward to that at all. Unfortunately, I can't talk to my brother or sister who live with him. And I'm actually getting another sister from mom's marriage, 'cause my mom's fiancé has a daughter, so I'll get another sister. I mean I can probably talk to her or get to know her or something like that.

Derek had lived in Minnesota for less than a year when I met him and had initially traveled to the state on a whim after dropping out of college and parting ways with family, who are scattered about the Midwest and South. This period of wandering seemed almost dream-like to Derek in retrospect; he could remember cycling through roommates in different apartments but couldn't remember any of their names; his income came through part-time wage labor in grocery stores, but the specifics of his employment were also a blur. Like many of my participants, Derek did not conceptualize treatment and rehabilitation as options that he could choose to help manage psychiatric difficulties; rather, the choice was made on his behalf by a mental health court after his suicide attempt. Living with severe mental illness often engenders feelings of passivity, and Derek did not experience the involuntary submission to treatment mandated by his civil commitment as an imposition; it was simply another event that pushed his life in unforeseen directions. Reflecting on the course of commitment, Derek said "You just have to do what they say; just basically get help for this amount of time, or the way the court says it... Just follow up with a therapist or something, seek help, continue to take medications. It's mandatory."

As he prepared to leave IRTS, nearly every aspect of Derek's life seemed rife with uncertainty. While he knew he still had several months of therapy and medication management visits to complete in order to comply with the requirements of commitment, little else was settled. Finding a place to live is a significant challenge for many IRTS clients, and Derek's options were few. He seemed resigned to that fact that he might need to live in a shelter temporarily while waiting for his mother, who lives in Illinois, to

help him lease an apartment, which she had recently offered to do; however, the two of them were just beginning to rekindle their relationship and “starting to get along,” so their communication was intermittent at best, and Derek hadn’t actually seen her in person in over a year. Derek repeatedly described himself as “confused” about the direction of his life, which, as he put it, “just kind of went nowhere for the past three years.” In addition to the basic question of where he would be living in the short-term, Derek hoped to find work in order to further his goal of independence:

I want to get a job so I can be independent again, because I’ve been wanting to be independent since I was 17. I mean, locationally I was, but most of the time I wasn’t and independent is something I wanted to do because I want to be able to do stuff for myself and say that I did something for myself. I hate depending on other people, like doing stuff for myself too. I’m more open to help now, but still I need my own life...Finding a job and my home, a permanent home, and friends too. God, that will be hard, but the job part definitely.

Beyond these basic short-term goals, life felt too much in flux and full of hardship for Derek to consider how he might make his way in the world; at the time of IRTS discharge, he simply wished to “start my life over.”

I got back in touch with Derek roughly three months after he left the IRTS facility, and we met at a small suburban public library. Upon leaving IRTS, Derek had initially landed in a short-term adult foster care facility before moving to a supported housing arrangement southeast of the Twin Cities just days before I got back in touch with him; the supported housing apartment was shared with three other people and administered by a social services agency. Derek clearly did not feel settled, he and felt like his post-IRTS experience was another challenging “adjustment period.” Living in supported housing felt isolating for Derek, and, despite that fact that he yearned for social connection, he found that he shared little in common with his new roommates. He

described several of his roommates as “mentally disturbed,” and felt incompatible with the other person he resided with: “We’re just two different people. I just, I just can’t talk to him; I just don’t. It’s just one of those people that you know you can’t talk to about things.”

Derek spoke of days filled with boredom during which he spent most of his time alone in his room, occasionally logging onto monster.com and other job websites to create resumes and check listings, though he admitted to not really understanding how to go about applying for jobs. Prior to his time at the IRTS, Derek had been accepted into the Job Corps program, but the organization did not seem to be responding to his recent inquiries. Derek was also waiting to receive a subsidized bus pass, and his lack of mobility further hampered his ability to access therapy, search for jobs, and participate in social events. He mentioned occasional visits to local bars where he hoped to meet other young people, but this strategy was not working out for him so he also began looking for ways to connect with people online.

Like other participants, Derek found coordinating mental health services to be a frustrating task. One of his urgent goals was to identify a therapist and schedule appointments. At first, it seemed that he would be able to participate in dialectical behavioral therapy sessions at a local clinic, but he had recently received conflicting messages from his case manager and the clinic:

I’m trying to go to counseling—well, I go to counseling at the Eagan Counseling Center. I used to go to a ten-day program there, now I’m trying to go to a regular therapist. It’s just been a lot of

confusion, they told me that I could go to DBT [dialectical behavioral therapy] one week, then one week they told me I can't. Now they're telling me I'm supposed to be there. It's kind of a confusing. They keep telling me two different things, and then my social worker said I was supposed to be there and then they told me I'm not supposed to be there. I'm not even registered.

Derek described the social worker's role in his life as minimal, and he felt that he was mostly responsible for obtaining any needed services. Difficulty accessing mental health services had left Derek feeling adrift, and he felt an urgent need to address the barriers in his life. When I asked him what he hoped a therapist could help him with he mentioned several key issues: "how I can meet people socially and how to get rid of—lower my depression so I can go back to work; how to approach life, because I'm kind of confused." Later he remarked that "I want to do it [therapy] so I can feel better; won't have to continue being sad or mad all the time." As far as therapeutic interventions for managing symptoms went, a recently-increased anti-depressant dosage was the only thing that Derek could point to, and he thought it necessary to take medication for the foreseeable future: "It's [drugs] fine with me; it helps me with learning about the bad stuff, the bad thoughts and stuff. I just keep taking it; it's kind of important for me to keep taking it."

I asked Derek about the family relationships he had been attempting to repair when we last talked and inquired about whether or not he had spoken with his mother further about finding an apartment of his own. Unfortunately, Derek's relationship with his mother had deteriorated since our previous meeting:

I: In terms of other people in your life like your family, we talked about that the last time. Have you been in touch with your mom? You mentioned that there was a wedding you were thinking about going to.

R: Yeah, I went there. We got along fine at the wedding, but I mean we typically never get along. We always argue, she is always bringing me down thinking I'm pulling out stunts just to...I don't know why but, just to act or something.

I: Have you been speaking with her as much as you were before or how often are you in touch with her?
R: Only when she calls.
I: How often would you say that is?
R: A couple of weeks.
I: Compared to the last time we spoke how would you say your relationship with her has changed?
R: We just argue all the time, everything is a disappointment or an excuse with her. So she's kind of pushing me away. I mean my dad did the same thing, I haven't spoken to him in ten months. It seems like it might go that way with her too.
I: Yeah, you mentioned last time that you guys kind of had a strained relationship. So with your mom why do you think things have gone downhill?
R: She never listens to me and thinks I'm lying about everything and she, unless she can see it for herself she thinks I'm making stuff up.
I: Are there other people in your life right now, anybody you're in touch with?
R: That's what kind of hurts, I feel like I'm missing out on my twenties because I don't have anybody to talk to or hang out with, and I don't want to wait eight years for it.
I: How do you see that maybe over the next year or so? Do you think that might change?
R: My relationship with family is always bad so I don't expect nothing from that anymore, I kind of gave up on it. So, I care, but it's just not something to...just don't think that's possible.

When I asked Derek how he planned to deal with this increasingly dire situation, he had few answers. The issue had come up in discussions with a social worker, but Derek felt that this person had few useful solutions beyond things that he'd already tried. Derek felt increasingly shunned by his family and, more generally, misunderstood by others. His circumstances afforded him few resources to leverage as he searched for answers, and he felt there was little to do other than try to make small changes to his life, wait, and hope for things to fall into place. Toward the end of our conversation he remarked: "I didn't think I'd be in this position. I ain't never really had a vision of my future; I don't know, I'm still trying to figure out if I have one. I just never thought I'd be here."

Anthony

I met Anthony at an IRTS in St. Paul, where he been undergoing psychiatric rehabilitation after experiencing the sudden onset of symptoms associated with schizophrenia. Prior to IRTS, Anthony had been an inpatient at a treatment center in

Cambridge, about an hour's drive from the Twin Cities. He was also under civil commitment order for mental health treatment. Anthony had no history of psychiatric illness prior to the episodes that led to his recent hospitalization and subsequent stay at an IRTS facility. Anthony revealed that he hears voices but provided little detail about his symptoms beyond that. He seemed relaxed and accepting of his situation, noting that he agreed with his diagnosis and felt that the various medications he was taking, including Abilify and Haldol, were effective for "keeping the voices away" and allowing him to have "clear thinking." Anthony emphasized the need to take the medications as prescribed to avoid adverse side effects and relapse, a point that he says was driven home during IRTS group sessions. To supplement his IRTS rehabilitation, was also attending a day treatment program once a week at an off-site location that involved group therapy; Anthony described the program as similar to what he was exposed to at the IRTS.

The IRTS facility that Anthony resided in was located in a neighborhood adjacent to the area where he had been living with his parents and two siblings. Throughout his time in rehabilitation, he was only a short bus ride from the part of the city that he called home, and the IRTS facility was very much embedded in his everyday world and routines. Outside of mandatory groups and appointments, Anthony came and went from the IRTS frequently, traversing the city to run errands and spend time with his two-month-old daughter, who lived with her mother—Anthony's ex-girlfriend—and her family. Anthony was delighted to be a father, and he described his young daughter as the foremost priority in his life: "My daughter, she's the most important. That's what I think about when I wake up, when I go to sleep, when I'm out on the go."

Parenthood also posed significant challenges for Anthony and added a number of new stressors to his life. Anthony described himself as “separated” from his daughter’s mother, but the two were in regular contact. Anthony felt that he was making an effort to be as present as possible in his daughter’s life but was finding it hard to balance the demands of commitment and rehabilitation with the requests from his ex to help out. He described their relationship as “bad business” and felt that their issues were further compounded by his ex’s family’s lack of sympathy for the mental health issues that he was trying to work through:

I: You say it’s like bad business, what happens when you see them?

R: They, sometimes they’re caring about what I’m going through, and then sometimes they have their days where they’re like, ‘oh well you’re crazy, you’re crazy, you’re crazy,’ and it’s just hard to deal with.

I: Do you feel like her [ex] and her family are less understanding, like about the disorder or mental health kinds of stuff?

R: Yeah, they’re not really too big on trying to figure stuff out.

I: So, they don’t really understand? You don’t feel like they understand what’s happening?

R: Yeah, they don’t understand at all.

I: When do you go and visit them? They call you, or how do you guys keep in contact?

R: Sometimes we talk on the phone, sometimes we go and visit, but most of the time I will go over to her parents’ and visit with them, sit down with them, spend time with my daughter ‘cause that’s where my daughter is at. I’m over there.

I: Yeah. And how often would you say that you see or talk with them?

R: I’m probably like twice a week.

I: You mentioned that the relationship with them has been tougher. They’ve given you certain kinds of support at times, but it’s kind of a more tense relationship?

R: It’s just, it’s more tense. The support they give me is very seldom, they choose to give me a hard time about this, so I can’t change that.

I: How do you think you are you going to deal with your daughter’s mother and her family?

R: Oh man, I don’t have any plans. I just don’t know how that’s going to work at all. I’m just hoping that they simmer down to my medication and mental illness.

To escape the strain of this relationship, Anthony often spent time with his parents and siblings, with whom he shared a close bond; he described his siblings as best friends.

Once his time at IRTS was over, he hoped to find a way to bring his daughter to stay with his family as frequently as possible.

Anthony seemed well-positioned to manage his impending transition out of IRTS. As we discussed this period in his life, he mentioned that he hoped to find an apartment of his own with the help of a non-profit organization called Project for Pride in Living but knew that he'd be able to stay with his family if need be. Anthony had previously worked at Walmart in a "loading" position but was looking to find opportunities in the construction field. In addition, he seemed to be close to finishing up his high school degree through a General Equivalency Diploma. He was interested in developing new relationships and being around more sober people, as his peer group was largely comprised of "smokers and drinkers." Anthony seemed quite sociable and found it easy to meet people, but he also noted that he found it stressful to spend time out and about in his neighborhood because he invariably ran into old friends that he would rather avoid for the time being. Since Anthony hadn't been seen much over the previous months, people were always interested in knowing what he had been up to, and he was unsure who to talk with about the issues he'd been dealing with and how to talk with them. Anthony mentioned that he'd spent a lot of time discussing these issues with peers and staff at the IRTS facility, and that he'd been given helpful advice about when and how to open up to others about mental health issues. He remained confident that he could "overcome" his symptoms someday and hoped to gradually decrease his medication dosage.

I followed up with Anthony after his IRTS discharge, and we met for coffee to discuss how things had been going for him. Anthony appeared to be well, and he seemed upbeat and composed, as he had when I first met him. He had been attending a GED completion program and was nearing the end of his studies; he had also been accepted

into a construction apprenticeship program that his cousin had referred him to and was set to begin after he was finished working on his GED. Plans for finding an apartment of his own had fallen through, and he was living with his family for the time being. He was also working part-time at the same Wal-Mart that his mother was employed at; she was able to secure the job for him as he left IRTS.

Anthony seemed to be connected to a number of mental health resources and had two months remaining on his civil commitment order. His primary point of contact with mental health professionals involved an Assertive Community Treatment (ACT) team, who he checked in with nearly every day to discuss symptoms and make sure that medications were being taken as prescribed. Anthony expressed surprise at the fact that there was little lag time between his IRTS departure and contact with the county-run ACT team; he also continued to visit a therapist that he had begun seeing while in IRTS and met with a psychiatrist several times a month to monitor the effects of his medication. While Anthony was initially pleased to feel supported by multiple providers—particularly the ACT team, which came to his home—he, as was the case with other participants, gradually began to feel that the ongoing home visits were becoming tiresome: “The whole thing, everyone checking up on me and treating me like a 12 year old...I’m not bothered; it still gets annoying though...I respect them [ACT team] for doing it, but after a while you just get tired of it.” In addition to his ACT team, Anthony’s family became engaged in his care, and his mother often provided him with reminders about his medication and upcoming appointments.

While Anthony found his community mental health team to be organized and responsive—he mentioned that one member of his ACT team even attended the same school as him and that the two would occasionally study together—the side effects of the medications that they were helping him keep track of were beginning to complicate his life in several ways. Anthony was taking an antipsychotic drug that made him extremely sleepy, and he typically found it difficult to remain alert throughout his fairly hectic daily schedule. He typically went directly from school to work but had to cut back on working hours and spread the remaining time out over a greater number of days because he was simply too fatigued to complete a full shift. In addition, Anthony was keen to join mental health support groups that he had learned about while at IRTS in order to meet new people adjusting to life with similar diagnoses but had been unable to go because of tiredness: “there is a lot of group offerings, I just don’t take them cause it would be pointless to go to a group when I’m all tired and sleep all the time instead of listening and hearing what they’re saying, so I choose not to go to groups.” While having a supportive family meant that Anthony could negotiate the challenges of side effects by reducing working hours, he nonetheless needed a steady source of income and was in the midst of the lengthy process of appealing a denied SSDI application:

I: So has that caused problems for you with school or anything?

R: No, but it causes problems for me when I have to work or anything like that because if I’m on the meds and I’m pretty tired at work, I can’t really get the job done, so I’m applying for social security and they keep denying me.

I: What’s the reason for them denying you?

R: I don’t even know, they say that some information I give doesn’t seem like I need it.

I: Do you get any help with that, like applying for that?

R: No, at first I was doing it by myself, so now that my case manager and I have to appeal it, he’ll help me.

Anthony estimated that the SSDI payment would amount to about one hundred dollars a month; not much, but enough to contribute to his family's grocery and household goods purchases while they were helping him get back on his feet. Despite these challenges, Anthony, like many participants, remained committed to drugs as a sort of preventive measure; while he hoped to wean off of them one day, he, for the moment, saw them as an absolutely essential piece of his striving for a "normal" life:

I: What's been the hardest thing, the biggest challenge about this whole transition?

R: Just waking up during the day knowing I have to take meds to keep myself from going through panic attacks and stuff like that.

I: Is that something you think about a lot?

R: Yeah

I: If you can think of yourself one year from now, what goals do you have and where would you like to see yourself at?

R: I'd like to see myself off meds. Living a normal life.

Another set of challenges in Anthony's post-IRTS life involved family relationships and attempts to establish a new social network. Anthony was pleased to tell me that his relationship with his ex and her family had improved significantly as both parties worked to put aside any differences and prioritize the needs of their now five-month-old daughter. His ex's family, who had previously been insensitive to Anthony's plight while in IRTS, now seemed to take an interest in his illness and tried to learn how they could offer support:

I: Has your relationship with your daughter's family...has it changed?

R: It really did, not too big, but it was like everyone was trying to be nicer though, so it's been pretty good.

I: What is their attitude towards your mental illness?

R: They're really open-minded about it, they're willing to learn more about it every day, so if I come and tell them hey, there is so many meds out here and this is what I have to take, they're open-minded about taking notes and stuff like that.

As the circumstances surrounding Anthony's daughter improved, he hoped to find a way to spend more time with her alone—he was only able to visit her at his ex's home when I spoke with him—but he acknowledged that it would likely be some time before this would be possible; fortunately, his ex was living nearby and he saw his daughter regularly. In some ways, his own family was creating more stress in Anthony's life, and he had ambivalent feelings about being at home. While Anthony was grateful that his parents had given him a place to stay and took an active interest in his psychological wellbeing, he also found it difficult to live in a fairly busy and crowded home and yearned for a place of his own. He mentioned that because he was unable to work as much as he liked and was somewhat reticent about establishing new social bonds of his own, he spent a lot of time at home and became the default babysitter for one of his sibling's children and felt that it was incumbent upon him to take on as many tasks and chores around the house as he could manage.

A well-liked, sociable person, Anthony had hoped to branch out and establish new friendships but concerns over how others might respond to his illness were inhibiting him. He mentioned that he had occasionally been spending time with people that he met online, and while he liked the fact that they had no sense of his personal history, he felt that he needed to be cautious about sharing his recent troubles. Around the neighborhood, he tried to keep interactions with friends and acquaintances brief and hadn't rekindled any past relationships: "I try to keep to myself 'cause I don't want to have to explain everything to people and what I am going through and have them look at me different, you know, so I keep to myself." Despite the fact that he feels that IRTS

staff did a good job of preparing he and his peers for difficult discussions about mental health, he hadn't yet found a way of communicating about his recent experiences to others outside of his family. When I asked him how he felt like his life compared to other people his age that he knew, Anthony replied:

Most people my age don't go through what I'm going through. I guess I kind of fit in and don't sometimes, I'm really not worried about that...I was watching a movie and it said a lot of people around their twenties go through like paranoid schizophrenia and it's around everywhere; it's like probably ten out of 100 that will have it...it makes me feel like it's not the sickest thing I could have in this world.

Anthony felt as though he was occupying something of a liminal space in which he understood that his diagnosis didn't mark him as entirely unusual, still, in the time after his departure from IRTS he struggled to figure out how to reestablish himself as a person while negotiating a host of family, work, and educational pressures.

I have used Derek and Anthony's stories to draw out the context of lives in the transition from psychiatric treatment and rehabilitation to community living. These two individuals represent two poles of the post-IRTS experiential continuum and their stories bring together a set of issues at the interface of the intimate and the structural characteristic of participant life beyond IRTS. Derek's story speaks to the experiences of socially-isolated participants who, for various reasons, have few other people to rely upon for social and material resources as they try to navigate life after IRTS discharge. In such cases, participants are highly dependent, at least in the short term, on benefits and supportive services that are accessed through an elaborate network of government agencies and nonprofit organizations in order to meet basic income, housing, and health care needs. Such benefits and services are also crucial to Anthony's transition, but in his

case the existence of stronger familial/social ties allow him to proceed with a bit more certainty; he is provided with a place to stay as well as a promising employment lead as he settles back into the rhythms of the everyday. In both cases, the management of mental illness in the community is entangled with obligations and pressures linked to relatedness and sociality. Derek's struggles with depression are compounded by the fact that his ties to his family seem to be withering away and that he is unable to establish meaningful, fulfilling connections to others. Anthony links symptom management directly to the pressures of contributing to family expenses and learning to parent, which necessitates a good deal of interaction with his ex-girlfriend's family; such interaction becomes stressful due to the way in which Anthony suggests that stigma is attached to judgements of his illness experience. Efforts to create meaningful futures intersect with structural limitations associated with their precarious living circumstances as both participants are left somewhat in limbo as they are forced to wait for the approval of needed benefits and supports. In the remainder of the chapter, I will analyze in greater detail the key themes that surfaced in Derek and Anthony's stories, returning occasionally to moments in their lives, but also weaving in examples from other participants' transitions as I unpack important concepts. My discussion of the emergence of self and person amidst subjective experience of mental illness and structural constraint in local worlds is organized around these themes: 1) the temporality of waiting; 2) coercion; 3) productivity through work and education; and 4) negotiating relatedness and belonging.

Waiting for Recovery

The temporal dimensions of both IRTS rehabilitation and the status of clients as severely mentally-ill contribute to the structuring of possibilities for client recovery in the community. The placement of IRTS facilities in communities is intended to give clients opportunities to reconnect with and practice being in the everyday world while still providing enough support and structure to keep them focused on the development of skills and habits that will facilitate independent living. Clients often recognize the utility of this structure and the “break” that it affords them while also often feeling as though they’re falling behind their peers with respect to normative life course goals such as education, employment, and developing as people more generally. One participant elaborated upon the frustrations that arose from a lengthy period of hospitalization and rehabilitation:

You know, I’m just kind of angry in general at this whole—all this that happened about being gone for so long I feel like I missed a lot, like I fell behind...angry at myself for ever getting myself into this situation. Like, all these places—like the treatment and this place—I think they’re good programs; I’d recommend them to people that actually wanted to go, but I don’t know. I just kind of wish I didn’t spend so much time in them; I’m anxious to get out. I’m anxious to find a new job and get my life back on track. I’m anxious to finish high school. I’m anxious to find new friends. So, I’m anxious about a lot.

Anne, a parent of two, also described IRTS as a kind of “vacation” from the stressors that she would soon have to face again:

Just the stress of everyday living. Here there is none; everything is handed to you. You don’t have to worry about where your next meal is coming, ‘cause it’s in the fridge waiting. You just don’t have to worry about anything here. At home there’s the what are my kids going to eat, what are they going to do when they get home, how am I going to occupy their time? There’s the cleaning of the house, the washing of the dishes; here there isn’t any of that. It’s just kind of like a vacation here. When I get home there’s just the stress of everyday life that I’m going to have to deal with again.

Clients are temporarily suspended from participation in a “real world” which nonetheless permeates their existence as they reconnect with (or, in some cases, attempt to avoid)

important people in their lives and scramble to complete a variety of bureaucratic tasks that will allow them to access various services to assist recovery after IRTS.

Most of my participants came from or found their way into precarious socioeconomic circumstances, and because of this they often became involved in an unpredictable waiting game as they submitted various types of applications for housing, SSI, SSDI, Medicaid, and any number of other benefits and services—not to mention the waiting and compliance associated with civil commitment orders. Pervasive waiting and indeterminacy contradict the ethos of recovery and its emphasis on individual action as the driver of health and independence. In his “patient model” of citizenship, Auyero (2011:24-25) argues that waiting is a governing technique through which the state cultivates a kind of subordination via passivity and acceptance of permanent uncertainty among poor benefit-seekers:

To be an actual or potential welfare recipient is to be subordinated to the will of others. This subordination is created and re-created through innumerable acts of waiting (the obverse is equally true; domination is generated anew by making others wait). In those recurring encounters at the welfare office, poor people learn that, despite endless delays and random changes, they must comply with the requirements of agents and their machines... It is through this practice, through this ‘governing technique,’ that the state seems to be aiming for the creation of a docile body of welfare clients.

While my research on IRTS suggests that the crucial attempts to engage clients in processes of subjectification occur as clients pass through rehabilitation programs, many of these same clients are then forced to endure various forms of waiting that compromise the subject position that they are expected to inhabit beyond their time in a rehabilitative facility. Such forms of waiting are not simply a forestalling of recovery and attainment of personhood; in the case of severely mentally-ill individuals with few resources at their

disposal, indefinite waiting can leave individuals stuck in potentially-harmful living arrangements where the management of symptoms and engagement with the social world become deeply challenging.

If we return to Derek's story, we find a prime example of the way in which the cumulative effect of waiting leads to what Luhrmann (2007), in her ethnographic work on schizophrenia in homeless populations, calls "social defeat." Luhrmann uses social defeat to conceptualize those situations in which an individual repeatedly and consistently experiences failure in social interactions, resulting in feelings of demoralization that may exacerbate illness; in the case of my research, I would extend the concept to explicitly include faceless systems, which, in their benign neglect, can engender the same sense of helplessness. In the wake of his IRTS discharge, Derek first attempted to find housing—a coordinated effort that would have involved IRTS staff and county government—residing first in a temporary adult foster care setting while waiting for something more appropriate, and then, by the time that I caught up with him, in a supported housing placement; in both situations, Derek found the living conditions difficult, in large part because of the people he was shared living arrangements with. Derek spoke about how he hoped to find other adults that he could become acquainted with, but in the first setting—which he described as temporary foster care—he found himself sharing space with a family, including kids; next, in the supported housing environment, he described two of the other residents as struggling with fairly severe forms of disability and incommunicative, while he shared nothing in common with the third. In these living arrangements, he described himself as "kind of isolated. I just kind

of felt alone so I stuck to myself.” Shifting living arrangements denied Derek the opportunity to feel grounded in a place, as did his repeated but ultimately fruitless efforts to get out and meet other young adults; he was also stymied in his attempts to secure access to outpatient therapy and left in limbo as health care systems and social workers seemed to miscommunicate with each other and him regarding his eligibility for services. In cases such as Derek’s where severely mentally-ill and withdrawn individuals lack any semblance of a support network, feel that their housing is inhospitable and inconvenient, and must rely on diffuse, sometimes uncoordinated systems of care, a series of seemingly minor setbacks can give way to uncertainty and defeat. Plagued by isolation, Derek described himself as almost incapable of sociality during our last conversation:

It’s hard for me to make friends, I rarely make friends. I feel like I’m missing out because I don’t have friends, and I get lonely and very isolated when I see everybody else have friends except for me. I just feel lonely in the world, and don’t, I mean, I just don’t feel like I’m part of where the people are, a person.

The form of social defeat that Derek experiences as a complete divorce from sociality and the corresponding inability to achieve personhood unfolds within the temporality of waiting. Derek’s lack of control over housing placements and eligibility for desired health care services reflects the limited resources available to individuals reliant upon public systems of care. Such systems lack the infrastructure to respond to the unique needs and desires of young people like Derek who might communicate particular goals and wishes but are often forced, after lengthy bureaucratic determination processes, to make do with accommodation and forms of assistance that are a poor fit; in such circumstances, recovery is undermined by structural disadvantage.

It would be a mistake, however, to simply read waiting in Auyero's terms as an act of domination. Knight (2013), in her work on addicted homeless women, contends that waiting is bound up with the administration of disability economies, the function of which is to provide state-sponsored options for managing poor, "unproductive" populations. Among people with comorbid mental health and substance use disorders, eligibility for benefits such as SSI hinges upon the ability to document psychiatric disorder. In such instances, Knight finds that mental health professionals and social workers have come to occupy roles as "neurocrats" responsible for assisting clients by marshalling evidence of disorder in ways that are consistent with complex bureaucratic requirements. While Knight argues that validating diagnoses as a condition of benefit receipt represents the biomedicalization of material and social deprivation, she observes that it is nonetheless also a vital means of providing some measure of social stability for vulnerable people. In such circumstances, to wait for a benefit determination is to wait to see if the documentation of one's illness reduces the complexity of that experience to a monetary value while also providing some small measure of relief.

Despite the fact that the benefit amounts mentioned by my participants were fairly small, they often went a long way toward subsidizing housing and reinforcing personal budgets for those who found it difficult to work. In Anthony's story, for example, we find a person in a stable post-IRTS situation relative to many of his peers; still, he seemed worn down as he attempted to balance work with parenting and educational commitments while also trying to adjust to the side effects accompanying pharmacotherapy. Anthony's SSDI application had been denied, and he was working on an appeal application when I

saw him after his IRTS discharge. In such circumstances, benefit payments would allow Anthony to contribute more to his family's living costs while also permitting him more time to manage the obligations in his life; however, there was no guarantee that his second application would be approved, and it was difficult to know when he would be notified of a decision. Waiting may be a burdensome fact of life for many but depending on the unique lifeworld of the potential recipient, it cannot be fully understood as a means of subordination when benefits and services—no matter how modest in amount or scope—have the potential to deliver meaningful relief.

Whether or not it is entangled with social defeat and abandonment, the experience of waiting and delay is woven into the fabric of everyday life for most of my participants. Waiting, due to its ubiquity, is often experienced as a banal activity that can seem to be a semi-permanent state of affairs in the absence of other options. Evan, who had been hospitalized and released to an IRTS after several episodes of hearing voices, offers an example of this sort of scenario. When I followed up with Evan after his IRTS discharge, he was living with three other people in a quiet suburban home that doubled as an adult foster care facility.³³ Evan appeared heavily sedated during our conversation—even nodding off at times—and he noted that his doctor had prescribed additional medications, though he was unsure what they were. He had no meaningful engagement with recovery-related activities, nor was he able to describe any plans that he had for himself beyond trying to get out of the foster home. Evan remained in contact with his mother but had

³³ Adult foster care facilities accommodate people with disabilities and seniors who need some care, but not at the level of skilled nursing. Provided that licensure requirements are met, this service can be offered out of regular homes.

fallen out of touch with his friends because he lacked access to transportation and could not visit them. He described his life at the time of the interview as “waiting for the county, waiting for everybody to come pick me up, waiting for some stuff to kind of happen.” He needed assistance from the county he was residing in to complete an application for SSI, though he had “no idea” how to follow up on this issue and was relying on his ACT team—which seemed to be his only connection to outside services—to make the arrangements. He made vague mention of looking for a job and trying to get back into school, but he seemed to have little guidance in these matters and felt like he had to take one step at a time, the first being the SSI application. Evan made mention of the fact that he disagreed with his diagnosis: “I’m just taking medicine for something I don’t need medicine for. They say I’m a schizophrenic, but I disagree with that.”

Between Evan’s deeply sedated state and the suggestion of what, to a mental health professional, would appear as a lack of insight into diagnosis, I left this meeting wondering about the extent to which he was effectively being warehoused until another mental health assessment was due. For his part, Evan told me that he felt like he had “a little more freedom” in this current setting compared with IRTS, and while he found it difficult to articulate concrete plans, he, like many of his peers, still conceived of the future as a time of general possibility.

Coercion

In addition to the forms of structural disadvantage that become visible in clients’ experiences of waiting, many are subject to an explicitly coercive form of power as they

move from rehabilitation to recovery. As I have argued, community mental health conceptualizations of treatment, rehabilitation, and recovery are rooted in ideas about client self-determination, autonomy, and choice. Conventional recovery models often overlook the various limits on choice and volition employed by courts and clinicians in the case of severe mental illness and give scant consideration to the role of direct coercion; however, in practice, the application of coercive power is often a crucial tool for ensuring client submission to treatment and rehabilitation. In my research setting, coercive power was most commonly exercised through outpatient civil commitment orders, which use legal authority to mandate treatment, both in institutions and the broader community. Brodwin (2013:153), tracing the history of commitment in the United States, argues that its outpatient form emerged as a compromise between opponents of mandated treatment and advocates for enhanced state power that inadvertently expanded the reach of treatment over time:

It [commitment] began as a way to preserve civil rights—an alternative to repressive hospitalization—but it became over a time a way to impose treatment far beyond brick-and-mortar institutions. Using this tool, therefore, draws clinicians into profound conflicts with their clients. The relationship starts to resemble, not coincidentally, the connection between an ex-prisoner and his parole officer, as clients maneuver around the mandated treatment or simply wait until the commitment order expires and then refuse medication. Clinicians fundamentally rely on the legal apparatus of outpatient commitment to get their job done, but the system casts them, by definition, as the adversaries of their clients.

In Minnesota, mentally-ill individuals who are deemed a danger to themselves or others can be committed by a mental health court judge provided that they meet certain criteria; commitment periods are typically six months long and can be extended if

necessary.³⁴ Mental health professionals often explain the need for coercive tools like civil commitment by framing them as an issue of client insight. One IRTS social worker that I spoke with put it this way:

It depends on their insight, I guess. They might experience some kind of psychosis due to not being on their medications or they're worse and severely symptomatic for whatever their mental health is, and sometimes they don't have the insight, so they don't realize. And they're lucky to an extent that someone's like 'oh, you're not doing well mentally, let's take you to the hospital and not to prison; but even if they go to the hospital a judge is going to be like 'Hey, you broke into this car. We realize you've got some mental health stuff; you need to do this treatment program; you're legally-obligated to; you have to.' And so a lot of times, like I said, it just depends on their insight.

In this interpretation, commitment becomes a positive, generous alternative to conventional criminal justice proceedings and the potentially dire consequences that follow from them. From the clinical perspective, lack of insight excludes the possibility of individual choice, thus rendering civil commitment a necessary tool for effective community health practice, and one that diverts individuals away from law enforcement and toward more appropriate behavioral health care systems.

More than half of my participants were subject to civil commitment orders issued by mental health courts demanding their compliance with treatment plans. Participants seemed largely indifferent to the idea of civil commitment when explaining to me how it was that they came to be IRTS clients. For the most part, they seemed to accept it as an unfortunate byproduct of poor decisions made at a time when they were struggling to manage extraordinarily intense symptoms. The perspective shifted, however, when some

³⁴ Minnesota civil commitment processes occur at the county government level. Mental health screening teams assess an individual's need for commitment and pass their findings on to a mental health court judge, who determines if those findings meet the criteria for civil commitment (Minnesota Statutes 2017 Chapter 253B. Civil Commitment).

clients began to consider the role of commitment in their lives as they prepared to leave IRTS facilities; after participating in a rehabilitative process that emphasized the agentive aspects of recovery and chronic illness management, they were nonetheless compelled to submit to restrictions on their autonomy in order to satisfy commitment requirements just as they regained independence beyond IRTS.

The most contentious of the commitment-associated restrictions on clients involved invasive forms of medication monitoring by social workers, which amounted to surveillance in the view of many participants. Maria, who was attempting to regain custody of her six-year-old daughter and was thus particularly motivated to adhere to commitment policies, summarized this position in response to a question about how she felt like her life compared to other people her age: “Well, they [peers] don’t have to worry about taking meds or going to the therapist and being on time, having all these people invading their homes, that’s how I’m starting to feel, invaded upon, ‘cause two-three people a week are coming in and looking at stuff, you know what I mean?” Seth, who had perhaps the most extensive history of psychiatric hospitalization of any of my participants voiced vehement opposition to the idea of surveillance. He was planning to leave IRTS in the next couple days when I spoke with him and had been working with a local mental health organization that places people in supported housing. As a condition of Seth’s commitment, he would need to allow an ACT team into his home and allow them to monitor his medication consumption habits:

I: Now how would you describe your current well-being? How are you feeling right now?

R: I'd say I'm really stable, doing well. I mean, I don't like all these people on my back telling me what to do, have to ask them if I can take a piss or not pretty much, it's not that far, it's exaggerations but...

I: What are some of the main restrictions or stipulations they put on your commitment?

R: I don't know, I gotta meet with this case manager and talk about shit. What am I supposed to talk about?

I: How often do you meet with her?

R: Once a week.

I: What kind of questions do they ask you?

R: How things are going, stuff like that. Do I have any goals. I don't need to discuss that shit once a week.

I: So you don't feel like that's useful?

R: It's too often

I: Anything else with the commitment you feel like is a waste?

R: Well they wanna put me on this ACT team and have this lady come to my house and go through my medicine and set it all up for me. I don't know what else it implies, but if they said if I was gonna be admitted they said I was gonna be on an ACT team. All I know is they said some nurse is gonna come to my house and setting up my meds and that's just a violation of privacy, man. I got this bitch coming into my house whenever she feels like it, and setting up my meds at her time, best time, when it's good for her, not when it's good for me. I don't like that.

I: So aside from the privacy issue, on one hand, do you feel like if you had more control of when she came or her schedule it would be better?

R: She's still coming into my place, going through my shit you know. That's my shit; I don't go over to her house and start digging in her medicine cabinet, do I?

I: So you feel like it's unnecessary; you can manage that stuff on your own?

R: Yeah, I overuse their tools.

Seth has more experience with psychiatric treatment than most of my participants, and he is thus perhaps more knowledgeable about social work routines and procedures, leading him to cleverly critique the conditions of commitment for fostering unnecessary “overuse” of services that are not needed in his case. Seth’s comments hint at the economic evaluation methodologies commonly applied to determine whether or not health care services are cost-effective; with respect to the management of mentally-ill populations, health care systems often focus on avoidance of “unnecessary” service utilization as a means of keeping costs in check. At the same time, it is clear that he views medication monitoring as both an incursion into his private space and a loss of control over the organization of time. From the clinical perspective, outpatient commitment is a necessary tool for inducing symptomatic individuals lacking insight to

get help; in addition, it is sometimes framed as a means of diverting individuals away from a criminal justice system that is not equipped to deal with psychiatric illness. Commitment may initially seem somewhat innocuous, but as its restrictions persist beyond treatment and rehabilitation settings, it can sometimes undermine ideas about where the locus of control over recovery should reside.

While the restrictions and surveillance inherent to commitment generally contradict the ethos of recovery, several participant accounts hinted at the ways in which coercion may intersect with racialized difference to become wholly constitutive of the experience of recovery. Among my largely white cohort of participants, the full force of commitment restrictions typically became apparent only as they clashed with expectations of independence when individuals prepared for IRTS discharge; in such instances, commitment becomes a nuisance, a temporary barrier to autonomy that must be overcome. For several people of color, on the other hand, it was not simply a question of the synonymous character of coercion and civil commitment and their opposition to recovery philosophies; rather, the application of coercive practices brings what participants view as ordinary problems into the psychiatric fold in the first place and then fundamentally shapes the experience of what it is to be treated and rehabilitated.

In one encounter, I met a man named Abdi, who had come to the US from Somalia several years earlier. Abdi had been involved in a fight with some friends of his brother in downtown Minneapolis, and in the aftermath of this altercation was arrested

and taken to the psychiatric unit of a local hospital; he described this situation as an outcome of his brother's friends telling the police "wrong things." Next, Abdi was placed under civil commitment and ordered to receive treatment; however, he described himself as feeling fine and could not understand why he was not allowed to return to his brother's home, where he had been living. Abdi could not recall receiving any kind of diagnosis and was given medication injections, which are often reserved for those deemed non-compliant with pharmaceutical regimens. He described days filled with boredom and uncertainty: "I sleep, I eat food, I sleep. Nothing, they didn't tell me nothing. They give me papers like this one that shows me when I leave. Group home, family, brother you go with them. That's all they told me."

Rob, an African-American man who had been diagnosed with schizophrenia and placed under commitment after refusing to take medication and running away from his first IRTS placement, felt a deep sense of frustration with his treatment at the hands of mental health professionals. While, acknowledging some past anger management issues, Rob vehemently disagreed with his diagnosis of schizophrenia, which he felt resulted from the fact that white doctors and social workers refused to attempt to listen to or understand his explanations for symptoms that they associated with the aforementioned diagnostic category. From Rob's perspective, mental health treatment and rehabilitation sought to medicalize emotions that he felt were part and parcel of normal life experience; in doing so, mental health providers became identified with a broader set of white institutions and actors who impose practices of discipline and confinement:

I: They don't know the problems that you have?

R: I tell 'em but they're just keep going through what they think is wrong with me.
I: How do you talk about your problems, or what do you think your problems would be that are different from what they say?
R: It's whenever I get mad, I don't get mad for no reason. I get mad for a reason, and it takes a lot to get me mad, but it's just basic stuff like shit shouldn't happen at the time. But the meds they get, it slows my thinking down. And then it's supposed to calm me, but even when I'm not mad and I take the meds it keeps me calm. I keep getting calmer and calmer till the meds wear out. So, if I'm calm and I take my meds at the time that they give me I'm going to keep getting calmer and calmer. But that pisses me off too because I don't like to, I'd rather just feel normal instead of keep getting calm.
I: Do you think the other stuff you were talking about [description of schizophrenia that had been provided to respondent], those kinds of symptoms about like maybe hearing voices, none of that either?
R: How the symptoms are hearing voices and I can't hear voices.
I: Can you tell me a little bit about why you said you were here one time before?
R: I was here and then I ran away.
I: You ran away?
R: Yeah.
I: What lead to that, you running away?
R: The way they run this place.
I: What don't you like about it?
R: The white people are crazy, and the way they are trying to run people's lives it's like they are acting like they own us literally. If something happens where it would make someone want to lock someone up or make 'em suffer for what they did, like say going to jail, they would physically force someone to go to jail—the cops, or white people, whatever.
I: So, you feel like here the people who work here, they don't give you choices? They make you do things?
R: Like, say we don't take our meds...what I'm saying is if you say that you're not going to take your meds and they send you to a hospital and you say you're not going to take your meds in the hospital, then they'll keep you there. And if you keep saying that for the rest of your life, they're going to keep you there for the rest of your life, and I'ma put an end to that.

For both Abdi and Rob, coercion is not an exceptional experience within their trajectories of treatment and rehabilitation; it is the norm that structures that trajectory. The experiences of both men suggest that journeys through the landscape of psychiatric care sometimes follow not from unfamiliar symptoms, but from incidents that precipitate the use of force to compel treatment or from the willful misrecognition of symptoms that necessitates the indefinite subjugation of the person; in both cases the specter of policing is invoked—literally, in Abdi's description of his arrest and detention, and more by way of analogy in Rob's discussion of his subordination to white institutions. These experiences of coercion within the psychiatric fold begin to shed light on both the unmarked racial dimensions of community mental health models and the contemporary

re-articulations of historical uses of psychiatric knowledge to medicalize and manage the behavior of troublesome Others.³⁵ In these two cases, choice and autonomy are not temporarily suspended; instead, these characteristics are denied altogether as the institutional misapprehension of experience is linked through force to forms of psychiatric pathologization that require ongoing coercion in order to address client doubt and resistance.

Work and Education

Recovery models often point to employment as a key vehicle for the socialization/re-socialization of mentally-ill individuals in community settings. In this view, working helps recovering individuals establish a meaningful social role and provides a means through which they can begin to assert control over the direction of their lives while developing a sense of self-worth (Boardman et al. 2003; Davidson et al. 2008; Myers 2015). The National Alliance on Mental Illness, an influential mental health advocacy organization, summarizes these ideas in a recent policy statement on employment and recovery:

Individuals with mental illness are a diverse group of people, with a wide range of talents and abilities. They work in all sectors of the U.S. economy, from the boardroom to the factory floor, from academia to art. Employment not only provides a paycheck, but also a sense of purpose,

³⁵ Metzl (2009), for example, analyzes the incidence of schizophrenia among black men in the 1960s as an instance of psychiatry's complicity in racialized social control. Schizophrenia became disproportionately prevalent among black men from the mid-1960s through the mid-1980s, and the sharp increase in its incidence within this population was associated with the threats to social order posed by black political mobilization. His discussion references a 1968 *General Archives of Psychiatry* article (Bromberg and Simon 1968) which contended that the incidence of schizophrenia among black men was the result of a "protest psychosis" stirred up by violent anti-white sentiment.

opportunities to learn and a chance to work with others. Most importantly, work offers hope, which is vital to recovery from mental illness (Diehl, Douglas & Honberg 2014:3).

In her ethnography of recovery, Myers (2015) argues that recovery models often predicate community belonging on employment. Following from this, rehabilitation and recovery programs often include employment readiness components that seek to bolster individuals' "capacities to become wage-earning, moral agents in a society where moral worth was often based on one's ability to contribute to the future of all. In order to be a welcome member of the broader community, a person had to work" (ibid: 126).

Most of the IRTS clients that I met expressed a desire to join the workforce as a means of achieving independence. The positions of IRTS facilities toward client employment varied, but in keeping with the philosophy of client empowerment, staff were committed to supporting those individuals who counted finding a job among their goals. Furthermore, as I have argued, IRTS rehabilitation strategies promote self-management techniques that are intended to enable individual action in the community; earning one's community membership by actively engaging in it as a productive citizen—via participation in economic life, in this case—is vital, and employment would seem to be a key indicator of one's recovery success in this context. The mental health professionals that I spoke with about this issue observed that young clients were often eager to work as soon as possible, though clinicians often urged caution and gradual integration into the workforce when possible. These sentiments are echoed in the words of an IRTS social worker:

That's the other thing with younger people, is they all want to work, which is good, but sometimes they aren't quite capable of working yet. And so, that's actually pretty much been a constant. They come in like 'I have a job interview' right away, and it's like they try to walk to the bus stop

to go to the job interview, but they got turned around walking out of the parking lot. So, it's like, ok, having those realistic expectations of you know, I know you want to work, you want money, but trying to let them know that they're not quite ready.

Many of my participants had work experience—typically in low-paying part-time service or retail positions (the types of work experience described by Derek and Anthony above are typical)—that they hoped to leverage upon departing IRTS. Desire for work was often complemented by goals pertaining to the pursuit of education in the form of General Equivalency Diplomas, vocational certifications, or college degrees. Few clients had more than a high school education—though a number had completed some college credits—and they imagined that additional education would give them a better chance of obtaining stable, decently-paid jobs. In many cases, it seemed that work arrangements were less welcoming to those attempting to manage psychiatric illnesses than educational opportunities; the latter, at least in the Twin Cities metropolitan area, include at least some schools and educational programs run by non-profit organizations that are sensitive to the needs of those coping with psychiatric illness and other disabilities.

Participants who felt able to work often found it difficult to secure employment. The few participants who did land jobs typically had strong social support networks that afforded them opportunities that were not always available to others. Anthony, as I previously discussed, got a job at Walmart with his mother's help (she was working in the same store and convinced her manager to give Anthony some hours) and was able to live in his family's home, where he was surrounded by people invested in his well-being; in these circumstances, he was able to ease his way back into a job (rearranging hours to

suit the fluctuations in his mood) while simultaneously attending school and participating in his daughter's life. At the same time, he had, with the help of a cousin, made progress toward joining a vocational training program that he hoped would prepare him for a well-paid construction position.

Erica, who had perhaps the most "successful" post-IRTS trajectory of anyone I met in terms of the speed with which she was able to adjust to the pressures of everyday life beyond rehabilitation, was completing an online GED program and working thirty hours a week at a shoe store where she had held a job in the past. Erica was also expecting a baby, and her parents had agreed to allow her to live at home and share in childcare responsibilities; this arrangement would allow her to save money in anticipation of enrolling in college to earn a nursing degree after several years. While we did not discuss her family's socioeconomic status directly, it was clear that Erica came from a class background different than that of many of her IRTS peers; for example, her IRTS stay had been paid for through private insurance, she lived in a somewhat upscale suburb of Twin Cities, she had begun seeing a private psychotherapist, and she mentioned nonchalantly at our follow-up meeting that she'd just purchased a new car due to the recent theft of her previous vehicle. Erica and several others stood out among my participants due to the ease with which they were able to access and deploy material and social forms of capital relative to the majority of young adults that I spoke with. On the one hand, privileged class status manifested itself in the absence of particular topics of conversation (e.g., discussion of completing applications for various types of public benefits), while also revealing itself in the way that a small handful of participants

casually mentioned their post-IRTS vacation travel plans or the expectation that they would enroll in college within the next few years.

In the absence of social support and material resources, the inability to find work can be a factor that exacerbates the challenges of coping with a psychiatric illness while trying to find one's way in the world. For example, Rebecca, a young woman from northern Minnesota, excitedly told me of her plans to continue working as a waitress in a popular tourist destination city once she left her IRTS facility. By the time I was able to get in touch with Rebecca several months after talking with her at an IRTS, I learned that she had suffered a relapse, been placed back on commitment, and was receiving care in a regional treatment center. I was able to visit Rebecca at the treatment center and we talked about how things had gone after she had left the IRTS. Rebecca had moved to an apartment in Duluth, Minnesota, a city where she had previously resided for a period of time and felt comfortable. Rebecca has a history of substance use in addition to a psychiatric diagnosis, and she attempted to join Alcoholics Anonymous and Narcotics Anonymous groups in order to meet other people with similar histories of mental health and addiction concerns; this was a priority because at the time of her IRTS discharge her existing social network was largely comprised of people still using drugs. She also began to search for jobs, casting the net widely to include a range of different positions:

I: So what happened with your friends when you moved to Duluth?

R: I tried to make sober friends but the only place I could find them at was AA and NA. I still don't have a sponsor. I had one, but her list got too full; I would try to go find new people there.

I: Did you feel like there were other places you could go?

R: Yeah, I could probably go to a job or something like that and find friends there, but I couldn't find no work.
I: Were you looking for work?
R: Yeah
I: What kind?
R: Waitressing or a cook or something.
I: It was just hard to...
R: It was really hard to find a job.
I: Just because there wasn't anything open or other reasons?
R: There was nothing open; most people weren't hiring or didn't get back to me.
I: Do you feel like when you were doing that job search you were pretty persistent about it, did you follow up with people?
R: Yeah
I: Did it become frustrating?
R: Yeah, it was really frustrating. I applied to Starbucks, for instance, and I had to keep going in there every day to see if the lady had looked at my sheet [resume] or not.
I: And so you just didn't, weren't getting responses back and things like that?
R: Yeah
I: How long would you say you were doing that job search?
R: Probably about a month.

Ultimately, Rebecca ended up reconnecting with old friends and using drugs again, leading to rehospitalization and recommitment. She attributed this outcome partly to difficulty finding opportunities to meet people and establish a new social network: "I guess I was just really depressed and had nothing to look forward to. Didn't have a job, wasn't with anybody at the time, so that was kind of harder." Initially, she had hoped that sober recovery programs and a new job might afford her the opportunity to develop a new social life, but neither strategy worked out. Rebecca recalled trying to keep herself busy by going on quiet walks in local parks or just staying in her apartment on her own, but as job and sober group prospects failed to develop, she began to feel isolated. In response, she got out and about in the city more frequently, and she eventually began socializing with people that she had used drugs with in the past. These "drug buddies," as Rebecca referred to them, were not just people that she got high with; they helped her out by driving her around to do errands (she was without a car) and generally provided a measure of sociality and friendship as Rebecca began to feel neglected by mainstream

systems of care. Rebecca had family living nearby at the time, but a sense of shame made it difficult for her to reach out to them, and in any case, she had never really felt comfortable consulting with them about mental health and drug issues in the past.

Despite the fact that Rebecca adhered to the recovery model by seeking to organize her life around stable employment and established support groups while attempting to avoid situations that could imperil her wellbeing, none of her efforts yielded access to the vision of community participation that mental health professionals typically endorse. From the clinical point of view, Rebecca's attempt at community reintegration would likely be deemed a failure borne of poor choices that led her back toward addiction and its attendant mental health complications. Such normative standards not only discount the context in which individual lives unfold, but they are also blind to the nuances of sociality that complicate recovery processes. In her work on heroin addiction in the American Southwest, Garcia (2010:112) argues that social affiliation among addicts sometimes "precedes the establishment of an autonomous self, the premise of personhood that most behavioral and biomedical models of recovery assume" and belies the notion that people struggling with addiction lead fragmented social and intimate lives. Likewise, Bourgois and Schonberg (2009) contend that forms of reciprocity among drug-using friends and associates stigmatized in expert discourses are often the basis for a sense of kinship and solidarity that is otherwise absent for people.

When Rebecca invoked the term "drug buddies" she drew attention to the friendships underlying drug use, and when she discussed reconnecting with these friends

she focused on the aid and company that these people provided. Rather than viewing Rebecca's resurrection of these friendships as a poor decision meant to leverage instrumental ties with others in order to secure drugs, one might ask how exclusion from conceptions of community valued in rehabilitation and recovery discourses lead people to reanimate relations—even those that may undermine their wellbeing—as a means of recuperating alternative forms of belonging. For many participants, the normative trappings of recovery are insufficient and cornerstones of community reintegration such as employment sometimes prove to be out of reach. In these circumstances, participant ambivalence toward old ways of being may give way to the need for some semblance of sociality despite the uncertain implications for mental health of reestablishing particular social ties.

Relatedness, Recovery, and Social Belonging

As individuals prepare to leave IRTS, the active subject of recovery that clients and mental health professionals perform in rehabilitation settings is often undermined by both temporal conditions that seem to suspend progress toward some measure of independence and coercive practices that place conditions on the exercise of autonomy. Against this backdrop, one's ability to achieve basic goals related to work, housing, and education that might cement one's status as a productive member of a community (as recovery discourse would have it) becomes increasingly tenuous. Underlying these challenging circumstances are participants' embeddedness in various forms of relations with family, friends, mental health professionals, and the state. Relatedness—and the

desire for it—is something that people must reckon with as they consider existential questions about leading a life with mental illness and, more commonly, make everyday decisions that are meant to address the complex admixture of inner experience, self-governance, temporality, obligation, and aspiration that comprises recovery in the community. While the course of recovery is, for most participants, deeply embedded within complicated domestic economies and social networks, even those who might, in other analytic frameworks, appear to be facing social abandonment are often incorporated into a mental health services apparatus—at least temporarily—through which they become involved in an ongoing set of relationships with community mental health professionals who provide care consistent with psychiatric norms. As my participants considered their futures beyond IRTS and resumed life in community settings, the force of existing relationships—as well as the way in which people imagined that living with mental illness might affect the ways in which they would relate to others in the future—animated decisions about the how participants would go about rejoining an altered social landscape. By tracing the ways in which the question of mental health is taken up in local worlds by participants and those with whom they maintain and cut social ties, the forms of personhood that are possible for and meaningful to individuals begin to come into view.

The import of relatedness was apparent in my discussion of IRTS discharge with Anne, whose encounter with psychiatric treatment and rehabilitation was precipitated by the sudden onset of panic attacks, which I discussed in the previous chapter. Anne is the mother of two young boys, aged three and seven, who she cares for along with Dave, her

partner of more than three years. The family rents a trailer in a small city in central Minnesota and live in the same neighborhood as Anne's mother and sister, with whom relations are tense. Anne had adjusted well to her medications and taken to the various illness management techniques—journaling, deep breathing, and mood rating, among others—that she had practiced in IRTS groups. In the days before her IRTS discharge, Anne was most concerned about how she would cope with the stress of everyday life while simultaneously shouldering the burden of managing psychiatric symptoms. Anne felt largely estranged from the members of her family living nearby and expected to rely primarily on Dave for both emotional and material support as she looked to get back on her feet. Anne had long smoked marijuana with her partner and friends as a means of what she called “self-medicating,” but decided to quit after she began to be troubled by symptoms of anxiety and panic (Dave also quit in solidarity). For the good of her mental health, Anne felt that she had to distance herself from her peer group, a move that would spread her social network even more thin, particularly for a self-described “anti-social” person:

I: I'm going to move on a little bit, ask you a few questions about people you've been in touch with and people who've provided a support network for you since you've been dealing with some of these issues. I guess I'm wondering who you've been in touch with since you've been here...who have you been in touch with the most?

R: When I first came here like I said we were on marijuana use a lot. Since I came here I don't talk to any of my old friends anymore. My family members really don't have much to do with me, like my mom and my sister, they really just don't understand what's happening. Since I've come here and been sober, my boyfriend has also; he's been sober about twenty days less than I have. And he's basically my only main support system, I see him on a daily basis, him and my two boys.

I: So they come visit you here or do you go?

R: They used to come here but now I go, now I leave. I have my own car now so I leave to go see them.

I: So you see them on daily basis. With your mom and your sister you mentioned they don't understand what you're going through...Have you talked to them at all?

R: I try, but throughout my whole life I've kind of been the outcast. I've always been the drug user, had kids too early, I had some mental problems when I was younger which I really don't remember too much of. I've just always kind of been the outsider of my family, they just, they'll have family gatherings and kind of forget to invite me, stuff like that, and I'm just kind of used to it now.

I: So you're just at this point not very close with them and haven't been much in touch with them since you've been here, so it's mainly your boyfriend...

R: Mhmm

I: And his decision to like quit using pot, was that, did that kind of coincide with what had happened with you?

R: Yep.

I: And if you could just talk a little bit more about your relationship with him and maybe some specific examples of how he has provided support for you?

R: Well I have two kids and they are not his.

I: How old are they?

R: I have a seven year old and a three year old. When I first came here, I signed over rights to my kids to my mother and my boyfriend was real upset about it, so I went back and signed my rights over to him.

I: He has a pretty close relationship with them?

R: Yeah, he's been in my life for about three to four years now, so real, he's real close with my boys. And he just, he's taken care of 'em, he's kept a job, made sure they had everything they needed, made sure that I had everything I needed while I was here. And he's just, really took care of everything while I've been gone.

I: And so you guys had been living together for quite a while before?

R: Yeah.

I: And it sounds like he'll continue to be sort of a primary person in your life once you leave?

R: Yeah.

I: Anybody else you've been in contact with, or just mainly him?

R: Pretty much just him, I kind of don't hang out with any of my other friends anymore 'cause they're drug users and just staying away from 'em.

I: And so were you still in close contact with them up to the point before you started having some problems with anxiety?

R: Yeah, I was still pretty close with them up until about a month after I was here, and then I kind of realized my life really did need to change and I couldn't be hanging out with them anymore.

Anne's past is a difficult one, and it structures the nature of the relationships—or lack thereof—that she maintains in her local world. These sets of relationships will both pose challenges and offer opportunities as Anne seeks to reestablish herself as a person. While Anne clearly is clearly estranged from—and perhaps to some degree abandoned by—her family, she has developed a strong bond with a partner who has been willing to assume responsibility for parenting her children in the wake of her psychiatric emergency. The strength of Anne and Dave's relationship and the forms of support and assistance that it engendered as Anne sought relief from her panic attacks seems to have played a crucial role in helping her keep the various components of her life intact. At the same time, she

has also decided to discard friendships that she now views as undermining her wellbeing and will be faced with the challenge of cultivating a new peer group.

As Anne considered her near term goals, she spoke about how she looked forward to improving her family's circumstances, which had become challenging after Anne's hospitalization and subsequent treatment led her to quit her job and resulted in lost income. For Anne, recovery was not simply a matter of adhering to pharmacotherapy and practicing mood hygiene; her vision of successfully living with mental illness was one in which the management of symptoms and material conditions at the level of the domestic economy stood in symbiotic relation to one another. To this end, Anne aimed to find more comfortable housing for her family and gradually settle into a new job with a healthier work environment that would complement a higher-paying new construction job that Dave had recently begun:

I: We've been talking a little bit on and off here about your goals for the future, so I want to switch to that topic maybe ask some more concrete questions about that. In the immediate future do you have an idea of what your living situation will be like, you plan to move in with your boyfriend?

R: Mhmm, yep. We live in a trailer right now, we kind of had to move into a cheaper trailer when I moved in here because when I came here I had to quit working, 'cause I didn't have insurance and as long as I'm not working I can have insurance; I don't know, through the state or whatever, however it works. So he had to move into a real cheap kind of grungy trailer, and before this I was working full time at Bio Corporation and it's dealing a lot with preserving specimens for dissection, and so we work a lot with formaldehyde, acetone, and it was just not a very good work environment, that I just finally discovered like the last month that I don't want to go back to work there. There's a lot of drug users there. I have felt a whole lot better since I've left there with my sinuses and just being able to breathe better without breathing in all the chemicals and stuff. So short term goal for me is I just got a job at Taco Bell, just kind of getting into there. Hopefully getting my family out of this trailer and into a little bit better spot for us, it would be real nice for us. I ate through all our savings while I was here, so kind of getting back on track with our savings again.

I: Is your boyfriend also working full time in town?

R: Yep, he used to work at the Bio Corporation too, and I made him quit there. He was at Taco Bell—he got me the job at Taco Bell—but now he's doing construction making double the amount of pay.

A bit later in our conversation, Anne returned to these topics with a view to the somewhat longer-term future of life after IRTS:

R: Of course we would love to have our own house, with the white picket fence and the dog in the backyard, but realistically it's probably not going to happen. But just kind of finding a nice rental unit, which would just really be lovely, a place that we could afford that's not worn down and with a crappy landlord, just kind of a nice place to be able to settle in for a while would be nice.

I: Are there certain jobs or types of employment that you would like to get into eventually?

R: I haven't been doing much thinking about what I want to do with my life, I just don't feel that I'm there yet. I don't know if I'm just not ready or what. But I just kind of feel that I'm a real hard worker, and I just need to stay somewhere where I'm busy. I'm just fine working a regular job, and my boyfriend is able to do construction and he makes pretty good money doing that, so I just kind of feel like I'll lean on him a little bit more for the finances instead of wrestling with it in my mind of what I want to do with my life. I just kind of, fast food is fine for me right now. It's not too demanding, I get to leave early and be with my kids in the evening, I don't have to go home and do paperwork or studying or whatever; I can just kind of be there with them.

I: Do you foresee any changes with your family or things you'd like to see happen in the immediate future in terms of your family?

R: Yep, I requested through the village to have some parenting classes with my older seven-year-old, he has ADHD and ADD and he's just a real handful, and I don't feel like I have much of a connection with him, so just kind of having parenting time with him, kind of building up bond more with him. Pretty much yeah, I mean my three-year-old and me, we get along wonderfully but my seven-year-old kind of relates to Jim more, I kind of have some jealousy along those lines 'cause you know he's mind (laughs), so just kind of strengthening the bond there for us, it would mean a lot to me.

I: And you mentioned that you, since coming here you've stopped talking with maybe your older circle of friends, or older group of friends, do you have any goals in terms of peer relationships, do you want to start forming a lot of new friendships, is that something you feel like you have the time for?

R: Yeah, it would be nice to have at least one or two friends. I've always kind of had a real close group of friends, usually like five or six is usually my kind of my limit of five or six. And now it's just kind of I'm lingering between zero and one, and I would just kind of like to have some more friendships. Not really sure where to go on that, I have been attending NA and hopefully the job at Taco Bell will help with some friendships of some sort.

I: And the one friendship that you mention now...

R: That would just probably be Dave. You know, he's not really a friendship 'cause he's my boyfriend, but he's still a friend; you know, he's the only one I have.

In this scenario, Anne's post-IRTS goals reveal the ways in which forms of care and support are reconstituted in the community and entangled with dreams of a better life.

Anne, while grappling with an unfamiliar form of illness, gave considerable thought to the ways in which maintaining particular relationships might impact her ability to cope with symptoms and pursue meaningful goals. The startling onset of symptoms led Anne to recast particular forms of sociality as harmful and perhaps even generative of the

extreme anxiety and panic that led to the unmaking of her selfhood. In light of these circumstances, Anne resumed life in the community with few relationships, having cut ties with most of the people that formerly comprised her social support network, as well as emotionally-distant parents and siblings; at the same time, she sought to forge closer bonds with her children and partner as they attempted to build a meaningful life together. This recovery trajectory is facilitated by the fact that Dave was able to stand in as a parent while Anne went through rehabilitation and also find a new, better-paid job—as well as setting Anne up with a low-stress employment opportunity that will provide the family with flexibility and some measure of stability as Anne weighs her options; the provision of care in recovery relies on the ability to reconfigure and rebalance limited resources within families and households in order to allow a person to readjust to everyday demands.

While Anne's initial assessment of the life possibilities that await her is cautiously optimistic, there is nonetheless an undertone of anxiety as she discusses her strategies for coping with what she expects to be a chronic set of symptoms without the kind of near-constant support and resources that have been available to her in hospital and rehabilitation settings. In Anne's example, we find someone who relies upon a mixture of self-management techniques while attempting to learn how to convey troubling moods and affective states to an intimate partner; in turn, Dave does his best to make sense of an unfamiliar set of challenges and contribute to Anne's recovery work. At the same time, Anne faces the impending loss of health insurance when she resumes work because her earnings will presumably push her household above the upper income threshold for

Medicaid eligibility; such a situation threatens to imperil recovery by placing mental health services out of reach:

I: Currently how would describe how you're feeling or your health situation?

R: Well when I first got here, on a rating from one to ten, ten being the best, I was probably about a negative three.

I: Wow.

R: And now I would probably rate it about somewhere between six, seven, maybe an eight on some days. When I first got here, I was just ready to end it all. I was just tired, I hadn't slept in about four days. I hadn't ate. I was just shaking so bad I couldn't even control anything. I hadn't showered or changed clothes. I felt like I was ready for the nut hut. And now I feel like I know what's wrong with me, I know I can control it, I know that life will go on, things will get better.

I: Massive improvement, huh?

R: Yeah. It was a very big improvement since I've been here.

I: What did you attribute those feelings of anxiety and depression to initially, when you first started experiencing them? Was that something you thought about much?

R: I really didn't know what was happening, but the more that I think about it recently I think it was kind of the bills, my drug use, knowing that I had to stop but not wanting to, but wanting to, but it was just such a way of my life. I've been smoking since I was like thirteen or fourteen, and I'm twenty-six now so it's a good majority of my life that I've been putting my life on hold by maintain being high. And it was knowing that it had to end, but not really sure how to go through with it. My bills were outrageous because of my drug use. Everything just seemed to keep piling up and piling up, and it was kind of like I couldn't handle it anymore.

I: It sounds like you have a pretty good understanding of anxiety, depression issues...How do you see yourself managing those problems in the future? Do you feel like this is something that is always going to be with you?

R: I think that I'll probably always have depression. I think it will always be there, waiting to come back. The anxiety I think is just a lot from my depression and my negative thinking. I think that I can control the anxiety if I try hard enough, if I keep going with the positive, stay away from the negative, I feel like I can control it versus when I first came in the anxiety attacks would last like an hour or two, sometimes longer, now it's about fifteen-twenty minutes and they are not nearly as...I don't know the word I'm looking for.

I: Intense?

R: Yeah, intense as they were before.

I: It sounds like you've definitely been able to decrease the number of anxiety attacks and deal with them much better. In terms of concrete plans it sounds like you'll continue to rely on a lot of the stuff you learned here to manage that. Is there anything else, any other ideas about how you'll manage those symptoms of anxiety and depression once you leave? We've talked about like religion as part of that, is there anything else?

R: No, the only thing is that I really know about to help me with it is the religion, the self talk, the deep breathing, and just journaling, writing down exactly how I feel. And a big one for me—I haven't really mastered the skill yet—but is just talking, just telling somebody what is going on, telling somebody how I feel at that moment, what I think is going on, asking for help. A lot of that stuff, I haven't really mastered yet, but I'm getting there.

I: Are you able to do that with Dave?

R: No, not really. More him than anybody else, but not as open as I probably should be.

I: Do you feel like he's pretty open and understanding to what...

R: Yep. Yeah. He's been wonderful throughout this whole process, he reads all my handouts. [IRTS counselor] usually prints off some, can't remember what they're called; they're like partner helpers, and he reads them and dissects them thoroughly, and kind of takes what he can get from 'em. He's read a couple of the books that I've bought, he's just really into it and wants me to get better. I mean I couldn't have asked for a better person to go through this with me.

I: Do do you have plans to see like a counselor or a psychiatrist once you leave?

R: Yep, I have a psychiatrist that I see at the Mental Health unit. I see her about every other week, I'll probably continue to see her up until the point that my insurance gives out, and then I will see what happens from there.

I: Is that mainly medication management or do you also talk about kind of things that you've been experiencing?

R: Yeah, she's just someone that I go and talk to. I have a, somebody else that I go for medication. She's just strictly there to talk to.

I: In terms of the medication, do you see that as a long-term solution too? How do you view that?

R: Medication is a little tricky for me because I do believe that I have made just a huge difference in my life with the medication, the Lexapro I believe that I should probably be on for quite a while. The Seroquel I'm not too sure about it. The medication in general kind of just scares me in general; the side effects, my mind kind of starts to wander with the side effects. I would kind of like to get off the Seroquel, but then again it helps me sleep at night. I would kind of just like to get off the Seroquel and find something less habit forming at night for me. But then again when my insurance runs out, I'm not exactly sure what's going to come of the medications.

I: How long does the insurance go once you leave?

R: The insurance stops once I start working.

I: Do you have any plans for how you guys will deal with that?

R: No.

I: At that point you maybe think of buying some form of insurance?

R: Yeah, they run about \$200 a month, so I'm sure I'll probably be able to get one but not the other [of her current medications]. The Mental Health unit said that they will probably help me with the samples, but you never know how long that's going to last.

In this passage of the interview, Anne locates the social elements of disorder and seems confident that she can use the tools learned at IRTS to keep the worst of her symptoms in check. At the same time, Anne reveals that she is likely to lose public health insurance benefits after she begins her new job, and it is unclear how she will be able to afford medication and professional help beyond that point; she even begins to weigh the benefits and drawbacks of the two medications she has been prescribed as it seems likely that she will need to dispense with one of them in the near future. In this context, the notion of recovery rings hollow; Anne seems invested and well-versed in the forms of self-cultivation that frequently circulate in mood hygiene discourse, but some of the fundamental tools that subjects of recovery are expected to avail themselves of may well prove unaffordable for her. This condition of service precarity is common among participants, and it often engenders what Biehl (2007) calls "proxy psychiatry," the assumption of responsibility for monitoring of moods and medication by close

relations—but not mental health professionals—in situations where resources are scarce; indeed, Anne herself has become the primary interpreter of psychopharmacological side effects and independently assigns value to the drugs that precipitate them by considering how willing she might be to compromise between their useful and disruptive properties. Quite inadvertently, it appears that Dave, in his efforts to understand and care for his partner, has begun to cultivate knowledge of psychiatric disorder that he may well be required to call upon as he and Anne are left to face a future that is likely to include many gaps in access to services; already we find Anne independently weighing the iatrogenic effects of several powerful psychiatric drugs as she ponders which one she can do without. Passive waiting, too, emerges in this lifeworld; Anne conveys the feeling that she is at the mercy of insurance eligibility criteria and will essentially have to take whatever resources come her way in the likely event that she becomes uninsured. Forms of social inequality bely community recovery's promise of autonomy, as Anne, whose narration of a reconfigured life course would seem to suggest a model self-governing agent, finds her well-being—and quite possibly that of her family—threatened by the inadequacy of systems of care that leave her and her intimate relations to manage illness against a backdrop of perpetual uncertainty.

While the sorts of everyday struggles that Anne faced as she sought to regain control of her life were common in participant narratives, the family and the household do not always function as the loci of negotiations over relations that are meaningful to personhood in the community. One need only recall Derek's case to find a participant who seemed to be altogether estranged from kin, lacking friendships through which he

might receive support and care, and, while not homeless, devoid of anything that felt like a welcoming living arrangement as he drifted through several post-IRTS housing placements. Among those participants with characteristics similar to Derek, it can be tempting to read experiences of and ideas about life beyond IRTS entirely through the lens of social abandonment and, in more extreme cases, perhaps even social death; however, these approaches are not entirely adequate for describing their circumstances either. Nearly all participants routinely experience a degree of social abandonment and isolation stemming from convergence of mental illness and difficult social circumstances, but there is subset of individuals whose social alienation is perhaps more profound than most. In these cases, participants may not be entirely without connection to social networks that include family and friends, but, for myriad reasons, those networks are frayed to such an extent that the assumption that there is some source of care, however tenuous, waiting to receive them in the community becomes untenable.

In such precarious circumstances, people are typically incorporated into a human services apparatus after treatment and rehabilitation through which their basic needs are met for an almost indefinite period of time; rather than joining an “institutional circuit” (Hopper 1997) in which psychiatric emergencies fix people in an endless cycle of short-term treatment admissions and discharges, social welfare benefits are now used to attempt to situate individuals in semi-permanent community dwellings managed by specialist non-profit organizations seeking to integrate supported housing residences with professionally-managed social supports, including tailored work and school-based programs in some instances. Participants are not entirely abandoned as they pass into the

care of a state-sponsored system for the community maintenance of mentally-ill and often impoverished individuals; rather, they become implicated in a temporary web of relations within mental health professionals and a host of others working in non-profit service provision roles who act as key points of social contact and support.

Tiffany, a participant who had for some time been living in the aftermath of significant trauma, was preparing to discharge from her facility and move into a nearby building operated by the same organization that managed her IRTS. Her new accommodation would be a form of supported housing where she would have her own room, which would be paid for using SSI; she would also be able to draw upon the expertise of social workers and other mental health professionals who worked out of an office adjacent to her new residence. Prior to her IRTS stay, Tiffany mentioned living in an array of group homes and foster care facilities, as well as on the street; she spoke of passing through different living arrangements so many times over the years that she had been unable to establish any meaningful friendships:

I don't really have any [friends], no. Well with being mentally ill and a little sick and living in group homes and all you don't really get a chance to meet people and hang out. And you keep moving, bouncing around and they tend to stay back that way. Like here, once I move there I may see some of them but it probably won't be the same as if I was here. You know, you move on.

Her family was living in the Twin Cities metro area, but they had only intermittent contact over the phone “once in a blue moon”; Tiffany told them little about her own situation because “they have their own problems” and were not particularly invested in her wellbeing.

Tiffany was anxious about her impending move because it represented a “test” of her ability to live more independently than she had in some time. Due to the risk for fairly significant impairment of functioning due to her PTSD and schizophrenia symptoms, Tiffany needed a higher level of continuing professional support in the short term than many of the other participants that I met. In the absence of any support network external to the group of mental health professionals who worked for the organization that operated her IRTS and managed her new home, Tiffany relied mostly on her case manager, Jenny, for advice about how to proceed with therapy, school, and work. In many cases, participants rely on mental health professionals to help them put plans into motion while still at IRTS and then attempt to gauge the level of support that they might need after they have attempted to follow-through on certain goals after leaving IRTS and settling into some sort of community setting. In Tiffany’s case, supportive housing and case management services that followed from IRTS and were managed by the same organization constituted community for the foreseeable future. Furthermore, Tiffany’s strongest social ties were with the one of the organization’s employees—Jenny—who was most familiar with her history of symptoms and was best-positioned to guide her through decisions regarding her capacity to take on new challenges. As Tiffany prepared to move on from IRTS, she had enrolled in a nearby adult education program designed for people struggling with mental illness in the hopes of earning a GED and was working with Jenny to identify volunteer opportunities that would allow her to become more comfortable with social interaction and prepare her to take a step toward part-time employment; in addition, Jenny helped her to coordinate regular visits to a psychiatrist and schedule group therapy appointments.

It is difficult to predict the likely trajectory of someone like Tiffany, and, as far as she understood, her new living arrangement was not time-bound. Tiffany articulated some vague dreams of employment and a modest house of her own at some point in the future, but it was quite clear from the way in which she had described the severity of her symptoms, her history of trauma, and general social dislocation and lack of support that it would be unlikely for her to live with a high degree of independence anytime soon. For the time being, Tiffany was dependent upon what were ultimately services provided by an agency contracting with local government; her benefits paid for her housing and health care, and most of her other needs were subsidized. It would be crude to suggest that methods for mitigating the abandonment of mentally-ill populations—the critique of which I noted in the first chapter—such as those applied to Tiffany’s situation amount to reinstitutionalization, although this may a defensible position; rather, I find that people in Tiffany’s circumstances and the kind of state-supported, outsourced micro-community that she inhabits comprise an emergent form of provisioning mental health care.

Tiffany and many of her peers face serious structural impediments and are not members of networks of relations separate from the state that can absorb them in the aftermath of psychiatric crisis. My cohort of participants was relatively youthful and, in relative terms, were not so seriously mentally-ill that they would be deemed in need of state guardianship; instead, the allocation of state resources to various community-based human service agencies that increasingly integrate once-separate sectors (housing, case management, employment readiness, education, therapy) ensures that there is no

appearance of social abandonment in recovery while human services agencies attempt to stabilize community-based clients in order to avoid costly utilization of health care and other services that often occurs in emergency situations. While I have observed the dedication and professionalism of various community mental health practitioners and have no doubt that client recovery is their foremost goal, my research suggests that recovery largely continues to be guided by the normative assumptions about what constitutes a productive community member: namely, participation in economic life and the various forms of preparation—from symptom management to education—that are involved with the attainment of such a goal. The activities that accompany these assumptions are not necessarily always incompatible with the long-term wellbeing of mentally-ill young people living in community settings, but, as we have seen, various structural impediments would seem to leave these people ill-equipped to embody the idealized forms of citizenship that take shape in discourses of community recovery.

Regardless of where sociality and relatedness end up being reckoned in the wake of psychiatric rehabilitation, an important dimension of social belonging that participants wrestled with was the question of how much they should reveal about their recent struggles to friends, acquaintances, and others who they valued and expected play a role in their lives. As participants mulled over this question, the key consideration for many—whether it was explicitly mentioned or more subtly hinted at—was the potential impact of mental health-related stigma on issues of acceptance and rejection within existing and inchoate peer groups. Stigma, in the context of my research, was meaningful to participants as an interpersonal process and an interactive phenomenon

that acts as a marker of negative social difference. Jenkins and Carpenter-Song (2009:520-521) build on Goffman's (1963) classic formulation of stigma to argue for the importance of interpersonal, interactive context in the lived experience of stigma, which is often ignored in prevailing social-psychological accounts of stigmatization processes that largely focus on the realm of individual cognition:

Although Goffman's formulation emphasizes stigma as a social construction, social psychological frameworks tend to reduce stigma to processes occurring at the individual cognitive level in response to social stimuli...An approach attuned to stigma as an interactive phenomenon will not be satisfied with a global notion of "spoiled identity," but will identify how differentness and otherness are constituted in instances of being snubbed, teased, rejected, talked about, or even looked at in an unusual way.

In many cases, participants found that living as a mentally-ill person in the community placed them in situations involving the application of a set of strategic judgments about the extent to which aspects of the self should be concealed from others. If we recall Anthony's story, we find a good-humored, socially-gregarious person who, prior to psychiatric treatment, thought of himself as someone who enjoyed meeting new people and maintained a wide network of friends and acquaintances within his neighborhood. Upon completing his IRTS treatment, Anthony moved back in with his family, who left him feeling well-supported, but struggled to reestablish a meaningful social life as he considered what details of his situation to share with those peers that he frequently encountered while out running errands; ultimately, Anthony began meeting new people on the internet who weren't familiar with his personal history and thus didn't pressure him to explain his absence from the community as others might have. Still, because of the active social life that he had maintained in the past, Anthony found it difficult to avoid unexpected encounters with friends and was working through strategies for

explaining why he had been away from the neighborhood without revealing more than he felt like a particular person might need to know: “there is this thing when you’re talking to people; there is conversation that you open up and don’t open up, and there is ways to avoid having to go through those conversations, so I’m using those skills.” While rehabilitation involves a reorientation toward a different kind of psychiatric self that demands constant attention and management, community reintegration leads many to publicly deny that very self for fear of negative social consequences.

Laura, a twenty-two-year-old who had recently departed from an IRTS, described the way in which stigma can disrupt close friendships and lead those diagnosed with mental illness to become anxious about relating to new people in their lives. After leaving IRTS, Laura moved back in with her parents while she attended a community college and was waiting for an opening on a subsidized housing list. She spoke about changes to her social life and noted that her relationship with her closest friend, Michelle, had deteriorated since she had resided in an IRTS facility. Laura began describing the decline of this friendship during her first interview just prior to leaving the IRTS:

R: The one friend I thought I had she thinks it’s weird to be friends with me now. So that’s hard, ‘cause she was my best friend, I mean the type of friend that you could go over and walk into their house. I loved her family, and she came to Florida with us for my graduation, and we just had a lot of fun and then all of a sudden she’s like, ‘it’s too weird.’

I: And that only came about because of this placement [at IRTS], not when you were in the hospital or anything?

R: No, the first time I was in the hospital she came and saw me almost every day, but then after that it started deteriorating.

In the subsequent discussion, Laura elaborated on her relationship with Michelle:

R: It's complicated. She [Michelle] comes over and sees me. She's only been here twice since I've been home and that was two days in a row. And that was just last week, so it's been a while. She wants me to go see a concert with her in the cities, and I'm going to go to that.

I: So you and Michelle, what do you think was causing not seeing her very often?

R: She said it was weird, she was weird being my friend.

I: Why?

R: Because of my illness.

I: Did she see things happening before you were there [at IRTS]? Did she know that you weren't doing very well?

R: Yeah, because it had been a year when I went into [IRTS], a little over a year. She had known the whole year what I was like. She came to see me once in a while, and I wouldn't hardly talk to her. I didn't smile; I didn't smile until I got to treatment. If you got a smile out of me it was really rare.

I: That's changed.

R: Yeah. I don't think she knew how to handle it.

I: Those two days that she visited you, how was that?

R: It was ok. She talks about a new best friend a lot, and that's weird because I was both of their friend, and I introduced her to Michelle.

I: And the three of you can't hang out?

R: Well, Michelle doesn't want to hang out with me.

In addition to the fraying of close social bonds, Laura described a more generalized concern about stigma that makes her circumspect about sharing her challenges with others:

I: What are some of the scariest things about that [leaving IRTS]?

R: You feel like you're hiding. Like, I feel like I'm hiding because my illness; like, I don't want everyone to know, but I feel like I'm hiding. That's really hard though.

I: Like you have a secret that no one knows.

R: Yeah. With the stigma and everything around it I want to talk about it, but I don't want people in school knowing because I don't want to deal with that.

I: Yeah, because you went from this supportive environment where everyone knows what's going on and how you're doing, and like you said, you go back to this world where you feel like you kind of have this secret and you don't want everyone to know.

R: Not having everyone know and not being in that supportive environment is really hard at first.

In Laura's case, the process of stigmatization led to the unraveling of her closest friendship, and more broadly, to a feeling of needing to hide the self in light of uncertain responses from others in her social world. Laura described leading a diminished social life relative to peers in the same age range and was finding it difficult to get out and meet new people in the months after her IRTS discharge. Such social isolation compounded some of the problems that Laura was having at home, where she was struggling to cope

with her younger brother's anger management issues and frustrated with her parents' inability to understand the ways in which symptoms impacted her everyday life. One of the few people that Laura has felt comfortable spending time with after leaving IRTS was Nicole, a fellow resident who was discharged around the same time. Laura found that because she and Nicole had gone through similar symptom to treatment trajectories the two were more able to relate to one another than others in their lives at the moment: "Nicole listens, and we've been through some of the same stuff like residential treatment we were together. It was really nice, so that just kind of continued and we were supportive of each other." This sort of post-IRTS biosociality was not common among participants, and Laura worried that she may not be able to maintain her connection to Nicole because she found it more comfortable to pass her free time on her own: "I spend it [her free time] on the computer, listen to music and stuff like that; that's my favorite thing to do. And I find myself sometimes taking that over, like, going out with Nicole, and that's not good because I'm going to lose Nicole as a friend if I don't do anything with her."

Conclusion

In this chapter, I have examined the experiences of participants as they prepare for and transition into life in the community. While category of community occupies a privileged place in recovery discourse as a non-institutional setting where those managing mental illness exercise responsible self-discipline and, as a result, are empowered to determine futures of their choosing, I contend that participants face

structural conditions that limit their ability to work toward and achieve the ideal forms of personhood underlying treatment modalities. Participants face complicated lives in the community where recovery is typically hindered by structural vulnerability, a type of positionality that subjects individuals to various manifestations of violence as a result of their marginal socioeconomic status. Occupying structurally-vulnerable subject positions, participants must navigate a complex disability economy in order to access the resources that will provide them with some small, partial measure of stability in terms of income, health insurance, and housing. As participants are absorbed into this disability economy, the temporal conditions of their transition to community living become bound up with various processes of waiting, which undermines the agentive thrust of the recovery narrative and induces passivity at the moment when autonomy and choice are thought to become accessible. In addition to the subtler forms of social defeat that accompany this vulnerability, many participants find that their ability to independently address their needs is compromised by the exercise of coercive state power through civil commitment orders, which mandate adherence to treatment and surveillance even beyond institutional settings.

Against this backdrop of structural vulnerability and limited resources, clients face questions of relatedness and social belonging. The possibilities for personhood are not individually-determined, but also bound up with a host of existing and incipient relations that comprise community for many. The force and nature of relations goes a long way toward determining how participants understand and make use of others as sources of care as they manage illness and attempt to pursue goals that matter to them. I

found relatedness to be an extraordinarily complex issue that cannot be reduced to a simple valuation of the presence or absence of social networks and bonds in one's life. Relations are fragmented and fluid; people seek care and support in settings where estrangement, material deprivation, and desire for particular forms of sociality coalesce in individuals' local worlds, both precipitating symptoms and shaping the conditions in which those symptoms can be managed. In various community spaces, clients must make decisions about how to go about sharing aspects of the psychiatric self that account for relations or their lack. Such decisions inform attempts to achieve basic goals, such as finding work, parenting, and going to school, and circumscribe which goals are possible in the first place. Relations have the potential to both allow people to flourish and undermine normative notions of recovery progress.

Contrary to the findings of recent anthropological scholarship regarding how the intersection of political economy of health care, domestic economies, and everyday practices of illness management intersect to produce social abandonment and even social death, I find that both the most marginal of my participants as well as those most deeply implicated in networks of relations become, by virtue of their structural vulnerability, enmeshed in a disability economy that has been erected to manage people whose psychiatric diagnoses and social status make them undesirable and unproductive. This economy includes a host of bureaucratic procedures that guarantee individual survival, and in the case of those who would otherwise face complete social abandonment, provides the infrastructure of locally-managed systems of care of indefinite duration; for those who find themselves anchored by more established networks of relationships and

care beyond the human services apparatus, qualification for various benefits factors into calculations about social belonging and ideas about the type of life that might be possible as a mentally-ill person. Personhood, in the world of former IRTS clients, represents an unfinished, difficult-to-characterize project that unfolds in circumstances of structural constraint that interact with complex social lives and forms of relatedness that cause certain aspirations to be valued and others foreclosed.

Chapter V. Conclusion

This dissertation has examined mentally-ill young adults' transition from treatment and rehabilitation settings to independent living arrangements in the aftermath of psychiatric emergency. I explored this process of transition in the context of Intensive Residential Treatment Services (IRTS) facilities, Minnesota's primary site for providing community-based residential rehabilitation for those whose psychiatric symptoms have been stabilized but who are still in need of additional support as they seek to resume their everyday lives. The purpose of the research was to understand how the deployment of psychiatric knowledge in community-based treatment and rehabilitation settings is involved in the reshaping of people's sense of self and understandings of the possibilities for being a person. IRTS facilities provide a unique site for investigating phenomena related to psychiatry, self, and person because they provide a structured setting in which clients are encouraged to reflect and work on the self through practices informed by dominant understandings of mental disorder as a neurobiological disease requiring psychopharmaceutical intervention; at the same, IRTS rehabilitation is designed to ease the clients back into their everyday, local worlds, and both the structural and intimate circumstances of those worlds impact the ways in which self and personhood are imagined and enacted.

As I explored issues of self-making and personhood in the context of the transition from psychiatric rehabilitation to everyday life in various communities, my research focused on the following topics:

1. The emergence of contemporary psychiatric reason and community mental health:

What are the historical processes that explain the rise of the dominant form of psychiatric reason that explains disorder in neuroscientific terms? How did these processes converge with other historical trends to determine how and where people diagnosed with psychiatric disorders receive treatment and other services? What are the core assumptions that have come to be associated with dominant models of psychiatric disease and treatment?

2. Processes of psychiatric treatment and rehabilitation

How do staff at IRTS facilities mobilize psychiatric concepts as they assess clients and provide rehabilitative services? How are processes of psychiatric diagnosis and rehabilitation entangled with practices of self-making and the emergence of forms of personhood? How do participants make sense of the psychiatric knowledge claims about the nature and course of illness for the purpose of thinking about their recovery trajectory?

3. The structural and relational composition of life in the community:

What are the structural conditions that shape life in the communities to which participants return? How are efforts to grapple with mental illness mediated by forms of relatedness and sociality that prevail in participants' local worlds? What sorts of challenges do people encounter as they attempt to adhere to the tenets of recovery models and make a life for themselves?

In Chapter II, I described the historical origins of the contemporary iteration of what I call psychiatric reason—the organizing logic that governs how psychiatry, as a branch of medicine, goes about its basic work of translating illness complaints into objective categories of disease. I argued that the contemporary understanding of psychiatric symptoms as signs of discrete underlying neurobiological diseases that can be targeted with increasing precision using sophisticated psychopharmaceuticals in community settings is not the outcome of linear scientific progress; rather, it represents the culmination of the historical convergence of a variety of socio-political processes. Mid-twentieth century American psychiatry was dominated by psychodynamic practitioners who rejected discrete categories of disease and focused on a continuum of disorder etiologically-rooted in maladaptation and unconscious conflicts. The field faced a full-fledged crisis of legitimacy by the 1960s as it struggled to contend with the increased demand for psychiatrists precipitated by deinstitutionalization of state hospitals and policy directives promoting community care; new reimbursement policies and demands for evidence of effectiveness by third-party payors; pressure from pharmaceutical companies seeking to tailor drugs to diseases; and social movements that viewed psychiatry as a means of social control.

Psychiatry's crisis of legitimacy allowed the field's empiricist branch to exert its influence and revolutionize the field with the 1980 publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders, which aligned psychiatric

practice with the conventional medical model by using a standardized nosology which mapped symptom clusters onto fixed disease categories and divorced those categories from etiological assumptions that were not biological in nature. As adherents to the empiricist branch of psychiatry began to gain institutional power, they directed resources toward research into the biological origins of disorder, which, over time, became dominated by a neuromolecular framework for disease, opening the door to the “pharmaceuticalization” (Biehl 2007) of mental health via the mass-prescription of a host of new drugs. Drug therapy also became a cornerstone of community mental health models which proliferated in the post-deinstitutionalization era; these models posited that mentally-ill people would be more likely to realize their full potential if treated in familiar community settings where it was assumed they would be free to exercise choice and benefit from naturally-occurring forms of social support. Furthermore, as developments in psychiatry became more aligned with the norms of scientific inquiry, so too was it assumed that community models would integrate best practices and be reproduced consistently across space. In practice, the challenges of working in community settings with people whose symptoms are often severe and persistent have made it difficult to develop models that consistently demonstrate sufficient service coordination and capacity to address the varied needs of mentally-ill populations.

In Chapter III, I focused on the process of psychiatric rehabilitation at IRTS facilities. I employ the concept of the work of recovery to describe how IRTS staff engage clients through the use of diagnostic categories and a host of evidence-based educational and therapeutic activities intended to guide client interpretations of symptoms

in a manner consistent with expert opinion and, ultimately, to produce people capable of living independently in the community. I argue that while the work of recovery at IRTS deploys psychiatric knowledge to influence conduct with the aim of producing particular types of subjects, this mode of subjectification often fails to fully engender transformation as participants' unique personal histories and methods of interpreting psychiatric categories cause them to recast illness experiences in ways that are inconsistent with psychiatric reason.

My participants often described the onset of severe psychiatric symptoms as an experience that unmoors taken-for-granted notions of being in the world; symptoms may represent an unmaking of the self when available interpretive frameworks fail the individual and leave the possible outcomes of illness experiences unclear. At IRTS, staff try to address this unmaking of the self by assigning diagnostic categories to client experience and reinforcing those categories during educational activities by describing how they align with specific symptom clusters. More generally, IRTS staff model psychiatric disorder as a chronic but manageable disease that they are typically careful to explain as existing apart from the self; in this view, having a disorder is not the same thing as being a disorder.

Given the characterization of mental illness as chronic and unpredictable, IRTS staff spend much of their time working with clients on “mood hygiene” (Martin 2007) practices that revolve around techniques of self-management and self-governance that are

intended to prevent symptoms or lessen the severity of their impact. I argue that these self-management techniques act as “technologies of the self” (Foucault 1988) that communicate particular ideas about the mentally-ill selfhood as perpetually at risk and in need of vigilant monitoring and intervention in order to achieve a high level of individual function. Mood hygiene techniques both render illness visible by means of rating scales and observational tools and prescribe means of acting upon the disordered self in a bid to keep symptoms at bay and allow one’s true self to emerge. Many of the means of acting upon oneself involve adherence to and recalibration of psychopharmaceutical regimens, which, because of their assumed ability to affect changes at the molecular level that can powerfully alter one’s experience of symptoms, act as the primary treatment modality for clients once they leave IRTS.

The mode of subjectification that these technologies of the self are part of is grounded in the discourse of psychiatric recovery, which posits that individuals who indefinitely embrace self-governance as a way of life and are provided with the proper supports will be free to make independent, meaningful choices about the direction of their future. As clients transition from IRTS to independent living arrangements, the discourse of recovery promises that ethical adherence to techniques of self-management will permit them to achieve an autonomous, self-determining, rational form of personhood; attainment or restoration of personhood bearing these characteristics is often framed as the precursor to productive, engaged citizenship in the community. In light of this framing of transition as recovery and the attainment of an ideal form of personhood, IRTS activities are largely focused on skill-building and strengthening clients’ ability to

actively do things in the world so as to avoid the passive debilitation that accompanies an improperly-managed symptomatic self; in this way, psychiatric rehabilitation explicitly distinguishes itself from conventional psychotherapy as it looks to quickly engender independent decision-making and action among clients.

Processes of subjectification are rarely complete and cannot be understood as comprehensively constituting subjects. Subjectification is dependent on the deployment of expert knowledge to ground its truth claims, and as mental health professionals at IRTS attempted to engage clients using dominant psychiatric concepts, a number of slippages and contradictions appeared, particularly with respect to diagnosis. Both clients and IRTS staff indicated that diagnostic practices were contingent and fluid. My participants sometimes found themselves frustrated that the diagnostic categories assigned to them betrayed some core element of their experience or overlooked a crucial precipitating factor in their experience of symptoms; in instances where clients had previous experience with psychiatric treatment, they sometimes noted the discontinuity of diagnosis—that it tended to shift across institutions and over time—or, in other cases, the continuity of seemingly inaccurate diagnoses that managed to wield undue influence over the way in which mental health professionals understood them. Diagnostic inconsistencies and incongruities sometimes caused clients to withdraw from meaningful participation in rehabilitative activities and engagement with staff, with some remaining committed to alternative illness narratives not sanctioned by mental health professionals. For their part, IRTS staff typically suggested that non-compliant clients lacked insight and were unable to accept the implications of valid diagnoses. At the same time, mental

health professionals acknowledged that diagnosis could be a messy, indeterminate process; they conceded that diagnosis was, in fact, malleable, and observed that their diagnostic assessment of a client may well differ from that of the referring hospital. Diagnostic inconsistencies were rationalized by IRTS staff who felt that they were obliged to privilege those diagnoses that most inhibited client functioning and were the cause of difficulties that could realistically be addressed in the three months that a client would reside in their facility.

In Chapter IV, I explored participants' plans as they prepared to depart from IRTS and delved into their lived experience beyond rehabilitation in communities throughout Minnesota. Well-intentioned proponents of recovery philosophies aim to empower those attempting to manage psychiatric illness by casting them as self-determining consumers in need of the freedom to choose the future that they wish to inhabit; however, this sort of idealized, autonomy-driven model necessarily rests upon a vision of community in which individual choice is unconstrained rather than bound up in complex, often unequal social arrangements. My research findings lead me to think through the possibilities for mentally-ill personhood in the community in terms of their partial dependence on the set of material conditions that structure everyday life for my participants. Furthermore, while IRTS treatment modalities encourage clients to adopt radically new ways of thinking about and acting upon the self as a means of producing particular forms of personhood, the strategies and techniques associated with community mental health practice are bound up with a complex assemblage of relations in participants' local worlds. In other words, decisions about how to manage mental illness and related

choices regarding the pursuit of short and long-term goals are not made individually; they draw upon and reflect the sets of relationships through which participants experience the social world and allow them to be recognized as people. Personhood, in the world of former IRTS clients, represents an ongoing, difficult-to-characterize project that unfolds in circumstances of structural constraint that interact with complex social lives and forms of relatedness that cause certain aspirations to be valued and others foreclosed.

As my participants begin to transition from IRTS into various sorts of living arrangements in communities around Minnesota, it became clear that most had few socioeconomic resources to fall back upon and were reliant to varying degrees on a limited social safety net. I argue that these people occupy positions of “structural vulnerability” (Quesada, Hart & Bourgois 2011; Bourgois et al. 2017), a concept that gestures toward both their subordination in a socioeconomic hierarchy and the exposure to structural violence that such subordination entails. In these relatively precarious transitional situations, many participants seek assistance from a “disability economy” (Knight 2013) premised on psychiatric diagnosis—a means of biomedicalizing poverty—requiring them to submit to complex, time-consuming bureaucratic procedures in order to receive a modest amount of income support and other benefits. Seeking relief from the disability economy introduces a temporality of waiting into participants’ lives that leaves them perpetually in a queue for one service or another, whether that be housing or supplemental security income; just as they are expected to take an activist orientation toward self-cultivation, former IRTS clients often find the progress that they had hoped to make to be forestalled. Many participants also find their sense of autonomy and agency

to be undermined by coercive power in the form of court orders that mandate adherence to specialized treatment protocols for a period of time beyond IRTS discharge. In some cases, this temporality of waiting can lead to the experience of “social defeat” (Luhmann 2007) as structurally-vulnerable young adults find themselves repeatedly faced with insufficient forms of support and unable to realize basic goals; the cumulative impact of these situations may exacerbate symptoms and deepen the sense of exclusion.

As participants made decisions regarding the future, they did not do so solely as individuals; rather, their embeddedness in a dense set of relations, for better or worse, played a significant role in determining the extent to which they are able to meet various obligations and achieve goals while learning to manage symptoms on their own. I found relatedness to be an extraordinarily complex issue that cannot be reduced to a simple valuation of the presence or absence of social networks and bonds in one’s life. Relations are fragmented and fluid; people seek care and support in settings where estrangement, material deprivation, and desire for particular forms of sociality coalesce in individuals’ local worlds, both precipitating symptoms and shaping the conditions in which those symptoms can be managed. In various community spaces, clients must make decisions about how to go about sharing aspects of the psychiatric self that account for relations or their lack. Such decisions inform attempts to achieve basic goals, such as finding work, parenting, and going to school, and circumscribe which goals are possible in the first place. The import of relations extends even to those who initially struck me as socially-abandoned. In instances where participants were deeply alienated and isolated, the human services apparatus stood in for community in the absence of other relations; such

people lived in a state of indefinite quasi-independence in which they cultivated a type of sociality through the bonds they formed with social workers who helped them plan and coordinate everyday activities.

This dissertation has explored the lives of young people whose lives have been upended by the incidence of mental illness and the attempts at the psychiatric remaking of the self that follows from the onset of symptoms. In doing so, I have addressed issues pertinent to a number of debates in anthropology and beyond. Perhaps the most germane of these are the attempts to reformulate subjectivity that have resulted in a burgeoning ethnographic literature (Biehl 2005; Biehl, Good & Kleinman 2006; DelVecchio Good et al. 2008; Good 2012; Ortner 2006). In this work, the use of the term subjectivity is intended to point to the shortcomings of earlier attempts to understanding inner processes and psychological experience of individuals and find new ways of linking the social and the psychological. Subjectivity, for those working in this vein, “denotes a new attention to hierarchy, violence, and modes of internalized violence that link subjection and subjectivity, and an urgent sense of the importance of linking national and global economic and political processes to the most intimate forms of everyday experience. It places the political at the heart of psychological and the psychological at the heart of the political” (DelVecchio Good et al. 2008:2-3). In this view, the use of concepts of self and person suggest an affinity with earlier generations of ethnographic work that emphasized cultural representation at the expense of lived experience; an emphasis on subjectivity is intended to draw out the social shaping of individual experience as it

unfolds between intimate relations and broader institutions in specific socio-political contexts.

While subjectivity functions as a useful provocation and reorientation of inquiry toward individual lived experience amidst extraordinary social and political change, its approach to articulating experience can sometimes appear as splintered and fragmented as the subject that it seeks to understand. In this dissertation, I have tried to reconcile some of the anti-humanist theoretical positions inherent in post-structuralist accounts of subject formation with the more experience-near tendencies of subjectivity proponents. In the former, individual experience is subsumed in the machinations of power and the production of delimited subject positions. I have attempted to demonstrate that forms of subjectification are still highly relevant to the study of sites such as psychiatric treatment where people explicitly attempt to reshape conduct and experience, but I have tried to expand the scope of such an inquiry to understand the extent to which attempts at subjectification gain traction in the local worlds and everyday concerns of those who encounter psychiatric knowledge. It is not just that IRTS clients sometimes resist subjectification by developing diagnostic counternarratives or refusing to adopt technologies of the self; rather, I have attempted to show how subject positions become meaningful (or not) only in the context of lived experience of a self that is deeply relational, intersubjective, and responsive to the various demands of others. Self and personhood remain highly relevant to the examination of such issues not simply as conceptual containers for inner essences and types of persons, but as ways of representing

the raw material that people mold as they reflect on the dimensions of inner experience and aspire to be different kinds of social beings.

The reformulation of subjectivity has also foregrounded the place of large-scale political processes and forms of social change in analyses of individual experience; the implications of such socio-political upheaval can be unearthed by examining how individual subjectivity provides the ground for thinking through people's circumstances and their contradictions against a backdrop of social uncertainty and precarity. In examining the lifeworlds of my participants, I chose to interpret their transition from rehabilitation to community life in terms of structural violence and structural vulnerability to draw attention to the often-unseen impacts of political-economic processes in their lives. Conceptualizations of structural violence have been criticized for their experience-distant, impersonal formulations of the impact of political-economic change on people's wellbeing, and I have attempted to make the types of consequences deriving from the concept more explicit by focusing on the unfolding of processes rooted in the everyday lives of those occupying structurally-vulnerable positionalities. Many of my participants, for example, were living with the legacy of the late twentieth century retrenchment of the American welfare state. As they sought forms of assistance that might provide them with a small measure of relief while adjusting to a life that requires the management of symptoms, they found that it is increasingly difficult to gain access to benefits; moreover, the process of applying for benefits itself took significant time and energy, which was profoundly devalued during what often become an indefinite period of waiting. For some, the indefinite waiting and disappointment of the inaccessibility of

forms of personhood promised by recovery discourse were psychologically crushing. In other cases, structural inequalities manifest themselves in the reorganization of intimate life as families and other relations look to marshal resources to provide care but find that they come up short and must forego a costly medication or make decisions about the value of employment in light of the way that it could potentially compromise eligibility for vital benefits.

Finally, ethnographic work on health-related issues inspired by or interested in reformulations of subjectivity often examines the processes by which people who strain networks of care are ultimately socially-abandoned and essentially expelled from the social order; these accounts typically focus on places where safety-nets have been shredded entirely and the potential consequence of social death hovers over decisions about whether or not to care for the afflicted. In the case of my research, participant options for psychiatric treatment and long-term care reflect political-economic circumstances that have greatly diminished health and social benefits, but left them extant to some degree. While some of my participants could certainly be understood as isolated and alienated to the extent that they felt a sense of abandonment, the understanding of social abandonment as a societal-level solution to the scarcity of resources for the care and treatment of people facing chronic health difficulties is less apt. Instead, I found something more akin to a reincorporation into a human services apparatus of those participants who were unlikely to make it on their own due to a near complete absence of social support and other resources. In these cases, I found a configuration of care in which the state outsourced its mental health resources to smaller specialist entities which

oversee a variety of services—from housing to therapy—and provide an indefinite living arrangement of sorts for people receiving benefits. While I am not suggesting that this sort of solution is desirable, I simply want to make the point that the lens of abandonment may, at times, cause us to overlook the way in which the scaling back of health-related resources may be leading to the emergence of new forms of treatment and care emerging at the interface of public and private that deserve ethnographic attention.

The experience of psychiatric disorder is devastating, and it can complicate nearly every aspect of a person's life. Psychiatric symptoms may profoundly unsettle and undermine one's sense of self, invoke shame and stigma, and compromise one's ability to plan and pursue a meaningful life. At a time when mental illness seems to be growing in prevalence, the examination of facilities such as IRTS provides a window into the treatment and rehabilitation options available to people with limited resources. The challenges associated with the public funding and provision of mental health services ensure that community settings, for better or worse, will continue to host many of those struggling with mental illness. Recent ethnographic work has paid little attention to IRTS-like quasi-institutional facilities that bridge the gap between more formal institutions and everyday local worlds. Anthropology and other social science disciplines have the potential to offer a unique perspective not only on people's experiences of treatment, but also their understanding of the way in which illness is socially-grounded in particular lifeworlds where access to care, social belonging, and conceptions of personhood intersect in the long-term trajectories of people's lives. To the extent that social scientists can more meaningfully articulate the insights they glean from working

among mentally-ill people and the professionals that serve them, they may begin to find new avenues for starting conversations with those who are responsible for crafting the policies that determine the fate of people waiting for some form of care.

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