Uncertain Adherence: Psychosis, Antipsychosis, and Medicated Subjectivity in Dublin, Ireland

by

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Abstract

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This dissertation is an ethnographic exploration of what it means to seek and provide care in Dublin, Ireland's community mental health network. Based on eighteen months of ethnographic research with both clinicians and patients, and situated at the theoretical intersection of science and technology studies and psychological anthropology, *Uncertain Adherence* examines the multiple logics of antipsychotic adherence, or the extent to which a mental health patient does or does not comply with their prescribed medicinal regimens.

Ireland's history as a colonial laboratory for early forms of experimentation in hospital care, as well as its contemporary status as an increasingly heterogeneous and cosmopolitan site of advances in cross-cultural psychiatry, mark it as an important locus for anthropological research into the aftermath of psychiatric deinstitutionalization and the development of more rigorous protocols for global mental health in the face of increasing immigration and cultural diversity. I argue that psychiatric discourse defines antipsychotic adherence as the condition of possibility for deinstitutionalized, patient-centered treatment, but ethnographic attention to patients' own understandings of their medications and the clinical injunction to adhere reveals far greater complexity.

Specifically, my ethnographic research sheds light on the ways in which patient attitudes toward the seemingly straightforward task of psychopharmaceutical adherence are entangled with the lived experience of psychosis and social marginality, as well as a host of culturally mediated interpretations of medicinal efficacy, institutional responsibility, and psychiatric rationality. To engage this complex scene, I explore the multi-sited nature of community mental healthcare in an inner-city, inpatient psychiatric hospital ward, its affiliated outpatient clinic, and a community mental health group run by and for people living with schizophrenia and other psychotic illnesses. Patients' movements through these primary and various secondary therapeutic settings uncover the distribution of psychiatric logic throughout a network of new institutions of care.

Reading across the ostensibly divergent theoretical traditions of science and technology studies and psychological anthropology, I analyze the sociohistorical construction of scientific knowledge about psychopharmaceutical efficacy and the

concept of patient insight, while also theorizing the vicissitudes of patient subjectivity. Patients' strategic engagements with psychiatric resources and ideologies must be understood in relation to their tendencies to find other forms of support from religious groups, patients' and immigrants' rights organizations, and from clinicians working in Dublin's burgeoning psychoanalytic community.

By virtue of this dual analysis, my dissertation formalizes the entanglement of these multiple orders of scientific discourse and patient experience as a problem of epistemological difference in the space of an increasingly globalized model of mental health. My research thus reveals the disparities between the theory and practice of psychiatric approaches to ensuring patient buy-in to drug adherence, as well as the ways that patients' understandings of their medications are informed by the shifting perspectives of illness and health, sanity and madness, and ever-increasing cultural diversity. In the practical encounter between patients and antipsychotic drugs, new forms of subjectivity take shape.

In memory of Patricia Brennan, who knew the breadth and the length and the height and the depth, and for all the others who have gone before.

Acknowledgments

If in this sleep I speak
it's with a voice no longer personal
(I want to say *with voices*)
-Adrienne Rich, "Phantasia for Elvira Shatayev," *The Dream of a Common Language*, 4.

In many ways, this writing was a haunting. At times the language of this text—in essence, the language of others—moved through me with uncanny fluency. At times it failed me utterly. Though it was often frustrating, this is nevertheless fitting, I believe, given the degree to which this work seeks to address the limits of mutually intelligible experience and shared meaning. Furthermore, it is written in the margins of a complex and contested history with which I am still only beginning to grapple. If one of anthropology's many and diverse programs is to explore and render explicit the hidden but nonetheless enduring problem of how to confront and understand difference while living in relation to others, then I don't yet have any authoritative solutions to such quandaries, but I hope that I have learned to ask better questions over the course of this dissertation. I am grateful to a multitude of people for helping me along the way.

I first came to anthropology as an undergraduate at the University of Chicago when I had the good fortune to meet Tanya Luhrmann and learn about her ethnographic exploration of the relationship between schizophrenia and homelessness. Under her guidance, and benefitting from the insights, encouragement, and fellowship offered to me by Greg Thompson, Erin Moore, and others, I found a desire to participate in the larger conversations that animate the discipline and, ultimately, something like a vocation. Each of them has my thanks for their part in welcoming me into the beautiful and often outlandish intellectual community that has become my home.

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I also owe a great debt to my cohort, with whom I was first formed as a scholar, and who tolerated my youthful enthusiasm and ignorance. I am especially grateful to Jerry Zee, Jason Price, Ian Steele, Ugo Edu, Mark Fleming, Rachel Ceasar,

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Words fail me when I attempt to express my thanks to my committee members. I feel that I first met Nancy Scheper-Hughes as a college student when, after picking up *Saints and Scholars*, I first began to explore the wider terrain of medical and psychological anthropology, as well as the possibility of conducting fieldwork in my ancestral homeland. Since my matriculation at Berkeley, she has been a counselor and a gadfly—reminding me of my scholarly and moral responsibility to Ireland as a field site and acting as an impromptu theologian and spiritual adviser, though I suspect she would reject such honorifics. Since our first meeting in the spring of my first year of graduate school, Ian Whitmarsh—my Trobriand Uncle—has pushed me to think more daringly and in stranger and more generative directions than I first imagined. His skepticism, humor, and intellectual openness have been indispensible to my own habit of thinking otherwise. Massimo Mazzotti, with the utmost beneficence and patience, oversaw my unorthodox and long-overdue education in the history and philosophy of science in the years following my fieldwork. His willingness to think with and through the conceptual particularities of my ethnographic concerns has deepened my belief in the possibility of a dialogue between scholars working in the tradition of Science and Technology Studies and Psychological Anthropology.

I owe more than I can say to Stefania Pandolfo, who—in my first semester at Berkeley—offered me the rare and transformative invitation to read and think through *The Interpretations of Dreams*. In the decade since this initial meeting, she has had a singular impact upon my thinking. Her dual attention to theoretical precision and the beauty and the risk inherent to experimental ethnography has allowed me to imagine new directions in the discipline of anthropology. I am deeply grateful for her mentorship and her friendship alike, and without them this dissertation would be inconceivable.

I am, of course, also indebted to the people of Dublin. First and foremost, I thank Dr. Lynch, his clinical colleagues, the patients of St. Dymphna's Ward, and the group members who comprised *Solas*. With grace, fortitude, and hospitality, they invited me into their lives, and in so doing they facilitated the entirety of this intellectual endeavor. I will never be the same. Jamie Saris, Nathan Coben, Brendan Kelly, and Susan McFeely were other vital interlocutors in the field, and I hope they will see their contributions in the heart of this text. Amy Rochford, Rachel Garvey, Daniel Dalton, Conor Fallon, and Megan Bus made my time in Dublin more exciting and thought-provoking than I could have dreamed.

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Finally, my deepest, most profound gratitude goes to those who are so much a part of the intellectual, personal, and spiritual work that has informed this document that I cannot read it without seeing the ways in which it is written for and addressed to them. They are—

Marije Boerma—Minnow—who showed me that fieldwork is like falling in love.

Bruno Biagianti—poet, poem, and revelation—with whom I have dreamed deeply.

Kathleen and Michael D'Arcy—mother and father—who taught me how to listen, how to wonder, and how to watch.

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Introduction: Writing Adherence

> Places are fragmentary and inward-turning histories, pasts that others are not allowed to read, accumulated times that can be unfolded but like stories held in reserve, remaining in an enigmatic state, symbolizations encysted in the pain or pleasure of the body. "I feel good here": the well-being under-expressed in the language it appears in like a fleeting glimmer in a spatial practice.
> -Michel de Certeau, *The Practice of Everyday Life*, 108.

"You have missed the event," Dr. Lynch wryly informed me during the first week of my fieldwork.

The director of a Dublin, Ireland psychiatric inpatient unit that I call St. Dymphna's Ward, Dr. Lynch was referring to a patient's involuntary admission to the ward the night before. More broadly, he opened the question of how to think about the time and space involved in the exercise of psychiatric power, from the admission of a patient to the problem of antipsychotic adherence, or the degree to which a patient does or does not take their medication in the extra-institutional context of community mental health.

When does adherence happen? Is it possible to confine the decision of whether or not to take a psychotropic medication to the moments before the pill is swallowed or discarded? Does the daily injunction to adhere open us to a paradoxical relationship between the intimate and mundane? Is it conscious or unconscious? Is it existential or quotidian?

Gaston Bachelard suggests an answer in his phenomenological text, *The Poetics of Space*, when he writes:

> At times we think we know ourselves in time, when all we know is a sequence of fixations in the space of the being's stability—a being who does not want to melt away, and who, even in the past, when he sets out in search of things past, wants time to "suspend" its flight. In its countless alveoli space contains compressed time.[1]

Not confined to a decision-making process mere seconds before a pill is swallowed, adherence unfolds through space or accretes in zones of intimacy, privacy, or protection. Walking through the city, we are potentially surrounded by adhering or *non*-adhering subjects, or even an ambivalent admixture of the two, tracing their trajectories of adherence-as-*process* around and past us on the street, on the train,

[1] Bachelard, *The Poetics of Space*, 8.

following us into restaurants and shops. Though the ideal practice of antipsychotic adherence is, at least in theory, perfected and performed in the general absence of a caseworker or a psychiatric nurse, a symbolic extension of clinical authority still transpires; practically, of course, this extension occurs *im*perfectly and with unexpected results, folded into larger life narratives, both conscious and unconscious, explicit and subterranean, lucid and hallucinatory.

Over the course of the four chapters that comprise *Uncertain Adherence*, I develop a tripartite argument. First, I argue that the concept of psychopharmaceutical adherence is the condition of possibility for community mental health in that it formalizes the ideal relationship between patient mobility and a psychopharmaceutical standard of care for schizophrenia, bipolar disorder, and other psychotic spectrum disorders. In this sense, I argue that the psychiatric injunction to adhere acts as a structuring logic for mental healthcare in the age of post-deinstitutionalization, a context of care wherein patients are expected to internalize a modicum of psychiatric discipline when they are seldom under the direct supervision of mental healthcare professionals. Second, I argue that attempts to frame this injunction to antipsychotic adherence in the language of biopsychiatry and public mental health often fall prey to a reductive, binary logic wherein patients are either understood to be resistant to or compliant with psychiatric authority. Such a framing discounts the degree to which the meaningful relationships that develop between mental health patients and their antipsychotic drugs often emerge from multiple, sometimes even contradictory feelings about the medications in question, are often to some degree imbricated with the symptoms of psychotic mental illnesses themselves, and are also greatly influenced by the multiple institutional contexts that reinforce (or sometimes problematize) compliant consumption in a complex, decentered system of community mental health. Third, I argue that the day-to-day activity of antipsychotic adherence can be productively rethought in terms of a practical engagement with the consumption of psychotropic medication *through*, as opposed to *against*, the social and intersubjective liminality of psychotic experience. The radical singularity of psychotic subjectivity that informs this daily encounter with the practice of compliance and, in a sense, sanity can produce new and unforeseen reimaginings of social and institutional space, as well as a potent form of critique of the limits of contemporary psychiatric care. Examining this capacity for subjective transformation and critique are ever more vital in the cultural and historical context of Irish mental healthcare.

In part one of *Uncertain Adherence* (Introduction and Chapter 1), I explore the historical nature of madness in Ireland, describe the structure and institutional characteristics of Dublin's community mental health network after the closure of classical Irish asylums, and establish antipsychotic adherence as a conceptual boundary object for further analysis. Drawing on Irish poet Seamus Heaney's (1996) translation of the Irish legend about a mad king, or the *Buile Shuibhne*, and the work of Claude Levi-Strauss (1967), I explore the mythic relationship between madness, the historical arrival of Christianity, and incipient institutional spaces in Ireland. Drawing on work by Irish scholars on the history of the country's many powerful asylums and their eventual deinstitutionalization (Brennan 2014, Kelly 2016), I then describe the new theoretical and methodological problems inherent to

conducting an ethnography of the new forms of clinical space emergent in the community mental health network, especially my three primary sites of an inner-city psychiatric inpatient ward, its affiliated outpatient clinic, and a community mental health group run by and for men and women living with psychotic mental illnesses. I draw upon the work of Michel Foucault (2009, 1994, 1990) to frame the larger questions of how to think through changing notions of institutional space, patient responsibility in the aftermath of the asylum, and the limits of possibility for conceiving of madness within the boundaries of an exclusively psychiatric discourse.

Part two of my dissertation (Chapter 2 and Chapter 3) contains the theoretical core of my argument regarding the relationship between adherence and psychotic subjectivity. In Chapter 2, I draw upon literature in science and technology studies to analyze my fieldwork in an inpatient psychiatric unit and its affiliated outpatient clinic with a primary focus on my observations of and interviews with psychiatric professionals, specifically the ways in which they interact with patients, antipsychotic medications, and attempt to instill the injunction to adhere to these medications in their patients. I attend to the status of drugs and mental healthcare workers as two types of actors, variously human and nonhuman/material, within a network of institutions and psychiatric logics (Latour 1987, Bennett 2010), which converge upon patients in an effort to produce the "assemblage of compliance" (Brodwin 2010). Though the practice of psychiatry perhaps more closely resembles a self-consciously imperfect enactment of a larger theoretical apparatus, closer to a reflexively performed "situated knowledge" (Haraway 1988) by psychiatric personnel than the practice of an ideal discipline, the effects of this at least partially improvised practice nonetheless produce a form of "knowledge as social order" (Shapin and Schaffer 1985, Latour 1993, Mazzotti 2008).

Chapter 3 explores the vicissitudes of psychotic subjectivity and their intersections with the psychiatric logic of adherence by describing three paradigmatic cases of what might be called *méconnaissance* (Lacan 1981) emergent in psychiatric inpatients' meaningful understandings of their encounters with drugs and diagnosis. Through the first case I return to materialist interpretations of the nature of drugs (Benett 2010) to explore the complexities of one patient's belief that he could join his doctors in experimenting with antipsychotic effects on his consciousness and psychotic symptomatology. In the second case, I examine another patient's repeated attempts to return to the inpatient ward as a search for subjective containment in the fashion of the old asylums, and in this search a form of critique of the limits of community mental health in the aftermath of the total institution (de Certeau 1992, Pandolfo 2018). These experiments and their curiously circuitous effects upon the discourse of psychiatry and the constitution of clinical space underscore the unsettling effects of psychosis on a broader field of social and institutional relationships. It is only by drawing on literatures from both science and technology studies and a psychoanalytically inflected psychological anthropology, I argue, that it is possible to understand the relationship between antipsychotic adherence and psychotic subjectivity.

In part three of *Uncertain Adherence* (Chapter 4 and the Epilogue), I describe the experiences of psychiatric outpatient and community mental health group members in their efforts to find and preserve social spaces and intimate retreats free of stigma. In Chapter 4, I explore the tactics deployed by outpatients and support group members to manage symptoms and stigmas alike in the daily practice of taking medications (de Certeau 1984), and I describe their ambivalences regarding allowing me into their homes to conduct rare interviews outside of clinical or support spaces. I also return to the inpatient ward to explore why some patients keep returning for extended stays, and I discuss the extent to which some of them feel that their identities are at least in part constituted in relation to their medications and to the specific kinds of care offered to them by the various forms of psychiatric institutions they encounter over the course of their treatment (Jenkins 2010, Whitmarsh 2014).

To conclude, I draw upon a home-visit to one of the patients whose experiences structure chapter 3 to explore the aftermath of hospitalization and the enduring force of medication and the psychiatric call to a species of psychotropic governmentality. I close by leaving open the question as to whether or not psychiatry is capable of understanding the extent to which some patients at times claim to enjoy their psychotic symptoms and find their cessation after medication to be a loss of a dimension of self.

Chapter 1: "The Plague of Outsidedness": Community Mental Health in the Aftermath of the Asylum

His brain convulsed,
his mind split open.
Vertigo, hysteria, lurchings
and launchings came over him,
he staggered and flapped desperately,
he was revolted by the thought of known places
and dreamed strange migrations.
- from *Sweeney Astray: a version from the Irish* by Seamus Heaney, 9.

Matthew was neither coming nor going when I met him at the threshold of St. Dymphna's Ward. His conviction, however, was incandescent, filling the fluorescent antechamber to the clinic. He raged into his mobile phone, half of an argument rising and falling in fits and starts. With some concern, I began to wonder if he was stuck—if perhaps a wheel on his wheelchair had jammed, or if the motor that propelled him through the halls of the ward had failed. He seemed stranded, fixed between the two sets of remote-controlled double-doors that separate the department of inpatient psychiatry from the rest of the hospital and, beyond that, the larger auspices of the institution's catchment area, a mapping of psychiatric authority onto the damp tangle of north Dublin streets.[2] In the fragments of dialogue that I could hear—"What's that?" "I *am* speaking up!" "Can you hear me?"—a familiar object of complaint took shape. Matthew's words rose to an indignant crescendo: "Of course you're much clearer on the phone than I am! You're not on drugs!"

I waited in the doorway of the ward while the conversation listed ever closer to soliloquy, but when the end came Matthew was already gesturing at me with his phone, words continuing to pour out of him. Through his frustration, a story began to take shape. After nearly two weeks as an inpatient, Matthew had been trying to arrange for someone outside of the hospital to fill a prescription for him, but I was unable to discern whether he had been talking to one of his sisters or a flatmate, or if he was returning to the ward from an afternoon of day-leave or just departing for the evening with the hope of finding his medications waiting at his nearby flat. Regardless, it was clear that Matthew's attempts to ease his eventual passage from the hospital where he had been an inpatient for several weeks had been subsumed by an ongoing debate about the necessity of the psychopharmaceuticals in question and the extent to which he would adhere to his doctors' treatment plans when he transitioned to outpatient care and the relative autonomy of home. Indeed, to meet Matthew in St. Dymphna's Ward was to become an interlocutor in this debate, and despite our hours of conversation about the intricacies and ambiguities of

[2] The catchment area is a zone of psychiatric responsibility/authority for a given hospital.

antipsychotic adherence, about poetry and the power of prayer, I found myself interpellated again, as if for the first time. "They want to give chemicals to a holy man, Michael. A holy man! It's wrong!"

As I listened to him plead his case, a hospital administrator approached from within the ward, worry knitting her brow. In the exchange that followed, I learned that Matthew had already been discharged; he had yet to leave the hospital, he replied, because he wanted to speak to a member of the psychiatric staff about his aftercare arrangement. This was impossible, the administrator apologized, as his doctors were now actively treating other patients, and she went on to suggest that he discuss his concerns with his case worker or follow up during an outpatient appointment. He turned to me again, in outrage: "They want me to *stockpile* tablets of Haldol in my home!" As I watched the administrator turn and retreat into the ward, I was struck by the discursive and institutional incommensurabilities at play. Matthew had returned to the ward immediately after discharge, I realized, to reason with his doctors, to continue a conversation that they understood to be closed until his next appointment. The antipsychotics he was required to take while away from the ward remained a stark but silent reminder of the price of discharge. Further, he seemed to receive the daily ritual of drug consumption as a symbolic accusation of madness and incompetence—an ironic and stigmatizing referential collapse of symptom and cure, crystalized and rendered material in the form of a psychopharmaceutical tablet.

I thought about the events that precipitated Matthew's involuntary hospitalization: oscillations between manic excitement and tearful preoccupations with his "sins," agitation during interactions with his caretakers, countless phone calls to his priest in the middle of the night to read from his self-published books of religious and anti-psychiatric poems. Perhaps most important was the admission that he hadn't been taking his medications when visited by a community nurse. And yet Matthew would tell anyone who would listen how much he despised his frequent trips to St. Dymphna's Ward. His regular admissions to the hospital clearly recalled the decades he spent as a patient at the now-defunct St. Brendan's Hospital at Grangegorman, a sprawling reminder of English colonial governance and its investment in the project of public mental health. Despite these antipathies, Matthew was equally loathe to acknowledge that antipsychotic adherence, or the degree to which a patient complies with medical advice about psychopharmaceuticals, is largely understood to be the *sine qua non* of patients' extra-institutional mobility by community mental health professionals. It stands as a sort of biopolitical requisite for a form of psychiatric independence suspended between outpatient clinics, support group meetings, and occasional periods of stabilization in inpatient wards. As Matthew seemed to understand his predicament, and despite the ostensive abolition of the old asylums in a wave of nationwide deinstitutionalization, the practically enacted psychiatric logic of antipsychotic adherence served to undergird his status as a perennial outpatient far more than it delivered on the promise of sanity.

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I was introduced to Matthew's case by the head of inpatient psychiatry a short time after I began working at St. Dymphna's Ward. Hurrying through a light drizzle on my way to morning rounds, I met Dr. Domhnall Lynch at the entrance to the hospital. A Dubliner without an umbrella, he brushed the raindrops from his shoulders and lead me on a brisk walk through the lobby and toward the psychiatric inpatient unit. An enthusiastic interlocutor on the history of Irish psychiatry, Dr. Lynch was obviously excited. He dispensed with the polite meander of typical Irish greetings and launched directly into a preview of the morning's briefings, chief among them that an old patient had returned to the ward the night before.

"This one will be important to you," he said with authority. "What you anthropologists might call a classically Irish story."

These sorts of pronouncements were a relatively common occurrence, and yet the weight of an historical and ethnographic record shadowed us as we walked from the sleek, refurbished administrative corridors to the older parts of the hospital. In stark contrast to the now-infamous, walled asylums that wielded enormous social, political, and scientific authority before Irish deinstitutionalization—indeed, extended confinement was the standard of care prior to the aforementioned process of reforms that began with the 1966 Commission of Inquiry on Mental Illness and formally concluded with the 2001 Mental Health Act[3]—the inpatient unit was a space designed for brief respites, the recalibration of psychopharmaceutical maintenance treatments, and discharge back into the larger community mental health system. The relative porosity of this new institutional form was striking.

Memories of the old hospitals often returned, however. More often than not, they did so in the embodied form of a patient whose treatment history straddled the closure of the asylums and the movement toward community care. Drawing nearer to St. Dymphna's Ward, we passed nurses retiring from the night shift, as well as several patients being discharged or going home for day leave. Far from a Goffmanian total institution, St. Dymphna's Ward epitomized the larger Western trend toward community mental health, acting as a nexus of clinical intervention within a distributed network of care, prioritizing the mobility of patients and, perhaps as importantly, their treatment regimens.

With a swipe of Dr. Lynch's key card, we cleared the locked double doors of the ward, murmuring hellos to patients as they moved from the drug dispensary line near the kitchen to breakfast in the day room. Passing the nurses' station, we entered the consultation room and greeted the rest of Dr. Lynch's team—two psychiatrists in training, a clinical psychologist, a social worker, an occupational therapist, and a community nurse. It was here that I discovered that the nurses working the night shift had deemed Matthew too agitated to attend rounds that morning, but after reviewing the rest of his patients' cases and speaking with each

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[3] cf., Damien Brennan, *Irish Insanity: 1800-2000*; Brendan Kelly, *Hearing Voices: the History of Psychiatry in Ireland*; and Nancy Scheper-Hughes, *Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland*.

one about their treatment, their concerns, and their medications, Dr. Lynch told me what he knew of him.

Devoutly Catholic, Matthew was a poet with a long history of collaboration with his twin brother, David. The brothers had each received diagnoses of bipolar disorder in the early days of their treatment, and Dr. Lynch owned copies of both of their self-published books of anti-psychiatric poetry. Matthew and David had been inseparable, both as writers, and as long-time patients at St. Brendan's Hospital at Grangegorman, until David's death a decade prior. Since that time, and despite the closure of the asylum that he had so long despised, Matthew seemed to have lost his mooring. His health had deteriorated, and though walking had troubled him since childhood, necessitating multiple surgeries and leg braces throughout his youth, Matthew now depended upon a variety of forms of support. He used a walker and, more often than not, a motorized wheelchair to go grocery shopping, to travel across the city to a weekly poetry night in Rathmines, and to attend mass. Beyond these more obvious forms of material support, Matthew lived in a small flat subsidized by the Dublin City Council a mere stone's throw from St. Dymphna's Ward—as well as his old lodging at the looming, empty Grangegorman—and he saw Dr. Lynch regularly in the outpatient clinic associated with the inpatient unit.

Matthew was frequently hospitalized, but this involuntary admission was particularly fraught, as the clinical staff made the decision to limit many of his privileges. He was especially enraged when the nurses confiscated his cell phone, and during one of the many confrontations that followed his screams echoed down the long hallway of the ward, interrupting morning rounds and startling some of the other patients. Had Matthew been born even a decade or so earlier, one of the older nurses remarked, he might have spent the entirety of his adult life in an asylum. Instead, his clinical history spanned the process of Irish deinstitutionalization, but Matthew still rejected the notion that he had escaped the grasp of the asylum; rather, he received each readmission to the inpatient ward with a growing sense of moral injury. For Matthew, and to a lesser extent for those who listened to him, Ireland's institutional past frequently erupted into the present.

Michel de Certeau's meditations on the distinctions between historiography and ethnological investigation are invaluable in exploring Matthew's embodiment of such historical eruptions and the extent to which they vex a straightforward narrative of psychiatric progress:

> History is homogenous to the documents of Western activity. It credits them with a "consciousness" that it can easily recognize. History is developed in the continuity of signs left by scriptural activities: it is satisfied with arranging them, composing a single text from the thousands of written fragments in which already expressed is that labor which constructs time, which creates consciousness through self-reflection.[4]

In contrast, and drawing upon the writings of Claude Levi-Strauss, de Certeau argues that ethnology concerns itself with orality and the inherent heterogeneity of

[4] Michel de Certeau, "Ethno-Graphy," *The Writing of History*, 210.

voice that emerges from "a *hermeneutics of the other*."[5] "History," he writes, "organizes 'its data in relation to *conscious expressions*, while ethnology organizes its data in relation to *unconscious* conditions of social life.'"[6] A seasoned clinician and researcher in his own right, Dr. Lynch grasped the terms of my inquiry from our first meeting. Beyond the obvious methodological relevance of his diagnosis and treatment with antipsychotic drugs, Matthew's years as a patient in a mental asylum led the clinician to think of him as a sort of living archive of Irish psychiatric history.

"He was quite distressed when he entered the ward last night," Dr. Lynch told me after rounds, "and the nurses gave him an injection to calm him down. He's not very happy with us right now, but he's a lovely man, and I think he will talk to you if you ask him. He's also not overly fond of his medications, so it's more than likely that he'll have many interesting things to say for the purposes of your research."

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Unsurprisingly, medication was still foremost in Matthew's mind at the time of our first meeting a day later. Leaning heavily on a walker and looking much older than his sixty-odd years, he moved slowly into the spare office that the ward staff had allowed me to use for interviews. His speech was quick and passionate, though somewhat slurred. His hands shook when he gestured to make a point.

"So, you are the anthropologist," he observed, easing himself onto a chair across from me and resting his elbows on the table between us. "Did you hear them fighting me down the hallway yesterday?" he asked, eying the small recording device I was using to document our conversation. "I'll talk to you," he continued, "but I need you to speak to Dr. Lynch about lowering the dosage of my medications."

When I explained that I could deliver his message but was neither qualified nor authorized to intervene in the supervising psychiatrist's decisions regarding psychopharmaceutical treatment, he responded with vehemence: "*I wish you were dead!*"

The conversation was far from over, however. Matthew continued to speak rapidly, often with great exasperation and little to no prompting, about the Godlessness of Ireland, the sinfulness of the current age, the stupidity of the psychiatric establishment, the violence of involuntary admission and unwanted antipsychotic injections, the ulcerations on his legs, and his difficulties with his wheelchair. For a time, he criticized my rudeness in not bringing him a cup of tea when I'd made one for myself prior to the interview. Occasionally he wept.

In the hours that followed, a deeper grammar of refusal and demand began to emerge. I would ask a question, and Matthew would decline to answer. One of us would read a poem of his choosing from one of his chapbooks, and we would pray. I would repeat the question, and if the mood struck him he might grant me an uncharacteristically laconic answer. The chapbooks, the recorder, my field notes, and the lone cup of tea formed a kind of constellation between us.

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[5] Ibid., 221.

[6] Ibid, 210.

"Do you mind me asking what it is that you're writing?" Matthew queried as I scribbled notes.

"I'm writing, 'We must talk as mediated by the poems'," I replied.

He nodded gravely. "You know the Our Father, yes?"

Matthew found my questions about medications particularly aggravating, especially when they touched on his refusal to comply with his doctors' care plan. "Why don't I take my tablets? Why don't *you* take them?" he sneered. Though he seemed to hate psychiatric intervention in all its forms—he claimed to have received electroconvulsive therapy 26 times while a patient at Grangegorman—he loathed pills with a special fervor. Matthew didn't like medication "on principle," he claimed, pounding the table for emphasis.

"The *principle* is that I have my own mind and my own life."

I pressed for further clarification, and he continued. "The point of treating mental illness is to get back to where you were before you became unwell," he stated with exasperation. "I don't want to be on drugs. I want to be a full person."

So profound was Matthew's antipathy for tablets, in fact, that he preferred taking antipsychotics in their liquid form. When I asked why he favored a form of medication classically associated with the treatment of acute psychosis in an asylum or inpatient setting, he narrowed his eyes in impatience. "Because it's more honest, of course. Tablets can bar the way." With that, he produced a rosary from the pocket of his cardigan, pouring the string of well-worn wooden beads onto the table next to my recorder.

"We'll pray now," he said with an authority that forbade argument. "We'll pray into the machine."

I pondered Matthew's words for hours after our final Hail Mary, struck by the entanglement of the practical activity of antipsychotic adherence, the imponderabilia of chemical efficacy, and beliefs and perceptions that could quite easily be considered misinformed, poignantly metaphorical, or even psychotic. Later I posed the scenario as a hypothetical to Dr. Lynch, wondering aloud whether or not a patient might associate liquid medications with a concept as abstract as "honesty" because of specific material characteristics. Did liquid medications boast a higher concentration of active chemical ingredients? Did this make them work faster? Might this influence a patient's perception of their qualitative characteristics?

Dr. Lynch was quick to correct me. Liquid haloperidol was used to treat particularly acute cases of psychosis like Matthew's not because of a higher concentration of active ingredient or faster activation—these measures were identical to those of antipsychotic tablets, he clarified—but for the simple reason that it is impossible to hide liquid haloperidol under the tongue as one might with a tablet. This was an old trick. The resistance to medication so often associated with acute psychosis in the historical space of the Irish asylum was easily subverted by an alternative state of matter, and the doctors and nurses at St. Dymphna's Ward continued to employ this strategy with patients who talked openly about or were suspected of noncompliance. And yet, the significance of Matthew's claim to a type of chemical "honesty" eluded an exclusively biomedical logic. As such, the uncanny

resonance of Matthew's words, suspended somewhere between delusion and poetry, continued to trouble me.

Though not trained as an analyst, Dr. Lynch's original invitation to attend to the multiple levels of salience in Matthew's speech—at once archival and critical—nonetheless recalls de Certeau's distinction between classical historiography and the task of writing a history of the discipline of psychoanalysis. In destabilizing the easy demarcation between the past and the present of Irish psychiatry's institutional memory, Matthew disturbs straightforward narratives of psychiatric progress wherein patients are understood to transition seamlessly from the asylum to the outpatient clinic or community group. Rather than postulating a genealogical "continuity" between past and present, Matthew's engagement with the psychiatric present *qua* his experiential memories of its historical past constitutes an "imbrication" of "the past *in* the present."[7] By facilitating something like the return of the institutional repressed, Matthew reaches beyond the totalizing discourse of biopsychiatric symptomatology and invites those who are capable of listening into the institutional Unconscious of Irish psychiatry.

Whereas some members of the clinical staff dismissed Matthew's perennial complaints about medication as a manifestation of his larger illness, Dr. Lynch did not understand the older man's speech to be devoid of truth or meaning. As such, he was also attuned to the ways in which his patient's decades-long objections to psychiatric treatment moved beyond the biopsychiatric definition of symptomatic speech and constituted a species of formal critique. Following de Certeau, the "pathological" dimensions of such a testimony are not only signs of mental disorder. Historically speaking, and in revealing the interplay between the diagnostic and juridical categories of the normal and the abnormal, the pathological is also "a region where the structural modes of functioning of human experience become intensified and display themselves."[8]

Matthew's psychiatrists had little to no difficulty in enforcing his compliance to psychopharmaceutical regimens in the institutional context of inpatient psychiatry, but adherence seemed significantly more difficult to discern, much less enforce, when a patient was discharged to their home, even with regular visits from community nurses and check-up appointments at the ward's nearby outpatient clinic. While liquid haloperidol ostensibly represented the apex of psychiatric authority and surveillance, it was nevertheless confined to the space of the hospital and the duration of his stay. Most tellingly, Matthew despised the degree to which his tablets followed him home, revealing both an historical transition in modalities of care as well as the concomitant extension of psychiatric power into the time and space of everyday life outside the walls of the asylum. The challenges Matthew posed to the distributed, multi-sited, and ostensibly post-institutional spaces of Dublin's community mental health network drew into sharper focus.

First, Matthew's insistence that proper treatment for mental illnesses like his bipolar disorder should be oriented toward a cure rather than a program of pharmacological maintenance underscores the expansion of the category of

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[7] Michel de Certeau, "Psychoanalysis and Its History," *Heterologies: Discourse on the Other*, 4.

[8] Michel de Certeau, "Psychoanalysis and Its History," *Heterologies: Discourse on the Other*, 5.

chronicity into psychiatric understandings of diagnosis, prognosis, and treatment protocols. The work of medical anthropologists Annemarie Mol and Joseph Dumit further supports this observation, exploring the ascendance of chronicity in medical definitions of patient choice, as well as emergent from the political economy of drug research and development. In both cases—be it the conceptual and practical collapse of long-term strategies of care into previously episodic engagements with medical treatment,[9] or the extent to which drug research and development and the growing clinical focus on preventative care have lead to an increase in the number of diseases understood to be chronic[10]—the *telos* of medical intervention has shifted significantly. The temporal horizon of illness shifts in the process, both at the level of institutionally mediated intervention, as well as within the space of a life.

Second, and as I would later confirm upon encountering him at the threshold to the clinic, Matthew seemed to abhor the very notion that he was required to take his medications while at home. Despite his perennial refusal of tablets, or perhaps at least partially inspiring it, Matthew appeared to sense the degree to which the psychiatric injunction to adhere undergirded the broader project of community mental health outside of the historical space of the asylum, and he found it intolerable. Such an interpretation, coded into the "pathology" of his speech, recalls Michel Foucault's own meditations on the relationship between the capillary action of power and the changing nature of institutional space under the sign of the biopolitical. While the closure of asylums like Grangegorman ostensibly represented the waning of a centralized and overarching psychiatric authority in favor of self-directed care by patients themselves, Matthew's dissent reveals the "uniformity of the apparatus" of disciplinary power and its dissemination into the wider community.[11] A transition from asylum-style care to community mental health was only possible due to the implementation of a strategy of adherence, and this produced a proliferation of psychiatric space rather than its abolition. In short, Matthew found himself inside a form of clinically mediated space wherever he went.

Matthew's words emphasize the historicity of this shift at the level of lived experience, as well as the existentiality inherent to such a transformation. His resistance to being medicated, much less his unlikely preference for liquid haloperidol, reveals a broader temporal and spatial critique of extra-institutional mental healthcare. In this light, his preference for liquid haloperidol suggests a desire to shape and contain the demands of psychiatric power. By turns poetic and prosaic, both within the space of a single life and as part of an historical concatenation of anti-psychiatric dissent, Matthew's protests reveal the shifting stakes of Irish psychiatric care, both in the aftermath of the asylum and in the face of the ever-increasing pharmaceuticalization of western mental healthcare.[12]

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[9] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice*.

[10] Joseph Dumit, *Drugs for Life: How Pharmaceutical Companies Define Our Health*.

[11] Michel Foucault, *The History of Sexuality, Volume I: An Introduction*, 84.

[12] João Biehl, "Pharmaceuticalization: AIDS Treatment and Global Health Politics," *Anthropological Quarterly*, Vol. 80, No. 4, pp. 1083-1126.

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"I'll tell you what I hate about Freud," Matthew said distractedly, pausing after the recitation of an older poem called "Screeching Paranoia." "He invented a new language. That's where I got the word 'paranoia.' It means extreme fear."

I leaned forward across the table between us, inadvertently betraying my interest. It was our second official interview, only half a week after our first, but Matthew was somewhat more inclined to share his thoughts. His tremors were no longer as pronounced, and his speech was clearer, but his mood was still labile, and he was adamant that he should not be involuntarily detained.

"How did you come to read Freud and his new language?" I asked. "Can you say more?"

"No, I will not!" Matthew answered indignantly. "He practiced euthanasia. He was a sinner."

Instead, he opened his chapbook again, selected another poem entitled "50 and Single in *Solas*," and began to read. I was still intrigued, however, recognizing the name of the organization *Solas* as another site of my ethnographic work. A community mental health group run by and for people living with psychotic spectrum disorders, *Solas* was unique in that it operated in consultation with clinicians affiliated with the New Lacanian School of Dublin who sometimes acted as group moderators or meeting facilitators.

"So you're a member of *Solas*?" I countered.

"They didn't want me," he answered with some resentment, muttering about the difficulty of making his way up and down the stairs to *Solas*'s basement meeting space. "I used to go to meetings with Thrive," he said, referencing another community group before trailing off.

"What drew you to the groups?" I asked.

"Thrive encourages people to stop taking drugs," he answered.

"Did you gain a sense of community with other psychiatric service users?" I pressed.

With great solemnity, he echoed a charge that he had leveled at me only a day before when he discovered me in the hallway of the ward and became incensed that I hadn't come to visit him.

"They are always abandoning me. Just like you."

It was a revelation that Matthew's ruminations on dislocation and abandonment, both poetic and conversational, passed through the idiom of psychoanalysis before returning to the familiar terrain of recitation and prayer. Indeed, this passage suggests a great deal regarding the transformations in Irish mental health discourses in the aftermath of deinstitutionalization and beyond. Whereas the history of American psychiatry is defined by a discursive shift from psychoanalytic to biopsychiatric understandings of mental illness,[13] there was never a moment of psychoanalytic ascendancy in Ireland. A lacuna in the history of Irish mental healthcare, the absence of psychoanalytic and psychodynamic therapies in the early and middle twentieth century can be attributed to a number of factors.

[13] cf., Tanya Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry*.

Long considered a luxury, psychoanalytic treatment was further marginalized by the hereditary and biological models of disease etiology historically favored in the British medical and psychiatric training that was then the regional standard.[14] Though an association of Irish psychoanalysis was founded in 1942, it remained isolated by Ireland's "peripheral location," meager support among members of the larger Irish medical community, and fierce opposition from Catholic leaders like Archbishop John McQuaid who claimed in 1963 that "Freud had not discovered reality but attempted to *construct* it."[15]

The growing significance of psychoanalytic thinking in Ireland in the late twentieth and early twenty-first centuries speaks to the complex entanglement of the rise of the so-called "Celtic Tiger" of economic prosperity; the opening of national, cultural, and intellectual borders to produce new forms of Irish cosmopolitanism; and the exponential growth of political and social liberalism, particularly in Dublin. In 2000, the Dublin Business School established a master's program in psychoanalytic psychotherapy, and in 2009 the Irish Circle of the Lacanian Orientation (ICLO) was founded in affiliation with the international community organized by the Paris-based New Lacanian School. The psychoanalysts and psychiatrists that I encountered in the field often attributed this flowering of psychoanalytic prestige to the growing cultural and discursive heterogeneity of Irish society, a product of the influx in immigration in the late twentieth century and the spreading intellectual and philosophical influences of the continent. Most interesting from the perspective of my own ethnographic investigations was the practical integration of psychoanalytic professionals, particularly Lacanian analysts, into the community mental health network that served Matthew and other patients like him.

I gained a subtler appreciation for the specific nature of Lacanian thinking in Ireland after speaking with Dr. Valentina Sheehan, a clinical psychologist and practicing analyst affiliated with ICLO, about the growth of psychoanalytic scholarship and clinical work in Dublin. Irish engagements with the work of Lacan were distinct in the English-speaking world, she argued, to the extent that they were primarily an outgrowth of the work of clinicians, both in their individual practices and in collaboration via associations like ICLO, rather than confined to the theoretical endeavors of philosophers and scholars of literature and film. When I asked Dr. Sheehan, herself an immigrant from Argentina to Ireland, for her thoughts on the relationship between the growing cosmopolitanism of Irish society and the burgeoning influence of ICLO, she was careful to note that psychoanalysis remained relatively marginal in Dublin when compared to other centers of activity like Paris, Buenos Aires, and New York.

Dr. Sheehan clarified:

> Psychoanalysis typically flourishes in a given society when it emerges from historical pathways that lead to a fragmented, non-unified sense of individual and collective identity. This can come from a strong element of immigration, of the mixing of different peoples and

[14] Nancy Scheper-Hughes, Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland, 164.

[15] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland*, 170.

> cultures, which produces conditions where the subject does not have an immediate or very easy answer at hand to the question "Who am I?" In Ireland it was largely the opposite…historically, there has been a very compact, very strong sense of Irishness, which has been reinforced by *emigration*.

The fact nevertheless remained, I mused, that many of my interlocutors who were psychiatric service users had established a species of contact with a Lacanian psychoanalyst—albeit not upon the couch in extended clinical sessions—via their participation in a popular community mental health group. This, in and of itself, was remarkable in the larger context of Western mental healthcare, especially given the historical homogeneity of Irish clinical paradigms. Dr. Sheehan agreed. The sociocultural and psychological conditions of possibility for psychoanalytic purchase in Ireland were changing.

When I asked Dr. Lynch for his thoughts on the unlikely resurgence of psychoanalytic thinking in Ireland, much less the fact that patients like Matthew encountered analytic practitioners in the context of community mental health groups, he affected a look of surprise. "But haven't you heard Freud's own assessment? The Irish psyche is impervious to psychoanalysis," he exclaimed with feigned earnestness.

Well aware of the contested, apocryphal status of these remarks, Dr. Lynch adopted a more serious tone. "As you anthropologists know, there is quite a long history of speculating about the nature of this Irish psyche. Some of it is a result of colonial prejudices, some of it is our own doing, and some of it is yours."

Was he referring, I wondered, to the degree to which new histories of Irish psychiatry question the statistics that inspired Nancy Scheper-Hughes's seminal *Saints, Scholars, and Schizophrenics*? Was he, like many leading contemporary historians, suspicious of the claims that Ireland actually suffered the highest rates of hospitalization for schizophrenia in the world for much of the early to middle twentieth century? More broadly, did he connect the purported historical absence of the critical capacities for self-regard so often associated with psychoanalytic theory and practice to the very status of the Irish ethnographic subject—a subject that was nonetheless famously dissimulating and difficult to capture in the fullness of its contradiction and complexity?

Dr. Lynch nodded. He was a student of these histories himself, and he gestured toward Scheper-Hughes's own critical reflections in the new prologue of the 2001 edition of *Saints and Scholars* about the socio-historical construction of psychotic mental illnesses (particularly schizophrenia) as readily available and socially useful disease categories, as well as more recent work on the subject by anthropologist A. Jamie Saris. Together, along with the work of scholars like Brennan, Healy, and Kelly, Scheper-Hughes and Saris link the constitution of the mad Irish subject to British colonial attempts at governance via the imposition of programs of social and moral hygiene,[16,17,18] as well as the institutional inertia that

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[16] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland*.

characterized the transfer of power following Irish independence, when the asylum system became nationalized, remaining a network of powerful local anchors of community and regional order.[19,20,21]

It was at once invigorating, vertiginous, and perhaps more than a little revelatory of ethnographic naiveté to encounter such an openness to constructivist critiques of psychiatry among mental health professionals, especially those whose institutional authority and practical expertise were largely grounded in a biomedical epistemology. Equally revealing was the degree to which many of my interlocutors—more frequently clinicians but in some cases patients—were familiar with and spoke back to the historical and ethnographic record regarding the problem of Irish madness. What is more, they grasped the degree to which the problem of institutionally mediated otherness, particularly relating to madness, preceded British colonial occupation, echoing through legends and myths that were at least as old as the coming of Christianity to Ireland.

If, as de Certeau claims, anthropological writing relies upon the researcher's capacity to transform the speech of his or her subject "into an exotic object," the ease with which my interlocutors often engaged the breadth of the historiographical and ethnographic archive destabilizes easy distinctions between writing about history and writing about the other.[22] Instead, my interlocutors seemed to readily understand themselves as implicitly in dialogue with a host of heterogeneous histories, disciplinary traditions, and folk narratives—from the isolated peasantry of Conrad Aarensberg's *The Irish Countryman*, to the rebellious "white Indians" of Roger Casement's insurrectionary ambitions, and the charges of psychic atavism so often (mis)attributed to Freud. They reflexively grasped the degree to which any claim to modernity would be judged in relation to this body of texts—an historical and ethnographic palimpsest—long before I did.

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"I edited this poem," Matthew said, gesturing toward his chapbook. "I took out the word 'insanity.'"

"What's the poem called?" I asked

"'The Plague of Outsidedness,'" he answered.

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[17] A.J. Saris, "Mad Kings, Proper Houses, and an Asylum in Rural Ireland," *American Anthropologist*, 1996.

[18] A.J. Saris, "The Asylum in Ireland: A Brief Institutional History and Some Local Effects," *The Sociology of Health and Illness in Ireland*, 1997.

[19] Nancy Scheper-Hughes, *Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland*.

[20] A.J. Saris, "Institutional Persons and Personal Institutions: The Asylum and Marginality in Rural Ireland," *Postcolonial Disorders*, 2008.

[21] Damien Brennan, *Irish Insanity: 1800-2000*; Brendan Kelly, *Hearing Voices: the History of Psychiatry in Ireland*

[22] Michel de Certeau, "Ethno-Graphy," *The Writing of History*, 212.

"What does that mean?" I followed.

"That you're always on the fringes," he returned.

I paused before continuing. Matthew was calmer at the outset of our third meeting, perhaps because he had just received communion from the Eucharistic minister who regularly visited the ward, but my questions clearly still annoyed him, especially when they spoke to his relationship to psychiatry. He tugged at his sweater restlessly, clearly not entirely happy to be talking to me but likely enjoying the break from the regular afternoon routine of tea and television in the day room.

"So this isn't a poem about mental illness?" I queried.

"Forget about labels," he said with irritation.

Despite Matthew's reticence, his poems suggested a host of internal contradictions. References to the old asylums, shifting diagnoses, and even specific dosages of medications were threaded through his reflections on family, religion, and unrequited love. At times, his words even revealed something like an ambivalent appreciation for the psychiatric care he had received throughout his life. The praise I found in these poems was jarring when held in contrast to the categorical rejection of doctors, drugs, and hospitals that characterized our more recent conversations. In one poem, which began "I need psychiatry to keep me sane / these pills and injections help my brain," he went so far as to thank God for the help of Dr. Martin, a psychiatrist who had worked at St. Dymphna's Ward even longer than Dr. Lynch and a frequent target of Matthew's criticism. When I asked him why he had been so thankful for Dr. Martin when he had written his first chapbook, Matthew frowned and coughed into a handkerchief

"I came to see Dr. Martin when I suffered from a delusion," he said curtly. "I don't want to see him again. All he gives is tablets."

"What kind of delusion?" I asked.

"I overshadowed someone," he answered with a grimace.

"Overshadowed?" I inquired hesitantly.

He waved his hand as if to dismiss the question. "My sexuality left my body and hovered over someone else. I was riding the bus, and I saw it leave me and overshadow another rider. God was angry with me. Blood was running down the window-screen. My eyes were showing me what wasn't there. I got off the bus as soon as possible…" he trailed off.

"You were afraid?" I asked.

"Yes," he answered, gloomily.

"Why? Did you feel as if a part of you went outside of yourself?" I pressed.

"Yes," he snapped impatiently. "There's nothing obscure about it!"

We sat in silence for a moment while Matthew brooded, and I considered terminating the interview. I risked another question.

"How did Dr. Martin take the delusion away? Did he use medications?" I ventured.

Matthew waved his hand again in refusal. "I want to get back to where I was before. I want to be a full person," he reiterated.

"You take communion everyday," I ventured. "Why not drugs?"

"Tablets and communion don't go together," he said in rebuttal. "Communion comes from God. Tablets are poison—manmade junk. They're killing me. Psychiatry is killing me."

"You think psychiatry is killing you?" I probed.

"Oh there's no doubt about that."

Matthew lapsed into silence again, tugging at his sweater. I elected to try another avenue.

"Why do you write poetry?" I asked.

"I write to clear away injustice," he answered. His voice did not shake, and there was a grim determination in eyes.

When I asked him to describe the injustices he wrote against, he returned to his earlier reflection on honesty and imprisonment returned.

"Taking tablets every day is an injustice," he insisted. "At least with the liquid you can see what's inside. Tablets are dishonest…they hide what's inside of them. They can be bars. A wall. They can be a prison."

"And poetry…?" I ventured.

"Poetry is a charism," he said passionately. "Poems are gifts from God. They come from somewhere else."

Matthew's words hung over us. In the resonances between his unceasing prayers, his condemnations of medication, his yearning for escape from the ward, questions of mobility and embodied histories, and the creeping threat of the plague of outsidedness, another constellation began to take shape. Most saliently, the commonly accepted and explicitly modern incommensurability of Matthew's claims to holiness and his status as an involuntary patient in St. Dymphna's Ward came to the fore, the structurally homologous ecstasies of each respective position notwithstanding. As de Certeau writes of the historiographical similarities between the speech of the mad and the speech of the possessed:

> From psychiatric discourse the "mentally ill" or the "madwoman" gains the possibility of uttering statements; in the same fashion, the "possessed woman" can speak only thanks to the demonological interrogation or knowledge—although her locus is not that of the discourse of knowledge being held about her. The possessed woman's speech is established relative to the discourse that awaits her in *that* place, on the demonological stage, just as the language of the crazed woman in the hospital is only what has been prepared for her on the psychiatric stage.[23]

It was from this space of alterity, and in the face of this injustice, I have come to believe, that Matthew wrote his poetry.

That poetry should come from "somewhere else" is nothing new, particularly when it contends with themes of madness and exclusion. Indeed, de Certeau invokes the words of the poet Rimbaud—"'Je est un autre,' or '*I* is another'"[24]—to formalize the internal otherness at the heart of both a psychoanalytic definition of

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[23] Michel de Certeau, "Discourse Disturbed; the Sorcerer's Speech," *The Writing of History*, 248.

[24] Michel de Certeau, "Discourse Disturbed; the Sorcerer's Speech," *The Writing of History*, 255.

madness and a theological estimation of speech that may be called, by turns, possessed or mystical. Matthew's own writings, however, seemed to attempt to stake a claim to that experiential space evacuated by demonological and psychiatric discourse. In the years following this conversation, I understand that Matthew seemed to seek what Seamus Heaney calls the "redress" of poetry, or the capacity of written verse to embody an "imagination pressing back against the pressure of reality."[25] This poetic "counter-weighting," in Heaney's words, "does not intervene in the actual but by offering consciousness a chance to recognize its predicaments, foreknow its capacities, and rehearse its comebacks in all kinds of venturesome ways […]."[26] In short, in the writing and the recitation of his poetry, especially within the space of St. Dymphna's Ward, Matthew found the fullness of personhood that he felt his medications denied.

In the moment of the interview, however, my understanding was inchoate at best. I recalled a portentous joke by Dr. Lynch that Matthew was "a Mad Sweeney for the modern age," a wandering pagan king who ultimately finds sanity in the moment of his spiritual redemption. In the rapidly secularizing context of contemporary Ireland, however, it was precisely Matthew's religious zeal that marked him as mentally ill—a "weakening of oppositions, accompanied by a reversal of correlations," following the thinking of Claude Levi-Strauss, and elevating Matthew's experience to the realm of the mythic.[27] Dr. Lynch thought as much like an anthropologist as he did like a psychiatrist, I joked in return. For my part, head swimming, I closed with a question better suiting a junior clinician.

"And what about adherence, Matthew? Will you take your medications when you leave the ward?"

"God knows what's going to happen when I leave here," he answered.

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When madness finds Sweeney, pagan king and blasphemer of Irish legend, it impels him to move. He flies "like a bird of the air"[28] from one end of Ireland to the next, stopping only in the "natural asylum" of Glen Bolcain where madmen were said to congregate.[29] The story, elegantly rendered in Seamus Heaney's celebrated translation of *Buile Shuibhne,* or *The Frenzy of Sweeney*,[30] meanders fittingly.

The eponymous king begins his fall to ruin after confronting the itinerant St. Ronan, whom he finds marking out the ground for a new church in a land largely unwelcoming to the newly arrived Christian missionaries. Sweeney runs from his great hall at the peal of the monk's bell, naked in his hurry to defend his pagan

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[25] Seamus Heaney, "The Redress of Poetry," *The Redress of Poetry: Oxford Lectures*, 1.

[26] Seamus Heaney, "The Redress of Poetry," *The Redress of Poetry: Oxford Lectures*, 2-3.

[27] Claude Levi-Strauss, "The Story of Asdiwal," 40.

[28] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 9.

[29] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 13.

[30] Heaney translates the traditional title as *Sweeney Astray: A Version from the Irish*.

territory, and he casts Ronan from his lands, flinging his holy psalter into a lake. Sweeney is quickly called away to the battle of Moira by his political allies, and Ronan cries out to God for vengeance. His psalter miraculously returned by an otter, the saint half-prays for, half-prophecies Sweeney's maddened doom, to be revealed at the second ringing of his holy bell. Gone to bless each side of the battle and argue for peace, Ronan meets Sweeney again on the field of war, and the angry king rejects his benediction, hurling two spears at the saint and his company. The first spear strikes and kills one of Ronan's psalmists and the second cracks—and in so doing, rings—the bell hanging from the monk's neck. As Ronan's curse descends on Sweeney, his mind breaks, and he flees the battlefield, his "fear of known places" driving him ever onward and away from the clamor of civilization. Heaney translates: "His feet skimmed over the grasses so lightly he never unsettled a dewdrop and all that day he was a hurtling visitant of plain and field, bare mountain and bog, thicket and marshland."[31]

In stark contrast to his previous involvement in the struggles between neighboring kings for political advantage and martial dominance, Sweeney's flight inscribes the entirety of Ireland into a geography of madness. Again, as Heaney translates: "there was no hill or hollow, no plantation or forest in Ireland that he did not appear in that day; until he reached Ros Bearaigh in Glen Arkin, where he hid in a yew tree in the glen."[32] Sweeney's break from rationality, as well as his rhapsodic departure, marks a transformation both figurative and literal within the space of the poem. More animal than man, he seems to now possess strange powers and a doubled consciousness, at once split and senseless but still given to self-referential exposition in moments of clarity. "Ronan has brought me low," Sweeney cries to his former subjects and allies, and "God has exiled me from myself— / soldiers, forget the man you knew."[33] Sweeney continues to travel the woods and the fields and the mountains of Ireland, occasionally haunting the edges of human settlements and discovers that, though his family and friends still search for him, his wife now lives with a new husband and his kinsmen's only plan is to confine him, to constrain his movements with the hope that his sanity might one day return.

Fearing confinement, Sweeney roams from place to place throughout Ireland and western England. His madness ebbs and flows, incited by extended contact with human settlements, but a "glimmer of reason" turns him homeward yet again.[34] In his wanderings, and over the course of many laments, it seems that Sweeney comes to know and fear the power of the Christian God. Heaney translates:

> My dark night has come round again.
> The world goes on but I return
> to haunt myself. I freeze and burn.
> I am the bare figure of pain.
>
> Frost crystals and level ice,

[31] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 9.

[32] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 9.

[33] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 10.

[34] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 68.

the scourging snow, the male-voiced storm
assist at my requiem.
My hearth goes cold, my fire dies.

Are there still some who call me prince?
The King of Kings, the Lord of All
revoked my title, worked my downfall,
unhoused, unwived me for my sins.[35]

Tiring of his wanderings, and newly possessed of something like a Christian faith, Sweeney eventually comes under the care of St. Moling, the Bishop of Ferns, who allows his new supplicant to live at the outskirts of his parish community. Though Sweeney prophecies his death by the hand of one of the bishop's flock, St. Moling entrusts him to the ministrations of a local woman who sustains the roving beggar with gifts of milk, poured into a hole in the ground at the edge of the settlement. When the woman's husband grows jealous of his wife's dotage upon Sweeney, he runs the erstwhile monarch through with a spear, mortally wounding him. The bishop comes to hear Sweeney's last confession, grants him communion, and supports him bodily at the moment of his death and the breaking of Ronan's curse, the mad king perishing at the threshold of the church of Ferns.

From a structural perspective, King Sweeney—or the legendary figure of *Rí Suibhne*, ruler of the northeastern kingdom of *Dál nAraidi*—plays the mad protagonist in a theological conflict between old and new religions, between madness and sense. Over the course of a penitential journey from lunacy to spiritual redemption, Sweeney's case dramatizes Ireland's long history of religious strife, political division, and contested institutional spaces, ending with an ultimate return to reason. Not quite a myth, the legend does not offer a creation story for either the island itself or the people who occupy it. Nor are there encounters with the *Tuatha Dé Danann*,[36] the inhuman rulers of Ireland who once who settled the west of Ireland after sailing in on storm clouds and ultimately fled from the surface of the island at the coming of human settlers, enduring a chthonic, subterranean existence, where they dwindled to become the *aos sí*, or "people of the mounds."

No longer nature deities, let alone the supernatural predecessors of human colonists, the so-called Other Folk are still sometimes said to live like ghosts or hallucinations, invisibly alongside humanity across the thin veil between Ireland-proper and the Otherworld, emerging only at the edges of wild places to torment humanity with invisible, maddening "elf-darts" and the theft of strong and beautiful human children whom they replace with disturbing and imperfect copies, the *síofra* or changelings. In the old stories, eventually written down in the *Lebor Gabála Érenn*,[37] the *aos sí* occupy a space at the edge of sanity and in a strange way have come to signify an autochthaneity, of sorts. Though their flight underground can

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[35] Seamus Heaney, *Sweeney Astray: A Version from the Irish*, 70.

[36] This translates as "the people of the goddess Danu."

[37] An 11th century text whose title is variously translated as *The Book of the Taking of Ireland* (literally) or *The Book of Invasions* (popularly).

surely be interpreted as a retreat from *human* incursion into Ireland, it can also be said to symbolically stake a rooted claim to their rightful sovereignty over the island. Such a retreat also counterintuitively marks a tropic acknowledgement, via mythic and legendary form, of eternal upheaval, of waves of colonization, and of unending revolutions in the institutional, political, and cosmological orders of human life in even the deepest history of Ireland.

Despite the absence of the Other Folk, Sweeney's legendary story nonetheless *mythologizes* this litany of transformations. In an early essay on the anthropology of myth, Claude Lévi-Strauss argues that by engaging multiple potential schemata of analysis, from the geographic and techno-economic to the sociological and cosmological, the study of myth and legend enumerates fundamental contradictions internal to the symbolic structure of a given culture.[38] These contradictions are integrated and, to some degree reconciled, within the architecture of the story.[39] This integration occurs because, rather than in spite of, the mythic depiction of impossible and fantastic events. As Levi-Strauss writes in "The Story of Asdiwal":

> This conception of the relation of the myth to reality no doubt limits the use of the former as a documentary source. But it opens the way for other possibilities; for in abandoning the search for a constantly accurate picture of ethnographic reality in the myth, we gain, on occasions, a means of reaching unconscious categories.[40]

Reminiscent of the *aos sí*—as both a lurking reminder of prior social and civil orders, as well as in his symbolic status as a creature of madness and natural affinity—Sweeney's frenzy functions to locate him in the liminal space between man and animal, between the incipience of human civilization and the atemporal netherworld of the old gods. In this sense, inasmuch as his ambiguous symbolic status suggests the Other Folk, Sweeney also serves as an analog for Asdiwal himself. Not only is he a flawed hero whose travels mark both infernal and divine trajectories, but his story details the symbolic oppositions that constitute the changing nature of madness in the cultural and historical context of Ireland.

As such, Sweeney's "strange migrations" serve a doubled rhetorical purpose. Most obviously, they historicize the sociopolitical and theological shifts in the etiology and treatment of the mad king's frenzy; more subtly, they *spatalize* the experience of this frenzy, as well as the aforementioned historicizations. The circuity of Sweeney's movements from one end of Ireland to western England and back, to say nothing of his redemption and death on ground hallowed by a Christian saint, recall the historical travels of early Irish pilgrims—penitents and ascetics whose journeys between shrines commemorating the sites of miracles and martyrdoms marked out a holy and institutionally sanctified geography of the island. The haplessness of Sweeney's flight into the unstructured chaos of the Irish wilderness, however, represent a sort of delirious inversion of the highly intentional

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[38] Claude Levi-Strauss, "The Story of Asdiwal," 17-21.

[39] Claude Levi-Strauss, "The Story of Asdiwal," 40.

[40] Claude Levi-Strauss, "The Story of Asdiwal," 30.

progression of the pilgrimage. The humanity from which Sweeney flees and then ultimately returns is not only typified by but also orgnanized around the Christian institution of the church; the legend both begins and ends, after all, with the founding of a church community by an Irish saint. In the former case, Sweeney is cursed by the breaking of a bell. In the latter, Sweeney's sanity is restored, sealed with the reception of the Eucharist and phsycial entrance into the institution itself.

In essence, Sweeney's peregrinations not only spatialize but also *territorialize* the pagan ur-history of Ireland. Beyond drawing a merely metonymical relationship between Ireland's mad past and its ungoverned wilderness, the structure of the legend produces a consubstantiality of time and place, marking an opposition between an inchoate age of pagan lunacy and the island's Christian missionization via the nascent institutional spaces of the early Irish church. The legend, therefore, imagines both madness and a history of religious conversion, symbolically instantiating the period of missionization that presaged a long concatenation of civilizing campaigns. These campaigns began with the Catholic Church's missionary efforts, continued with the respective Tudor and Cromwellian conquests, and extended well into the 18th, 19th, and 20th centuries in the form of English colonial violence, both overt and via the establishment of a multitude of workhouses, prisons, and asylums.[41]

These myriad interventions into the political, cultural, and ultimately psychiatric welfare of the island tell a Foucauldian story, wherein the agent and ideology of intervention change over the course of centuries, but the presumed irrationality and primitivism of the Irish people and land alike remain a steady constant.[42] Following anthropologist A. Jamie Saris's historical analysis of this littany of interventions, the Irish asylum emerges as the apotheosis of this long march toward the taming of Ireland's disorder by English colonial overlords, a disorder that is again shared by population and landscape alike. Saris writes:

> […] the asylum was […] a multilayered model of spatiotemporal order whose structure imposed not only a curative influence on troubled individual minds but also, implicitly, a critical gaze upon a local landscape that shared few of its organizing assumptions. At this level, the logic of the asylum in Ireland must be understood in the context of colonial understandings of disordered persons, disordered living spaces, disordered landscapes, and the importance of state appendages in the redemption of such disorder.[43]

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[41] It is important to acknowledge that the Catholic Church was also responsible for the creation of a number of these institutions as well, to say nothing of the ongoing crisis in Irish Catholicism surrounding the clergy sex abuse scandal.

[42] Here I look to Michel Foucault's work in *History of Madness* for an archaeology of the conceptual transformations in developing disease etiologies and ideologies of confinement, as well as *Discipline and Punish* and *History of Sexuality: Volume I* for an examination of the disciplinary anatomopolitics employed by institutions to reform and control socially recognized abnormalities.

[43] A. Jamie Saris, "Mad Kings, Proper Houses, and an Asylum in Rural Ireland," 554.

Insofar as the legend of *Buile Shuibhne* imagines a historical transformation in the theological character of madness in Ireland, it also enumerates—and to some degree prefigures—the conceptual confluence of disordered subjetcs and disordered spaces. In this sense, Sweeney's body is, itself, a territory under dispute; his wanderings locate the mad autochthaneity of the *aos sí* within the very landscape of Ireland while giving corporeal form to the juridical and symbolic stakes of institutional investments in Irish governance. A true Levi-Straussian protagonist, the arc of Sweeney's frenzy enacts an entanglement of sociological and cosmological registers, wherein "real and imaginary institutions are interwoven"[44] in the mythic "counterpoint" of the legend, "which seems sometimes to be in harmony with […] reality, and sometimes to part from it in order to rejoin it again."[45] With the body of God fresh within him and his mind restored, Sweeney's story ends with a tripartite consecration and a cure: psyche, soma, and the mad land of Ireland itself all find a salvation, of sorts.

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Like Asdiwal and Mad Sweeney before him, and in the spirit of Heaney's own analysis, Matthew imagines Irish psychiatry otherwise. In a sense, the arc of Matthew's life charts a history of transformations in Irish institutions of care, namely the large-scale movement of psychiatric patients from long-term treatment in massive asylums run by the state (first British, then Irish) into a more diffuse, multi-sited system of public mental health. To attempt to follow the scattered recollections of such a movement from within the space of a single life—from the colonial model of therapeutic confinement and proto-pharmaceutical intervention that predated the Irish war for independence to the assemblage of institutional, individual, and material actors within a network of community mental health—is to elucidate the stakes of contemporary psychiatric ethnography in the Irish context. In the aftermath of the total institution, and from a collective history of traumatic colonial dispossession, diasporic imaginings, and often-ambivalent definitions of care, new forms of psychotic subjectivity take shape. What does it mean to hear the speech of the mad in such a place and time? What does it mean for madness to escape confinement and to wander yet again?

Our conversations served to remind me that adherence is not merely a concept or metric employed by psychiatrists, psychiatric nurses, and public health workers. It is also a lived experience, a ritualized practice, a daily encounter with the substance of psychiatric medication and the enduring force of diagnostic expertise. I have begun to think that Matthew speaks a form of counterpoint in his renunciation of the tablet form, and that in laying bare the power relations inherent to the injunction to adhere he is enumerating not the disappearance of the psychiatric institution but its proliferation.

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[44] Claude Levi-Strauss, "The Story of Asdiwal," 13.

[45] Claude Levi-Strauss, "The Story of Asdiwal," 10.

In this sense, and though his wheelchair was fully functional, Matthew was indeed stuck when I encountered him at the threshold of St. Dymphna's Ward on the day of his discharge. After his request to review his aftercare arrangements was denied, I offered to accompany him out of the hospital and hold open the many sets of remotely operated security doors that would make navigating the hallways in a wheelchair somewhat difficult. Looking spent from his diatribe against his medications and concomitant claims to holiness, he wearily accepted. As we moved slowly through the hallways of the hospital, I asked him if he would go to a vesper service at the church near his house, hoping an evening mass might assuage his demoralization at failing to escape his obligation to the psychopharmaceutical. He said only that he was tired. I held open the final door and watched him roll through and toward the street.

"Be well, Matthew," I called after him.

"Whatever that means," he replied, not turning back.

Chapter 2: Antipsychosis and Institutionality: Networks of Care and the Psychopharmaceutical Paradigm

> Boyle was not "a vacuist" nor did he undertake his *New Experiments* to prove a vacuum. Neither was he "a plenist," and he mobilized powerful arguments against the mechanical and nonmechanical principles adduced by those who maintained that a vacuum was impossible. What he was endeavouring to create was a natural philosophical discourse in which such questions were inadmissible. The air-pump could not decide whether or not a "metaphysical" vacuum existed. This was not a failing of the pump; instead, it was one of its *strengths*. Experimental practices were to rule out of court those problems that bred dispute and divisiveness among philosophers, and they were to substitute those questions that could generate matters of fact upon which philosophers might agree.
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> -Steven Shapin and Simon Schaffer, *The Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, 45-46.

"You like this poem," Matthew began, "because it is a crazy poem." I watched Dr. Lynch with some uncertainty as Matthew began to recite a piece that I had heard before called "The Invasion of the Masses to Kill the Psychiatrists"—but he was unfazed. In fact, he broke into a wide smile. I recalled that he owned both of Matthew's self-published books of anti-psychiatric verse.

A month and a half after our first encounter, Matthew had returned to the hospital, and I was reminded again of the years of history between the two men. Over the course of Matthew's periodic hospitalizations for bipolar disorder they had developed a relationship that was alternately jovial and, in an institutional sense, adversarial. Pleased though he seemed by the recitation, Dr. Lynch adopted a more serious look when it was finished, leaning across the large, circular table around which the rest of the consultation team was loosely gathered to return to the all-too-familiar topic at hand: Matthew's status as an involuntarily detained patient, his disinclination to take his medications when not being directly supervised, and the need to nevertheless plan for his eventual discharge from St. Dymphna's Ward.

"If you were at home in your flat, Matthew, would you take your medicine?" Dr. Lynch asked.

"Well, that's a very good question," Matthew parried dryly.

"If I made you a voluntary patient, would you stay in the ward for a few more days to make sure you feel well enough to go home?" Dr. Lynch returned.

"I don't approve of psychiatry," Matthew answered archly. "I'm bored here. I'm wasting my time in this hospital. I want to go home." His invective continued apace, and he vented his frustration with his new roommate, his desire for the ward's occupational therapist to arrange a creative writing course, and warned the consultation team that, regardless of the status of his commitment, he planned to attend a requiem mass for David, his deceased twin brother, in a week's time.

Dr. Lynch tried a different approach: "I would like to discharge you soon, Matthew, but we have to begin planning to make the process easier for you."

"Ah, so you *do* think I'll take my Haldol," Matthew laughed.

His mood suddenly darkened, and his speech became quick and vehement as he returned to an earlier line of argumentation. "If the object is to stop taking drugs—to get better—then how can I be expected to continue taking them?" Matthew demanded, his voice rising. "I'm a good Roman Catholic! I look to Jesus Christ as my savior—how can you think the tablets will save me?"

A sense of fatigue seemed to descend upon the consultation team. Matthew's perennial resistance to the ways in which the standard of outpatient psychiatric care for bipolar disorder increasingly resembles the pharmaceutical management of chronic illnesses like diabetes or heart disease was nothing new, but from the perspective of the ward staff it was an intractable barrier to their ability to provide a basis for extra-institutional continuity of care. Though community nurses, social workers, and psychiatric aftercare specialists often visited Matthew in his nearby, state-sponsored flat, they were unable to visit every day. Even if it was possible to see Matthew that frequently, and even with the help of his concerned sisters and the two other men who shared his apartment by virtue of Dublin City Council's disability services, the clinical evaluation was clear: Matthew's buy-in to his psychiatric team's prescribed medical regimen was arguably the most important part of establishing a species of adherence to the antipsychotics that were supposed to stabilize his moods and prevent him from slipping back into manic psychosis.

"If you'd like to speak more frequently with Moira, we can of course schedule more meetings between the two of you," Dr. Lynch said, gesturing toward the ward's psychologist who smiled and nodded in acknowledgment. "And we can certainly arrange some leave for you to attend your brother's memorial service if you haven't yet been discharged."

Dr. Lynch leaned forward and spoke slowly and emphatically, "But God and drugs are not incompatible. One can help the other."

The salience of Dr. Lynch's intervention escaped me for a moment. If it occurred to Matthew, he seemed to reject it altogether. With some effort he stood and, leaning heavily on his walker, began to shuffle toward the door and away from his psychiatrist's rare invitation to epistemological pluralism. As I watched Matthew's slow passage to the hallway and the rest of the ward beyond it from my place in the corner of the consultation room, I was struck by the extent to which Dr. Lynch's statement articulated both the potential *for* and the limits *of* something like an existential psychiatry within an institutional space defined by an explicitly biomedical logic and a psychopharmaceutical paradigm of care. I was also struck by the extent to which Matthew's history of periodic returns to St. Dymphna's Ward

articulated the stakes of psychiatric practice in Dublin's wider network of community mental health.

Following Latour's invitation to conceive of a network as "the trace left behind by some moving agent," the importance of understanding community mental health in relation to psychopharmaceutical adherence draws into sharper focus.[46] Patients like Matthew, after all, represent only one possible form of the agents whose relational movements trace the contours of the network in question. Patients, psychiatrists, nurses, case workers, institutions, and, of course, psychopharmaceuticals are all Latourian "actants" in that they exert their own iterations of agency within the community mental health network—an agency which manifests as variously human and non-human, material and ideological—all with the ostensive goal of keeping Matthew and others like him stable and out of the inpatient ward. The space that the network occupies is more conceptual than actual, in this sense, in that it is emergent from the complex web of relationships between these multiple forms of agents. As Dr. Lynch's plea for compliance reveals, however, it is the *practical* engagement of patients with their psychopharmaceutical medications via adherence that produces the conditions of possibility for such a space.

According to Latour, an actant "can literally be anything provided it is granted to be the source of an action" within a network, revealing the entanglement of psychopharmaceutical chemical efficacy with patient cooperation.[47] In this sense, adherence can be understood as a Deleuzian "assemblage" of human and non-human elements under the overarching rubric of community mental health. As political philosopher Jane Bennett writes of Latour's own engagement with the concept:

> Assemblages are ad hoc groupings of diverse elements […] that are able to function despite the persistent presence of energies that confound them from within. They have uneven topographies, because some of the points at which various affects and bodies cross paths are more heavily trafficked than others, and so power is not distributed equally across its surface.[48]

Though Latour's formulation of actor-network theory is specifically designed to subvert classical philosophical distinctions between subjects and objects, especially as this distinction pertains to delimiting the potential for objects to exert a force in the world, Matthew's case nevertheless reveals an implicit hierarchy of agency within the assemblage of adherence, at least insofar as this assemblage is apprehended by and functions as a part of psychiatric discourse.

In an inversion of the Cartesian triumph of thought over matter, and to a degree that Latour himself would contest, Matthew's capacity to be recognized as a "source of action" within Dublin's community mental health network by the

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[46] Bruno Latour, *Reassembling the Social*, 132.

[47] Bruno Latour, "On Actor-Network Theory: A Few Clarifications," *Soziale Welt*, 373.

[48] Jane Bennett, *Vibrant Matter: A Political Ecology of Things*, 23-24.

majority of the system's mental health professionals is directly related to his compliance with the directive to adhere. It is not uncommon for psychiatric professionals to relegate any patient resistance to this directive to the realm of delusional, paranoid, or simply uneducated thinking with the ultimate effect of excluding it from rational conversation. Therefore, the structuring "logic" of the drug, insofar as the majority of Matthew's custodians apprehend it, remains fundamental to any practical understanding of the logic of the larger network. Even prior to his departure from the ward and re-entry into community mental healthcare, and for all his psychiatrist's apparent ambivalence, the psychotic *subject* finds himself at the mercy of the psychiatric *object*.

Matthew's debate with Dr. Lynch is exemplary for several reasons. Not only does his distaste for a long-term commitment to antipsychotic consumption reveal the extent to which adherence serves as an implicit foundation for community mental health, but the specifically religious inflection of Matthew's aversion to a drug-based treatment paradigm and the limited degree to which his psychiatrist could engage with him on the subject articulate the discursive ambit of psychiatric reason in addressing the grander, meaningful dimensions of patients' subjective experiences with psychosis, spirituality, and any admixture of the two. In short, Dr. Lynch could implore his patient to adhere to his antipsychotics but was reluctant to join him in his request for common prayer. He found other ways to attempt a deeper connection, however.

"I don't want you discussing me further when I leave," Matthew said when he finally reached the door of the consultation room, a weariness in his voice.

"Shall we listen to him?" Dr. Lynch asked the rest of us, when the door had fully closed. No one spoke.

Wordlessly, Dr. Lynch gestured to the nurse tasked with escorting patients to the consultation room for weekly rounds. She rose, followed Matthew into the hallway, and left us in our temporary quiet, halfway between reflection and reverie.

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Methodologically, I primarily situate the analytic scope of this article within the institutional space of the psychiatric inpatient unit that I call St. Dymphna's Ward. During my time at St. Dymphna's, I chiefly shadowed Dr. Domnhall Lynch's consultation team, attending team meetings for rounds and patient intake sessions. When I was not actively engaging with Dr. Lynch or his staff, I spent time with patients in the day room that functioned as the social hub of the inpatient unit. Dr. Lynch ran one of three consultation teams that staffed the ward, and his service included two psychiatric residents, a psychiatric social worker, an occupational therapist, a clinical psychologist, and two community nurses. As the director of the inpatient unit, Dr. Lynch oversaw the day-to-day workings of the ward in collaboration with the head nurse and her team of supporting nursing staff.

Patients usually came to the ward in states of phenomenal, cognitive, and relational disorganization that the clinical staff ascribed to acute psychosis,

whereupon the consultation team would work to stabilize them with a combination of psychopharmaceutical treatment, cognitive behavioral therapy, and community and skill-building exercises. The twin goals of this initial process of stabilization were to cultivate insight, or patients' capacities to recognize their disorganized experiences as manifestations of mental illness, and a concomitant commitment to adherence.[49] Psychiatrists commonly adjusted patients' psychopharmaceutical regimens over the course of their time in the ward with an eye toward ensuring more faithful adherence after discharge. If a patient returned to the ward, as a number of patients did during my time at St. Dymphna's, the clinical staff usually assumed that poor adherence was one of the primary causes for the resurgence of debilitating psychotic symptoms. Though Dr. Lynch was more than familiar with meta-analyses suggesting that the poor insight associated with psychotic spectrum disorders did not necessarily correlate to impaired antipsychotic adherence,[50] the metrical logic of adherence—its promise to both measure and contain the comparative chaos and variability of patient experience and behavior—nevertheless seemed to capture the clinical imagination of those working in the ward and Dublin's broader network of community mental health.[51] I came to understand the hospital as a space defined by profound patient experience, as well as the site of collaboration by multiple orders of clinical staff in preparing patients for discharge, in large part by working to inculcate patient commitment to extra-institutional self-governance via largely unsupervised adherence to antipsychotic medications.

St. Dymphna's Ward also emerges as a theoretical nexus in my analysis of the multifaceted nature of antipsychotic adherence by virtue of its status as a theater of crisis, clinical intervention, and epistemological contention. As one of the primary sites of the psychiatric injunction to adhere in Dublin's network of community mental health, the ward ostensibly operates under a biomedical and psychopharmacological logic within a larger health system increasingly defined by the pharmaceuticalization of clinical infrastructures.[52,53,54] The complexities of patient experience, however—and the degree to which unreality, phenomenological vicissitude, and symbolic rupture are understood to characterize the subjective state that psychiatrists frequently label "psychosis"[55,56,57]—inherently challenges

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[49] Laurence J. Kirmayer and Ellen Corin, "Inside Knowledge: Cultural Constructions of Insight and Psychosis," *Insight and Psychosis*,

[50] Ivana Marková, *Insight in Psychiatry*, 2005.

[51] Joseph Dumit, *Drugs for Life: How Pharmaceutical Companies Define Our Health*, 2012.

[52] João Biehl, "Pharmaceuticalization: AIDS Treatment and Global Health Politics," *Anthropological Quarterly* 80(4): 1083-1126.

[53] Clarke, Adele, Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman. 2003. "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine." In *American Sociological Review* 68(2.): 161-194.

[54] Tanya Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry*, New York: Vintage Books, 2000.

[55] Ellen Corin, "The 'Other' of Culture in Psychosis: The Ex-Centricity of the Subject." In *Subjectivity: Ethnographic Investigations*, edited by João Biehl, Byron Good, and Arthur Kleinman, 273-314. Oakland, CA: University of California Press, 2007.

straightforward, hegemonic understandings of psychopharmaceutically managed mental health. This is especially true given the increasing cultural and discursive diversity of Dublin's mental health system, which currently serves a heretofore-unseen population of immigrant patients and boasts a growing number of therapeutic modalities, most notably a burgeoning community of Lacanian psychoanalysts.[58]

While mainstream psychiatric discourse on the nature of adherence might appear to suggest a binary opposition between submission to and resistance against psychiatric authority, ethnographic attention to patients' relationships to antipsychotic medications reveals a complex interplay between the deployment of psychopharmaceuticals as medical technologies, extra-institutional processes of psychiatric subjectivation, and the capacity of psychotic subjectivities to articulate the horizon of a culturally mediated world.[59,60] Questions regarding clinical evidence and patient autonomy circulated freely around St. Dymphna's Ward, revealing the imbrication of clinical science and the psychiatric moral imperative of collaborative care; this collaboration ideally prioritized patient responsibility while nevertheless allowing for the primary authority of expert knowledge.[61,62,63,64] Nested within the multiple epistemologies at play in conversations between doctors and patients, however, were often-divergent models of personhood, insight, and the capacity for moral agency, as well as a host of implicit and at times largely inchoate and hotly contested claims about the nature of psychiatric facts and the identity of scientific actors. If, following work in the Sociology of Scientific Knowledge and Science and Technology Studies, questions of epistemology are necessarily questions of social order,[65,66,67] then work in Psychological Anthropology on the

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[56] Byron J. Good, Subandi, and Mary-Joe DelVecchio Good, "The Subject of Mental Illness: Psychosis, Mad Violence and Subjectivity in Indonesia." In *Subjectivity: Ethnographic Investigations*, edited by João Biehl, Byron Good, and Arthur Kleinman, 243-273, Berkeley: University of California Press, 2007.

[57] Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam*, Chicago: University of Chicago Press, 2017.

[58] Kelly, B.D. Kelly, *Hearing Voices: the History of Psychiatry in Ireland*, Newbridge, Co. Kildare: Irish Academic Press, 2016.

[59] Michel Foucault, *History of Madness*, Jonathan Murphy and Jean Khalfa, trans, Jean Khalfa, ed, Routledge: London, 2009.

[60] Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam*, Chicago: University of Chicago Press, 2017.

[61] Paul Brodwin, *Everyday Ethics: Voices from the Front Line of Community Psychiatry*, Oakland, CA: University of California Press, 2013.

[62] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life*, Oakland: University of California Press, 2014.

[63] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice*, London: Routledge, 2008.

[64] Ian Whitmarsh, "The Ascetic Subject of Compliance: The Turn Toward Chronic Diseases in Global Health," In *When People Come First: Critical Studies in Global Health*, edited by João Biehl and Adriana Petryna, Princeton: Princeton University Press, 2013.

[65] Bruno Latour, *We Have Never Been Modern*, translated by Catherine Porter, Cambridge: Harvard University Press, 1993.

intersection of subjectivity and psychosis further explores what it means to make claims to knowledge about the experience of madness, just as surely as it indexes questions of moral responsibility and care.

The institutional and conceptual diversity of Dublin's network of community mental health—to say nothing of the divergent epistemological positions taken in Dr. Lynch and Matthew's debate—mark antipsychotic adherence as a deceptively complex ethnographic boundary object in the analysis of the scientific and ethical foundations of psychiatric medicine.[68] Though the relative stability of the psychiatric definition of adherence helps to trace the deployment of psychopharmaceuticals across disparate institutional registers of the inpatient ward to the outpatient clinic and beyond, the flexibility of the practice itself acts as a diffracting lens, revealing the myriad, idiosyncratic interpretations of the daily ritual of psychopharmaceutical consumption made by patients. The anthropological examination of these multiple iterations of the practice of adherence further underscores the necessity of attending to the tensions between medical discourse and psychotic subjectivity, each a form and structure of knowledge in its own right.

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The debate between Matthew and Dr. Lynch was exemplary for several reasons. First, it reveals the direct relationship between psychiatrists' expectations of patient adherence and the likelihood of discharge to outpatient care, as well as the extent to which doctors and patients often openly acknowledged such a link. Second, Matthew's status as a frequent occupant of the ward who shared a long history with many members of the clinical staff challenged normative assumptions about institutional responsibility, while also gesturing toward the historical roots of deinstitutionalized, outpatient care as a moral goal of contemporary Irish psychiatry.

In a sense, Matthew embodied the specter of the Irish "institutional person"—he was enmeshed in local networks of community-based care, but in the narrative elaboration of his life and subjective experience, both in his poetry and in the pages of his hospital chart, "the presence of the asylum looms."[69] Indeed, Matthew spent many years as an inpatient a scant few kilometers away from St. Dymphna's Ward in one of the grand, sprawling, and now almost entirely defunct

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[66] Massimo Mazzotti, "Introduction to Knowledge as Social Order," In *Knowledge as Social Order: Rethinking the Sociology of Barry Barnes*, edited by Massimo Mazzotti, 1-13, Aldershot, England: Ashgate Press, 2008.

[67] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985.

[68] Susan Leigh Star and James R. Griesemer, "Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology," *Social Studies of Science* 19(3): 387-420, 1989.

[69] A. Jamie Saris, "Institutional Persons and Personal Institutions: The Asylum and Marginality in Rural Ireland," *Postcolonial Disorders*, page 322.

mental hospitals that defined Irish psychiatric care before the national project of deinstitutionalization that began in the late 1960s and accelerated in the 1980s.[70] Some of the older personnel on the ward had received their training at the now-shuttered asylum, and several of them had known Matthew for close to forty years. The length of this relationship and others like it often produced an especially intimate iteration of care, patients and clinicians talking and, at times, arguing like old friends. When it came to perennially non-adherent patients like Matthew, however, the clinical staff sometimes displayed or even professed a modicum of professional anxiety.

Given the largely self-directed nature of antipsychotic adherence and the implicit, ideological emphasis on patient autonomy as a clinical and moral goal of outpatient care, it was hardly surprising to hear the staff of St. Dymphna's Ward worry that they were repeating the mistakes of their professional forebears who worked in the total institutions of the past. Patients were often overmedicated by contemporary standards, and episodes of "therapeutic confinement" could span decades if not the rest of a patient's post-intake life.[71] At best, they worried that the robust, multidimensionality of the treatment they provided in St. Dymphna's might render their patients entirely dependent upon a network of institutional support and, at worst, that they might find themselves the jailors of these as yet still "institutionalized persons." Dr. Lynch, for his part, was fond of joking with patients about the potentially pathogenic nature of clinical space when negotiating the length of their stay in the ward: "You mustn't stay here for too long," he would say in mock conspiracy, "or this place will drive you mad!"

The joke never failed to inspire mirth from patients and clinicians alike, and in the collective laughter—the shared sense of self-evidence—a further elaboration of the moral imperative to outpatient care emerged. Allowing patients to become too dependent upon the institutional supports offered by inpatient care would be an affront to the remediating mission of a deinstitutionalized psychiatry and potentially undercut their capacities for self-management. Once the ward's clinical staff was able to shepherd patients out of active psychosis with a combination of pharmacological and psychosocial interventions, the team's psychiatric social worker and one of the ward's several community nurses took steps to ease their transition into outpatient care by guiding them to appropriate support agencies and community groups, as well as establishing a protocol for periodic follow up home visits. When possible, Dr. Lynch preferred to allow patients to reset their pharmaceutical regimens upon admission to St. Dymphna's and begin treatment with relatively low doses of antipsychotics to establish a threshold of efficacy in the controlled environment of the ward, but when particularly acute patients like Matthew refused their tablets the team would sometimes resort to restraining and injecting them with antipsychotic medication. This course of action was always undertaken as a last resort.

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[70] Brennan, Damien Brennan, *Irish Insanity: 1800-2000*. London: Routledge, 2014.

[71] Nancy Scheper-Hughes, *Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland.* Berkeley: University of California Press, 2001.

Sitting in Dr. Lynch's office after a day of shadowing the consultation team, I reflected on Matthew's repeated claim that the ward's nurses had assaulted him the night before when they injected him with haloperidol. "Well, of course we *did* assault him," said Dr. Lynch with more than a little regret, "but he quickly becomes a danger to himself and a source of great agitation for others when he goes too long without his medication." With a glance toward Dr. Lynch's bookshelf—replete with histories of psychiatry and philosophical and psychoanalytic treatises, as well as multiple volumes of psychiatric critique by scholars like Michel Foucault, R.D. Laing, Erving Goffman, and Gladys Swain—I wondered aloud how amenable many of his colleagues might be to discussing the disciplinary dimensions of psychopharmaceutical treatment that endured even in the aftermath of deinstitutionalization. Dr. Lynch remained circumspect, allowing that it was possible "to an extent," but that Dublin's community mental health network still largely depended upon psychopharmacological interventions. Large-scale changes would require something on the order of a Basaglian revolution, wherein patients were called upon to restructure and ultimately help to govern the institutions of care upon which they depended. Critique clearly played an important role in his own thinking about the theory and practice of contemporary psychiatry, but Dr. Lynch was realistic about the extent to which many of his colleagues might share in his appreciation of anti-psychiatric literature, and he was quick to note that, from a clinical perspective, robust institutional stop-gaps were often an important part of preventing patients from completely unraveling.

Though there was an implicit moral calculation regarding the relationship between a patient's risk of harm to themselves or others and overriding said patient's refusal of consent to be medicated, it was also clear that Dr. Lynch was nevertheless deeply ambivalent about forcibly medicating patients against their will. Such an intervention was, perhaps, too reminiscent of the authoritarian approach of the old asylums, when patients had little choice in matters of compliance.[72] When clinicians felt they could not appeal directly to patient insight, however, psychiatric and legal protocols allowing for forcible medication were grounded in the assumption that the patient in question was "incapable of functioning as a subject of

[72] I reserve the somewhat older language of compliance to indicate a more direct relationship between institutional authority and patient decisions regarding whether or not to take their medications than the one that characterizes largely self-directed and unsupervised patient decisions to adhere in the context of outpatient or community-based mental healthcare. By this definition, compliance can be located in three separate contexts: the historical context of the mental asylum as a total institution, in a highly supervised inpatient psychiatric unit, and in the contemporary context of Assertive Community Treatment. This last instance of compliance, which Paul Brodwin analyzes in his excellent book *Everyday Ethics* (2013), features near daily contact between patients and a psychiatric nurse or case manager who effectively function as agents of institutional oversight. This mode of supervision has proven relatively effective in managing psychotic mental illness per Brodwin's analysis, but it is often quite costly due to the expense involved in producing and maintaining a human infrastructure capable of supervising what is essentially a psychiatric version of directly observed therapy. In a sense, the historical transition from the language of compliance to adherence mirrors the transition from asylum-style care to the new standard of psychopharmaceutical self-governance.

choice,"[73] as well as "morally incapable of directing their own self-care."[74] It was not that the clinicians working in St. Dymphna's Ward thought their patients were intentionally shirking the moral obligation to discipline, asceticism, and self-care that increasingly defines the position of the biomedical subject,[75] but rather that a categorical feature of psychotic mental illness was the very interruption of this capacity for self-care. By this logic, psychotic mental illness would seem to decenter the patient's "locus of ethical agency,"[76] requiring the intervention of the psychiatric institution. Though patients were ostensibly free of the physical constraints of the asylum, the subjectivizing dimensions of the practice of adherence—intended to produce a return to insight—rendered the question of patient "choice" murkier than ever, linking the legibility of any attempt by patients to reclaim moral agency directly to their relationships with institutions of care.[77]

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Larger questions about patient choice regarding antipsychotic adherence outside of the inpatient ward demand a deeper analysis of the forms of psychiatric subjectivation inherent to producing a clinical model of self-care. Foucault's writings on the concept of *technē*, or the "rules and practices that allow an action to achieve its ends," help to illuminate the extent to which antipsychotic adherence can be understood as a technology of deinstitutionalization, as well as the degree to which the rules and practices involved in the routinized intake of psychopharmaceutical medication can be interpreted to produce and preserve something like the aforementioned relationship between forms of scientific knowledge and the "social order" of a community mental health network.[78] Not only does adherence emerge from a practical, anatomopolitical relationship to chemical substance, but it can also be understood to represent a daily, almost ritual commitment to what Foucault calls a "*hygieinē pragmateia*," or a "permanent framework of everyday life" that implies "a medical perception of the space and circumstances in which one live[s]."[79]

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[73] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice*, London: Routledge, 2008, page x.

[74] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life*, Oakland: University of California Press, 2014, page 43.

[75] Ian Whitmarsh, "The Ascetic Subject of Compliance: The Turn Toward Chronic Diseases in Global Health," In *When People Come First: Critical Studies in Global Health*, edited by João Biehl and Adriana Petryna, Princeton: Princeton University Press, 2013.

[76] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life*, Oakland: University of California Press, 2014, page 47.

[77] Neely Laurenzo Myers, *Recovery's Edge: An Ethnography of Mental Health Care and Moral Agency*, Nashville: Vanderbilt University Press, 2015, pages 85-86.

[78] Michel Foucault, *History of Sexuality, Volume III: the Care of the Self*, Robert Hurley, trans. New York: Vintage Books, 1986, page 15.

[79] Michel Foucault, *History of Sexuality, Volume III: the Care of the Self*, Robert Hurley, trans. New York: Vintage Books, 1986, page 101.

When the clinical staff of St. Dymphna's Ward sought to stabilize patients they had diagnosed with a psychotic spectrum disorder, they employed a combination of psychopharmaceuticals and psychosocial interventions with the intention of producing the aforementioned quality of insight—in a sense a critical distance from the delirious experience of psychosis that could serve as the basis for the extra-institutional internalization and practical enactment of a pharmacologically oriented "right disposition."[80] From a clinical perspective, this kind of psychiatric governmentality entails not so much an outright submission to psychiatric power as a participation in its propagation beyond the walls of the traditionally bounded psychiatric institution.

Giorgio Agamben's further writings on Foucault's concept of the *dispositif*, or "apparatus," are also instructive. In Agamben's analysis, the interdependence of elements that constitutes an apparatus is not only distributed and capillary in nature but also distinctly "heterogeneous" to the degree that it is composed of a combination of abstractions and concrete objects alike, all ordered in relation to one another with a "strategic function" and "at the intersection of power relations and relations of knowledge."[81] Emergent from Foucault's theorization of economic governance, the apparatus is, to some extent, "devoid of any foundation in being," in large part because it "must always imply a process of subjectification," producing subjects rather than apprehending them ready-made.[82] Even so, in his investigation of the degree to which the apparatus represents the "concretization" of historical and institutional power relations—and by way of a recourse to the etymology of the French *dispositif's* resonance with technological as well as juridical and military meanings—Agamben suggests the possibility of exploring the subjectivizing capacities of explicitly techno-scientific systems, specifically by analyzing the ways in which technological objects can ground a network of affiliations between power and knowledge.[83]

The historicity of the apparatus is that which "takes the place of universals in the Foucauldian strategy," thusly situating any potential analysis of antipsychotic adherence in Dublin's community mental health network in the sociohistorical specificity of Irish psychiatry's intellectual traditions and idiosyncratic, contemporary practice.[84] It is therefore possible to return to the concept of antipsychotic adherence as a technology of deinstitutionalization; emergent from a now-disavowed history of asylum-style mental healthcare by total institutions, the scientific and moral capacities of extra-institutional psychopharmaceutical self-care

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[80] Michel Foucault, "Governmentality," *Michel Foucault: Power*, edited by James Faubion. New York: The New York Press, 1994, page 217.

[81] Giorgio Agamben, "What Is an Apparatus?" In *What Is an Apparatus? and Other Essays*, translated by David Kishik and Stefan Pedatella. Stanford, CA: Stanford University Press, 2009, page 3.

[82] Giorgio Agamben, "What Is an Apparatus?" In *What Is an Apparatus? and Other Essays*, translated by David Kishik and Stefan Pedatella. Stanford, CA: Stanford University Press, 2009, page 11.

[83] Giorgio Agamben, "What Is an Apparatus?" In *What Is an Apparatus? and Other Essays*, translated by David Kishik and Stefan Pedatella. Stanford, CA: Stanford University Press, 2009, pages 6-7.

[84] Giorgio Agamben, "What Is an Apparatus?" In *What Is an Apparatus? and Other Essays*, translated by David Kishik and Stefan Pedatella. Stanford, CA: Stanford University Press, 2009, page 7.

define the psychiatric injunction to adhere. But what of the extent to which the life histories of specific patients, particularly patients like Matthew that returned to the ward again and again, seem to challenge the efficacy of this apparatus?

Several months after meeting Matthew, I observed a second-order commentary on the difficulties involved in measuring and enforcing outpatient adherence addressed to a group of medical students who joined Dr. Lynch's consultation team for a clinical rotation. Arriving to morning rounds only a few minutes after me, they too had walked past a line of patients queued up in front of one of the nurses' stations, waiting to receive their morning medication and looking for all the world like a shuffling, sleepy group of parishioners processing to communion.

The consultation team moved quickly, reviewing nurses' notes on patients' statuses from the prior evening and overnight shift with special attention to a patient who had only just been transferred to the ward after spending most of the night with the psychiatrist on call in the larger hospital's emergency department. A frequent visitor to St. Dymphna's, the consultation team agreed that it was less than surprising that the patient in question had returned. "Historically, we have failed to produce compliance in this individual," explained Dr. Lynch, before noting that this was one of if not the most common reason for readmission of a previous patient to the inpatient ward. "Some studies indicate that perfect adherence to a standard antibiotic regimen is as low as 50%. The fact of the matter is that it is very, very difficult—if not altogether impossible—to measure rates of adherence to all but a very few antipsychotic medications, and those require regular blood tests," said Dr. Lynch, several of the medical students' eyebrows rising in muted surprise. He went on:

> But if rates of adherence are already low for standard antibiotic treatments, for medications with comparatively minimal side effects and a drastically shorter timeline for consumption, how well do you imagine your patients will adhere when they're asked to take antipsychotics for at least the foreseeable future, and to endure all the attendant side effects indefinitely? We must also ask ourselves: why should patients adhere? Is it possible that they have perfectly good reasons not to do so?

Dr. Lynch laughed wryly when I later noted that he had attributed the failure to adhere to antipsychotics not only to the harshness of the medications in question, but also to the imponderabilia of patients' lives—not as a function of ignorance or as an outgrowth of epistemological error but as a potentially reasonable and rational position. What was it, I wondered, to prescribe psychotropic medication while reckoning with the nebulous status of the adherent subject? Could I indeed think and write about a psychiatric *dispositif* designed to produce antipsychotic adherence via multifarious processes of subjectivation when psychiatrists themselves were only cautiously optimistic about the success of their endeavors to rehabilitate their sickest patients?

Ultimately, I was missing the point, Dr. Lynch explained. The challenge, as he understood it, was to support patients regardless of the degree of their fidelity to the psychiatric injunction to adhere with a form of engaged community psychiatry that did not presume perfect compliance with a pharmaceutical regimen. Such a position with respect to care required clinicians to understand that periodic returns to the inpatient ward were a potentially unavoidable side effect of patients' illnesses and their respective degrees of economic and social precarity. He continued:

> When a patient tells me that they'll take their medication after discharge, I generally believe that they mean what they say…that they mean that they'll take the medication in the moment that they make the promise. But I also think that patients generally don't accord as much importance to the medication as we clinicians do. I think they accord a lot more importance to other circumstances, like do they have money and food or friends…do they have a place to stay? We are bit players in these patients' lives, for the most part. An hour or a day after they leave the hospital, events may unfold that drastically outweigh the events that take place within the hospital.

In this sense, I came to think of Dr. Lynch's commitment to psychiatric social medicine as a form of mental health harm reduction, as well as a rejection of deeply-rooted biomedical assumptions about patients' capacities for moral agency within a restrictive medical model of self-care. If the project of antipsychotic adherence both relied upon and reproduced a narrow, psychiatric interpretation of insight, Dr. Lynch's agnosticism with respect to the tenability of definitive psychiatric data about his patients' reasons for taking or not taking their medication opened the possibility of pursuing care that was truly collaborative.

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Dr. Lynch's skepticism regarding the measurement of adherence ran deeper than I first realized, extending to a posture of critical distance from some of the most fundamental orders of psychiatric knowledge production about antipsychotic medications as objects of scientific knowledge. By prioritizing a patient-centered clinical practice, he was able to make space for a more systemic critical analysis of the apparatus of adherence, its relationship to the formalization of diagnosis and prescription, and as a practice meant to re-inscribe a mental health patient within a normative discourse of self-knowledge and moral agency.

Prior to any attempt to inculcate the biopsychiatric logic of adherence in their patients' modes of self-care, the staff of St. Dymphna's Ward grounded their clinical decisions regarding psychopharmaceutical prescriptions in multiple, distributed orders of scientific authority. Through implicit and, at times, explicit reference to diagnostic and pharmacological resources like the *International*

Classification of Disease, the *Diagnostic and Statistical Manual of Mental Disorders*, and the Irish edition of the *Monthly Index of Medical Specialities*, the ward's clinical staff relied upon these texts as a form of "social" and "literary technology" providing "conventions of social relations" within psychiatric discourse and practice while also allowing for a "virtual witnessing" of the complex, experimental processes involved in the clinical trials for psychopharmaceutical medications.[85] An example of what sociologists of scientific knowledge might call an archive of epistemological authority, the *ICD*, *DSM*, and *MIMS Ireland* all function as contemporary psychiatric forms of an "objectifying resource" in that they render "the [experimental] production of knowledge visible as a collective enterprise," collapsing the "public space" of the laboratory with the clinical space of the inpatient ward, and ratifying the ward staff's membership in an epistemological community in the process.[86] Drawing upon this archive, the ward staff could fold experimentally verified claims about antipsychotic efficacy into their clinical commands to adhere, thereby grounding clinical expectations of patients' moral duty to self-care in biopsychiatric models of agency and personhood.

Somewhat surprisingly, and echoing historic debates on the nature of scientific knowledge production and authority, Dr. Lynch professed a measure of skepticism regarding the objectivity of the experimental procedures that ostensibly provided the scientific basis for his practice in the ward and beyond. Following a host of work in medical anthropology and medical history investigating the historical co-constitution of psychiatric diagnostic standardization and early clinical trials, and as a student of psychiatric history himself, he was familiar with the circularity of the relationship between experimental measurements of the efficacy of older generations of psychopharmaceuticals and the specificity of the symptom clusters and diagnostic categories that they were hypothesized to treat.[87,88,89] In addition to acknowledging the degree to which scientific data is socially constructed, while also appreciating that this nevertheless does not affect the socially relevant facticity of the trials to the broader psychiatric community, Dr. Lynch was also more than willing to point toward the practical limits of antipsychotic efficacy as such.

The first impassioned indication of these limits came roughly halfway through my time as an observer at St. Dymphna's Ward. Arriving late in the day for a patient interview, I found Dr. Lynch concluding a particularly intense consultation with a non-compliant, floridly psychotic patient. He leaned against the wall of the

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[85] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985, page 77.

[86] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985, page 78.

[87] Tanya Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry*. New York: Vintage Books, 2000.

[88] David Healy, *The Creation of Psychopharmacology*. Cambridge: Harvard University Press, 2002.

[89] Andrew Lakoff, *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry*. Cambridge: Cambridge University Press, 2005.

ward's main corridor as if to catch his breath, massaging his temples with his fingertips. The ward's clinical staff had worked with the man several times before, patiently attempting to find the right combination of psychopharmaceuticals and psychosocial engagements to establish a basis for outpatient adherence, but all parties involved were at a loss. When I asked what had gone wrong, Dr. Lynch shrugged and said, "A whole host of things. A number of barriers to the patient's adherence have emerged." With a weary reference to further statistics regarding the limited and at times waning efficacy of even second generation, atypical antipsychotics,[90,91] he continued, "Sometimes it's also the case that these medications quite simply do not work in the way we believe they will."

Later in the day, I was still troubled by specter of antipsychotic inefficacy when Dr. Lynch and I retired to his office for a restorative cup of tea. Potentially attributable to the vagaries of patient adherence, but also potentially attributable to the murky standards of experimental reproduction in clinical trials, the locus of the medication's failure seemed impossible to isolate. Again ensconced among the critical histories and case studies that dominated Dr. Lynch's office, I asked him for his thoughts on a controversial new publication in the *British Journal of Psychiatry*. The article in question was called "Psychiatry Beyond the Current Paradigm," and it was written by a group of Irish and British clinicians, lead by an Irish psychiatrist and activist named Dr. Patrick Bracken who was based several counties away in the city of Cork. Largely touted as a pre-emptive call for a new commitment to psychiatry-as-social medicine prior to the publication of the *DSM-5* in the following spring, Bracken et al use unequivocally Kuhnian language to critique the "epistemological paradigm" of contemporary biopsychiatry, especially the overinvestment in neuroscience and technological innovations such as brain imaging, which they argue has lead to the neglect of basic standards of clinical care. Moreover, the article cites numerous studies directly questioning the chemical efficacy of antipsychotic medications, studies that also suggest a link between antipsychotic prescription and serious forms of iatrogenic injury, increased cardiovascular risk chief among them.[92]

Dr. Lynch tempered his criticisms of the pharmacological paradigm, at times quite sharp, with rhetorical diplomacy. He found antipsychotic medications to be a potent tool for clinical interventions, but while he was more than capable of rattling off a cascade of official statistics regarding pharmaceutical efficacy, he nevertheless remained skeptical regarding the objectivity of these statistics:

> Drug companies do not exist—or conduct their scientific investigations—to access Eternal Truth. They exist to make money for their stockholders. In fairness to drug companies, they're pretty open about that. It's up to us to monitor how

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[90] APA, American Psychiatric Association, "Practice Guidelines for the Treatment of Patients with Schizophrenia," *American Journal of Psychiatry* 16(1): 1-56, 2004.

[91] Neely Laurenzo Myers, *Recovery's Edge: An Ethnography of Mental Health Care and Moral Agency*, Nashville: Vanderbilt University Press, 2015, page 79.

[92] Pat Bracken, et al, "Psychiatry Beyond the Current Paradigm," *The British Journal of Psychiatry* 201: 430-434, 2012.

> patients respond to their medications and to exercise our critical faculties.

In a sense, Dr. Lynch seemed to straddle both of the epistemological positions classically espoused by Boyle and Hobbes in their debate about the nature of scientific knowledge production.[93] He relied upon experimental science for the standardization of clinical practice required to do his job, but he was suspicious of the naturalized assumptions, propagated by literary and social technologies and embodied in technological artifacts, that so often served as the formal basis for this experimental scientific work.[94]

Dr. Lynch's capacity to straddle the epistemological positions represented in the debate between Robert Boyle and Thomas Hobbes following the former's attempts to formalize the contemporary scientific method speaks to larger questions regarding experimentally verifiable truth and the formal concerns of natural philosophy within the sociology of scientific knowledge and in medical and psychological anthropology. Shapin and Schaffer chronicle the antagonistic relationship between these two respective positions, namely the former tradition's capacity to produce epistemological community and the latter's capacity to reveal the extent to which ostensibly objective facts are socially constructed.[95]

As a result, Dr. Lynch often engaged other members of the clinical staff on his service in a virtually Socratic form of dialogue, challenging straightforward interpretations of patients' responses to medication and cautioning that a responsible clinician should proceed from a position of nescience, both with respect to what could hypothetically be known about an individual patient's brain chemistry as well as with respect to the nuances of the relationship between this neurochemistry and a given patient's life. Not only did such assumptions serve as the conditions of possibility for clinical trials within a biopsychiatric scientific paradigm, they could also come to stand in for uncontested facts during the day-to-day activities of the ward. Though Dr. Lynch always consulted clinical texts, he was adamant in acknowledging the limits of their usefulness. "The moment I give the patient the tablet, all of the drug trials become irrelevant," he said. "Once I've made the decision to prescribe, the only trial that matters is how the patient gets on. Trials inform me to the point of prescription, but not beyond. To some degree we have to wait and see which drug the patient responds to, and that is impossible to predict with perfect precision." With this simple statement, Dr. Lynch articulated a deep clinical ambivalence regarding the capacity of the psychopharmaceutical-as-psychiatric technology to stand in for something like experimentally verified objective fact—the imbrication of this ambivalence with an enduring moral

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[93] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985.

[94] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985, pages 112.

[95] Steven Shapin and Simon Schaffer, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton: Princeton University Press, 1985.

obligation to care for patients emerged as an aporia at the heart of the psychiatric endeavor.

When I asked him if there was a scientific ethics inherent to such a rhetorical posture, he spoke at length about the necessity of humility in the face of uncertainty, especially when practicing clinical psychopharmacology:

> Genetic and neuroscientific advances are incredibly important in increasing our understanding of mental health, but the magnitude of the advances in genetic screening and brain imaging and all sorts of other technological innovations are *tiny* in comparison to what we still don't know. We have billions of neurons in our brains, all communicating with one another, and it's all vastly more complex than we understand even when dealing with a so-called "normal" brain. Now if we are dealing with people who can be clinically determined to be in distress because of abnormal behavior or turbulent emotions, or perhaps we're labeling them "mentally ill"…then we have to presume that something has changed, at least to an extent, in this incredibly complicated organ that we don't fully understand, but now we probably understand even *less*. The scientific explanation that is given [in the context of clinical trials for antipsychotics]—that there's an abnormality of levels of dopamine in a particular area of the brain, and this fully accounts for psychotic symptoms—that doesn't hold water with me.

The frankness with which Dr. Lynch spoke about the circulation of piecemeal, easily-regurgitated experimental science in the context of the clinic could be disarming, no less because he seemed to be flouting the very epistemological basis for the more disciplinary dimensions of psychiatric practice. His penchant for eschewing the easy position of "arguing from authority" and instead readily opening the "black box" of discipline-specific jargon when dealing with a non-clinician was, by his own admission, unusual.[96] As a result, Dr. Lynch did not shy away from acknowledging the limits of experimental knowledge about the tools of his trade, regardless of whether or not he was speaking with patients, other clinicians, or even an observing social scientist.

Analytically speaking, a plurality of Latourian actors enters the scene. Some are human, like the staff of the ward and the patients they serve; some are institutional, like the very setting of the hospital, the outpatient clinic, and the community mental health group; and some are non-human objects, like the medications themselves. All are defined by their capacity to produce "a movement, a displacement, a transformation, a translation, an enrollment" in relation to one

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[96] Bruno Latour, *Science in Action: How to Follow Scientists and Engineers Through Society*, Cambridge: Harvard University Press, 1987.

another, each with their particular attendant brand of force.[97] A doctor could influence a patient's likelihood to adhere, but so could an eviction or a reunion, a requiem or the pills themselves. So could the voice of God. In an effort to appreciate the complexity of patients' experiences, Dr. Lynch and the other clinicians at St. Dymphna's Ward sometimes appeared to be pushing the limits of epistemological openness, experimenting with a distinctly reflexive mode of thought in the process.

As such, the stability of the antipsychotic-as-scientific-object, emergent from careful, objective experimentation never seemed more uncertain. Uncoupled from its putative epistemological origin, this object seemed to command a force all its own, pushing back against and, to some degree, helping to structure the forces by which it was also constituted. Struck by the subtlety of this response, I returned to Dr. Lynch's earlier statement regarding the importance of integrating patients into larger networks of support so as to ease their transition from inpatient to outpatient care. I wondered aloud: would the multifarious nature of this extra-institutional landscape, defined as much by its curiously agential technological objects as by its epistemological and organizational heterogeneity, constitute another order of the complexity of which he spoke? Dr. Lynch leaned back in his chair and laughed ruefully. This was, of course, the space of crisis and uncertainty in which so many of his patients lived their lives.

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Bernadette was already weeping when I entered the consultation room for morning rounds, her face contorted with pain. "I want to try and stop taking overdoses, Dr. Lynch, I really do," she gasped. "I don't know why I do it. I think it all just gets to be too much."

I shifted uncomfortably in my seat, overwhelmed by the palpable sense of her suffering. Taking in the rest of the consultation team, I could see that they received the outpouring of grief with an air that I could only describe as compassionate stoicism. Like Matthew, Bernadette was a recurrent patient of St. Dymphna's Ward, and her story was a familiar one. A slight woman in early middle age, she was one of the patients who frequently came to the ward requesting what the staff called a "respite"—essentially time away from chaotic or overwhelming circumstances and experiences, some psychological and some distinctly social. Diagnosed with bipolar disorder and burdened with an unstable home life, she frequently checked herself into the ward after or sometimes in lieu of a suicide attempt, usually in response to a dispute with her boyfriend or one of her children. In this case, a series of bereavements and a fight with her eldest daughter about the gift she'd given her grandson for his First Holy Communion lead her to attempt an overdose. When she woke in the morning to find herself still alive, she presented at the hospital's emergency room and was checked into St. Dymphna's Ward.

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[97] Bruno Latour, *Reassembling the Social: An Introduction to Actor-Network-Theory*, Oxford: Oxford University Press, 2005.

A review of Bernadette's medications revealed a dizzying assortment of antidepressants, benzodiazepines, other hypnotic sleep aids, and antipsychotics. Bernadette herself seemed to be of two minds regarding the intensity of her psychopharmaceutical regimen. While she doubted the long-term efficacy of her treatment enough to suggest electro-convulsive therapy (she was friends with another patient on the ward who was midway through the customary 6 weeks of treatment and appeared to be responding strikingly well), she recoiled when Dr. Lynch offered her the opportunity to wean herself off of the majority of her medications and experiment with lower doses under the direct supervision of the ward staff. He was particularly worried, he explained, about the 5 milligrams of diazepam that she took thrice daily and the 15 milligrams of zopiclone she took at night. He found the addicting qualities of benzodiazepines and hypnotic sleep aids even more worrisome when paired with the 45 milligrams of the antidepressant mirtazapine and 30 milligrams of the typical antipsychotic clopixol that she took in three doses of 10 milligrams over the course of a day.

"But I need *some*thing, Dr. Lynch," she said, aghast. "If you take me off of the tablets…I…you might as well get a box ready for me."

Bernadette was still fiercely opposed to any reduction to the dosages of her medications when I spoke to her later in the day. Tugging at the neckline of her terrycloth bathrobe, she apologized for the informality of her attire, explaining that she had packed only the essentials when she left her home for the emergency room. She had regained her composure in the several hours since morning rounds, but she was still visibly unhappy and wept intermittently throughout the interview that followed.

The antidepressant was all that elevated her mood above a constant state of suicidality, she explained, and the antipsychotic held racing, intrusive, and morbid thoughts at bay. The benzodiazepine and hypnotic sleep aid, in turn, calmed her down and prevented surges of panic that threatened to incapacitate her during the day and kept her up at night. She seemed genuinely frightened by the prospect of a dwindling pharmacopoeia, but lingering doubts regarding the efficacy of her medications nonetheless remained. When I asked if she knew why she had been prescribed an older generation of a drug like clopixol when so many of the newer, atypical antipsychotics were available and found to produce fewer side effects, she claimed that she regularly appealed to her doctors to try new antidepressant and antipsychotic medications because they began to stop working after several months. She had tried the others, she said, until she couldn't bear the steady escalation of intrusive thoughts about calamity and death or the swelling inclination to swallow all of her pills.

It was also possible, she mused, that the dosage was simply too low for her to experience the actual effects of the drugs she consumed. So finely tuned was Bernadette's self-professed sensitivity to the psychoactive effects of her antipsychotic that she claimed to have an embodied sense of when it was time for her next dose.

"It's like my body is detoxing from the medications," she explained.

"Why do you use the language of 'toxicity'?" I asked tentatively.

"Because me moods return when the tablets wear off," she answered. "I can feel them leaving my body."

After some hesitation, I pushed forward: "Do you think your doctors are wary of prescribing higher dosages because you've previously used your medications to attempt suicide?"

"I'm so tired of people worrying I'm on too much," she retorted. "My doctors, my family. Fuck them, honestly. It's my pain, it's my depression—not theirs."

"Why do you use your psychotropic medications, specifically, when you overdose?" I pressed.

"Because I won't feel any pain," she answered, grimacing.

Dr. Lynch was clearly troubled when we departed St. Dymphna's an hour or so later. We walked slowly from the ward to the hospital cantina, comparing notes in hushed voices. "At what point do the medications themselves become the symptom of a larger disorder?" I asked.[98] He shook his head sadly.

Polypharmacy was common among patients of St. Dymphna's Ward, but this case was deeply troubling to the clinical staff. Bernadette's pain was unmistakable, and the risks she posed to herself were considerable, but Dr. Lynch and the rest of the consultation team were also necessarily vigilant for signs of incipient addiction and drug-seeking behavior, especially given the ongoing crisis in opioid addiction that beset Dublin and much of the rest of Ireland. Bernadette had checked herself into the ward, however, so she was a voluntary patient, which limited Dr. Lynch's capacity to intervene short of involuntarily detaining her. At my request, he weighed his options over a cup of tea. Did he lower the dosage of her medications without her consent and risk her leaving the ward and seeking out another nearby doctor who prescribed with a heavier hand—or, worse yet, chance her making another attempt on her own life?—or did he grant her the respite that she was requesting, try to establish a more regular clinical relationship with her via the outpatient clinic, and tactfully direct her toward extramural resources for addiction prevention? Though the distributed, multi-sited nature of the community mental health network was indeed a mark of its sophistication by the very standards of the deinstitutionalized psychiatry that many of the ward staff sought to practice, the multiple points of patient contact with a prescribing clinician also revealed a new

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[98] I am indebted here to multiple scholars (Jacques Derrida, João Biehl, and A. Jamie Saris, in particular) who think and write on the notion of the *pharmakon*, as well as to Dr. Bruno Biagianti—a psychiatrist, clinical researcher, and psychoanalyst—who introduced me to the Italian concept of *tossicophilia*. In their respective works, Derrida (1981), Biehl (2005), and Saris (2013) explore the ambiguous doubling of poison and cure within a single entity (and, by extension, it's symbolic capacities), as well as the proliferation of substances that produce both the possibility of danger and care in a contemporary psychiatric context increasingly defined by polypharmacy and diagnostic co-morbidity. In conversation with Dr. Biagianti, I have come to appreciate the usefulness of the concept of *tossicophilia*—the persistent desire for an altered state of consciousness, if not outright intoxication—when exploring patients' implicitly and explicitly stated desire to achieve a state of chemically mediated subjectivity. This concept is especially useful for thinking with patients who live in the penumbra between institutionally mediated forms of treatment and self-medicating or addicted relationships to nominally curative substance, further revealing the reach of the negative dimensions of the *pharmakon* into otherwise "legitimate" forms of treatment and care.

order of risk to patients within a clinical infrastructure defined by the logic of pharmaceuticalization.

Was it possible, I speculated, to think about the potentially addicting chemical agencies of Bernadette's psychotropic medications in continuity with larger questions regarding the socio-behavioral valence of psychiatric interventions oriented toward producing adherence? Following Saris's observation that patients' capacities to exercise a critical will are only medically and legally discernible when considered in relation to the drugs, both licit and illicit, that produce or undermine a pharmaceutically mediated engagement with choice,[99] I asked: did adherence and addiction exist on the same spectrum of patients' relationships to their medications? Regardless of the *intended* effects of the medications in question, Bernadette and patients like her often claimed to be adept at discerning their embodied effects and experimenting with how best to control them. Their pursuits unsettle normative psychiatric assumptions regarding distinctions between these intended medicinal effects and potentially dangerous or addicting *side* effects, as well as the aforementioned assumption that adherence exists as a binary between unsupervised compliance with and resistance to medical authority.[100] This experimentation was potentially dangerous, of course, but the only metric for adjudicating such a risk was its deviation from the authority of psychiatric prescription. Dr. Lynch murmured an assent into his tea.

"Consider Theresa," Dr. Lynch offered, referring to a patient who'd come to the ward several weeks prior. "She's previously presented to the emergency department with acute alcohol withdrawal, but her psychiatric comorbidities make treating her substance abuse much, much more complicated than would be a simple case of delirium tremens. Her most recent admission, of course, was also for an overdose of the medications we want her to take in well-regulated, daily doses."

Previously diagnosed with bipolar disorder and major depressive disorder, Theresa was a demure woman in her late fifties who seemed almost embarrassed to be back at St. Dymphna's Ward. An alcoholic since her early twenties, she shared Bernadette's experience of fluctuating psychotropic efficacy, though she also acknowledged that her episodic binge-drinking often lead her to forget to take her tablets, complicating her ability to distinguish between disruptions to her medicinal routine and the potentially waning effects of the drugs themselves. Her early years of heavy drinking were potentially an attempt at self-medication, she reflected, but she had badly damaged her liver in the process, and each relapse was more dangerous than the last. When I asked her to try and determine which came first—the treatment resistant depressive episodes that lead her to doubt her medication and begin to drink or the cravings for vodka that made her forget her tablets and lead to further mood disregulation—she shook her head helplessly. One thing was certain, she noted: the antipsychotic and hypnotic sleep aid she took at night often

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[99] A. Jamie Saris, "The Addicted Self and the Pharmaceutical Self: Ecologies of Will, Information, and Power in Junkies, Addicts, and Patients," *Pharmaceutical Self: the Global Shaping of Experience in an Age of Psychopharmacology*, 2010.

[100] *cf*., Eugene Raikhel and William Garriott (2013), A. Jamie Saris (2013), Angela Garcia (2010), and Emilie Gomart (2002).

drifted perilously close to the obliterating effects of alcohol. Strikingly, a respite at St. Dymphna's Ward seemed to assuage the creeping anxiety that she was abusing her medications.

"I'm on the olanzapine and a couple sleepers when I'm outside," she explained, "and on a bad day I can't wait for it to be ten at night so I can take the sleepers and blot it all out. It's almost like an addiction itself."

"But you don't worry about that here?" I queried. "You're on a relatively similar dose of the medications when you stay in the ward, no?"

"Yes, but here…when I'm here—it takes me out of the picture, and I can focus on healing," she clarified.

Dr. Lynch echoed Theresa's analysis. He believed that she had every intention of avoiding alcohol and continuing to take her medications as prescribed, but he feared the extent to which even slight deviations in her routine could produce a cascading effect of disorder and, eventually, crisis.

"Theresa doesn't simply wake up one day and decide to forego her antipsychotics and pick up a bottle," he said. He continued:

> Nor does she suddenly arrive at a breaking point and swallow all of her medications. Difficult circumstances define her living situation. She also makes innumerable, tiny decisions over the days and weeks and months of her life, and ultimately—together—they may lead to her death if we are unable to intervene and prevent it. But it seems to be a cumulative process when we examine it with respect to the substances she abuses and the substances we prescribe. It is never black and white.

One thing was certain, Dr. Lynch acknowledged, downing the dregs of his cup—like Theresa and Matthew before her, Bernadette would be discharged soon, but they would all likely return to the ward in due time. In fact, it seemed like an inevitability.

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I was still pondering the uneasy relationship between the deinstitutionalized aims of Dublin's community mental health network and Dr. Lynch's clinical discomfort with the structural and conceptual primacy of the pharmaceutical when Bernadette left the ward a week later. In the end, Dr. Lynch had lowered the dosage of her benzodiazepine and hypnotic sleep aid and offered her more regular sessions with his consultation team's psychotherapist, but the nurses soon discovered that Bernadette's family members were smuggling her anxiolytics during visitation hours. To Dr. Lynch's disappointment, she did not respond well to the intervention that followed and discharged herself shortly thereafter.

Collective efforts to think beyond the psychopharmaceutical paradigm were no less fraught. Despite the appeal by Bracken, et al to reconsider the hegemony of

biomedical approaches to mental health—and despite Dr. Lynch's own skepticism regarding psychopharmaceutical efficacy, much less his patients' capacities to cultivate a form of "right disposition" in relation to their medications—the practical and theoretical gravity of the tablet were undeniable and profound. The psychopharmaceutical remains a nonhuman actant of manifold influence and surprising resilience. As the material substratum upon which the apparatus of adherence rests, it is the concretization of the biopsychiatric epistemology that makes extra-institutional mental healthcare possible.

That the clinical staff of St. Dymphna's Ward, and to some degree even their patients, were at least partially aware of the degree to which this epistemological concretization was scientifically constructed and institutionally mediated did little to dull its power. At times, I found myself mentally rehearsing a Latourian dialogue between fact-driven "Moderns" and the fetishists whom they accuse of fabricating an object of worship and then "being mistaken about the origin of the power in question."[101] The difficulty, in fact, lay not in engaging with the theoretical inversions of Latour's formulae, but in attempting to mark out a clear position for the doctors, patients, and finally the anthropologists who participated in the ongoing debate. Was the patient who refuted the efficacy of her antipsychotics based on decades of embodied intuition more or less of an empiricist than the doctors who prescribed the drugs in question despite increasingly inconclusive data regarding positive pharmaceutical outcomes? Or were the prescribing psychiatrists more or less fetishistic than the patients who favored prayer as a road to recovery? What of the place of addiction and the putative misuse of psychopharmaceuticals as inhuman actors within a larger network of power and knowledge? Ultimately, it might not matter. Belief in the practical utility of the medications as explicitly *social* actors, tinged as it was with a skepticism informed by the rhetorical tension between "constructivism and realism," afforded clinicians like Dr. Lynch the capacity to occupy both positions. On the one hand, he could reject universal and universalizing claims to pharmaceutical potency from a position of empirically derived knowledge; on the other hand, he could "calmly assert," much like the Latourian fetishists when confronted with charges of fabulation, that he and his colleagues "were building something that went beyond them."[102]

Such an engagement with the practical utility of psychopharmaceuticals as scientific artifacts, following Latour, often reveals the "clandestine wisdom of the passage that stubbornly maintains […] that construction and reality are synonymous."[103] In the hands of a practitioner who invites patients like Matthew to contemplate both divine *and* material agency, however, it is also an invitation to a uniquely pluralistic approach to mental healthcare. In his refusal to oppose the efficacy of medication to Matthew's belief in divine intervention, Dr. Lynch suggests the possibility of understanding pharmaceutical potency via a reflexive and ultimately demystifying engagement with the figure of the Latourian "factish." In such a way, the factish is less an emblem of modern hypocrisy regarding the socially

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[101] Bruno Latour, *On the Modern Cult of the Factish Gods*, 8.

[102] Bruno Latour, *On the Modern Cult of the Factish Gods*, 16.

[103] Bruno Latour, *On the Modern Cult of the Factish Gods*, 24.

constructed status of scientific facts than a supple conceptual posture, resembling an anthropological attempt at something like transubstantiation. It simultaneously "allows for the truth of facts and the truth of minds" by permitting the "robust certainty that allows practice to pass into action without the practitioner ever believing in the difference between construction and reality, immanence and transcendence."[104] The psychopharmaceutical-as-factish both emerges from human ingenuity while remaining partially beyond it, is both abstract and concrete, and is at once deeply socially constructed and disarming in its capacity to act on and to structure social relations with an inhuman force. Further, in the hands of practitioners like Dr. Lynch who acknowledge this dual force, it is efficacious precisely *because* it undoes easy distinctions between the interiority of subjects and the externality of objects.[105]

Though the agency of the pharmaceutical-as-object is something of a given within the discipline of psychiatry, the intensity of this dual force—both epistemological and material—can also put patients at risk. In fact, the injunction to adhere almost uniformly carries more institutional weight than the preferences and subjective experiences of patients; in this sense, the psychiatric subject is always already at the mercy of the object. With his attention to the ambiguities of medicinal efficacy, as well as the imponderabilia of his patients' lives, it is tempting to think of Dr. Lynch's more philosophical meditations as part of a larger project to provincialize the psychopharmaceutical within the broader discourse of psychiatry. His challenges to the hegemonic status of psychopharmacological knowledge are many and varied—both direct, via his avowed skepticism, and indirect, via his appreciation for the multiple orders of truth claims embedded in his patients' testimonies. Most significantly, these challenges seem to explicitly target the capacity of psychopharmaceuticals, like Boyle's air pump before them, to "create a natural philosophical discourse" that renders questions of patients' experience and interiority "inadmissible" to a larger conversation driven by experimental procedures patterned after Boyle's own scientific method.[106] Despite the pluralistic thinking that informed his practice in St. Dymphna's Ward, Dr. Lynch himself was quick to point out the limits to his efforts. He still worked within a heavily pharmaceuticalized system of mental health. Matters of "metaphysical" speculation, from the possibility of a perfect void to the structure and vicissitudes of patients' subjectivities, remain unaddressed in such a scientific social order when unchallenged.

Many such questions remained. Among them: what are the natures of the subjectivities in question, and what is their relationship to the institutional and scientific social order that is contemporary psychiatry? Following Foucault and Agamben, what is the nature of the subject prior to its apprehension by the apparatus of adherence, and how do the conditions of this subject's formation influence the nature of its relationship to this apparatus? Thinking beyond the biopsychiatric and psychopharmaceutical paradigm, how might anthropologists

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[104] Bruno Latour, *On the Modern Cult of the Factish Gods*, 21-22.

[105] Bruno Latour, *On the Modern Cult of the Factish Gods*, 39.

[106] Shapin and Schaffer, *Leviathan and the Air-Pump*, 46.

understand these subjectivities otherwise and on their own terms? What were patients, psychiatrists, and anthropologists to make of "crazy poems" and the presence of God in the psychiatric mise en scène?

Chapter 3: "All of this is the Body of Christ": Antipsychosis and Psychiatric Méconnaissance

> A certificate tells me that I was born. I repudiate this certificate: I am not a poet, but a poem. A poem that is being written, even if it looks like a subject.
> -Jacques Lacan, *The Four Fundamental Concepts of Psychoanalysis, viii.*

Grinning, Paul offered me a drink some five minutes into our first conversation. Taking a deep pull from the plastic cup of water he had been nursing since the beginning of the interview, he set the remainder down on the ward room's table, precariously close to my recorder. Somewhat disarmed, I answered his kindness with a laugh and—hoping to split the difference between the subversive absurdity of Irish humor and potential delusions of transfiguration—attempted a Dublin deadpan, understated and sardonic. "Oh absolutely," I returned. "I'd love one." The cup sat, untouched, between us.

A thin man in his early thirties with a history of bipolar disorder featuring manic psychosis, Paul lived in a flat near the Four Courts, roughly a kilometer and a half from St. Dymphna's ward and only a few blocks from the banks of the River Liffey. He primarily worked as a sound engineer and part-time computer programmer but talked openly about his experimentation with psychotropics and interest in psychotherapy and mental healthcare. Provocative and witty, Paul frequently confounded the expectations of the ward staff. He was as likely to make them laugh as he was to slyly challenge their authority. He objected to the language of "suffering" so often associated with mental illness but was amenable to being medicated. His favorite antipsychotic was Largactil,[107] he volunteered, and he enjoyed the taste.

Several hours earlier, when the admitting psychiatrist asked why he had walked into the Bridewell Garda Station on the previous morning and asked the officers on duty to take him into custody, Paul cited a profound moment of epiphany. He had been granted special insights into the nature of time and space by mysterious, extra-dimensional entities—a host of inhuman presences that had spoken to him, inhabited his body, and shown him that he was struggling with something akin to poly-substance addiction. He had gone to the station, dressed only in a bed sheet, to begin the process of detoxing, he explained. When I asked him what he was addicted to, hoping to piece together the progression of the acute, drug-induced psychosis that had precipitated his presentation at St. Dymphna's Ward, he replied: "I'm addicted to alcohol, to marijuana, to water, to air."

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[107] Largactil, sometimes also called Thorazine, is one of the trade names of the first-generation, typical antipsychotic called Chlorpromazine.

I pressed on, curious to hear his thoughts on the psychotropic medications that the ward staff was using to stabilize him, and he rattled off another list: olanzapine, lorazepam, procyclidine, and liquid haloperidol. Tugging at the baggy, blue sweatshirt that the gardai had loaned him, he reported that he would be happy to adhere to the drugs he had been prescribed upon his eventual discharge. He had weathered several psychotic episodes before, he explained, and he was open to the idea that medication could help. Beyond help, he was particularly intrigued by the notion of experimenting with the various effects of the drugs in question. Still smiling, he explained that he had been chewing up his tablets and gargling with the liquid haloperidol when his antipsychotics were dispensed in the morning because he wanted to taste the medication and chart its immediate effects as he absorbed it through his gums and tongue.

Such a frank attempt to grapple with the materiality of antipsychosis was striking, to say nothing of the extent to which Paul insisted upon framing his engagement with this materiality as a process of experimentation. Even more significant was the degree to which such a framing stages Paul's embodied subjectivity as a laboratory for this experimentation, collapsing the institutional categories of patient, clinician, and researcher into a point of experiential singularity. I wrote in my notebook: *He is much less agitated than he was during morning rounds. His speech isn't quite as rapid, and his eyes aren't quite as wide. The problem of commensurability, of language, remains…how to adequate this experience to something mutually intelligible to a psychiatrist, to an ethnographer?*

"What does haloperidol taste like?" I asked, imagining something acrid and chemical as he drained the rest of the liquid from the plastic cup.

"It tastes like order," he answered blithely, a shimmering inversion of subject and object taking shape in his words.[108]

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Paul posed a special kind of challenge to the discourse surrounding antipsychotic adherence in St. Dymphna's Ward and the psychiatric social order that it both produced and described. He cooperated with the pharmaceutical treatment prescribed by his doctors, but his strange ideas about the qualia of his medications seemed to fall squarely within the realm of what psychiatrists would call delusional ideation, and the unusual ways in which he took his psychotropics often shocked or outright horrified the nurses who dispensed them. He accepted the opinion of the clinical staff that he was in the grips of an acute psychotic episode, but he refused any language that might indicate pathology, crisis, or "breakdown." Winking, he suggested that he was instead experiencing a "chug-along." Was it possible to call such an enthusiastic consumption of antipsychotics "adherence," or did Paul wrest something of the juridical power inherent to the practice from the institution of

[108] Gaston Bachelard, *The Poetics of Space*, *xix*.

psychiatry—producing a form of moral experimentation following Mattingly[109]—by virtue of the "delusional" character of his conception of the medications in question? Did this medicinal *méconnaissance* reject or transform the logic of biomedicine?

These questions were already circulating several hours earlier, prior to Paul's formal introduction to Dr. Lynch and the rest of his team during morning rounds. The nurse overseeing his care reported that the Gardai had delivered Paul to the hospital's emergency room the evening before amid talk of alien contact and chemical dependency, whereupon he was promptly detained as an involuntarily patient. He seemed happy enough to take his medication, she noted hesitantly, but he was oddly excited to do so, while nevertheless not exhibiting any of the drug-seeking behavior that normally worried the ward staff. There had been some conflicts with the head nurse over his sleeping arrangements, but he was mostly compliant, and he was already making friends with the other patients. Throughout the briefing, Paul danced up and down the hallway in his borrowed hospital scrubs, his comings and goings visible through the window in the conference room door. When he finally entered, fidgeting and stifling intermittent laughter, he observed: "Lots of people taking notes in here…you should see my notes about you."

Dr. Lynch led Paul through his introduction to the consultation team in fits and starts. Together, they isolated a weeklong cannabis binge as the etiological event that precipitated Paul's decompensation, with Dr. Lynch assuring him that he was in the right place if he wanted to take some time away from controlled substances and "detox." The conversation progressed in a syncopated fashion, with Paul interjecting observations and, at times, questions into the routine enumeration of care plans, medications, and dosages. The team largely bore with these interruptions, though they could not always answer Paul's questions. Several stood out. The first—"Do any of you know Dr. Rik Loose?"—marked a surprising, if ultimately unsuccessful, appeal to the work of a Dublin-based Lacanian psychoanalyst who has written widely on the subject of addiction.[110] Though only Paul and I seemed to be familiar with Loose's contributions to psychoanalytic approaches to conceiving of and treating substance abuse, the appeal offered further insight into the nature of Paul's ongoing sense of rupture and revelation, as well as the overdetermined status of psychoactive substances in his personal narrative, clinically authorized or otherwise. Specifically, the profundity of Paul's encounter with the more-than-human and his attempts to describe it gesture toward a perceived poetics of continuity between psychoactive materialities, his experience of a turbulent internal reality, and the destabilized boundaries between this internality and the rest of the world.

Significantly, this configuration exceeds the confines of a single institution or intellectual tradition, be it biomedical or psychoanalytic. It also suggests the

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[109] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life*, Oakland: University of California Press, 2014.

[110] Loose is the Head of the Unit of Psychoanalysis at the Dublin Business School and an important thinker in Dublin's community of Lacanian analysts. I became familiar with his work after hearing him deliver several papers on the theory and practice of psychoanalysis at the ICLO meetings that were open to the broader, non-practicing public.

necessity of a plurality of interpretations being brought to bear upon psychotic symptomatology in the space of the clinic and beyond. As such, Paul's speech invites a consideration of psychotic subjectivity that privileges discursive polysemy, overdetermination, and internal contradiction, recalling Ellen Corin's observation that a psychotic spectrum disorder like schizophrenia or bipolar disorder fundamentally "resists incorporation into a social order [...]."[111] Rather, Paul seems to draw upon *multiple* orders of epistemology to make his claims regarding the peculiar efficacy of his medications, and in the process his audience bears witness to the psychotic propensity to "borrow, displace, and transform cultural signifiers," producing something like a poetics of adherence, or an experimental approach to reclaiming the stakes of pharmaceutical intervention at the level of symbolic form.[112]

Prior to working as a sound engineer, as I soon learned, Paul had pursued a degree in Lacanian psychoanalysis at the Dublin Business School, briefly studying under Loose in the process. Just as his reference to the psychoanalyst and his work marked an unlikely interruption in the rhythm of psychiatric rounds, so too did it presage the degree to which Paul himself would interrogate the limits of a single epistemological approach to thinking psychiatric subjectivation via the apparatus of adherence. Paul's psychotropics were "actors" in the Latourian sense, to be sure, but they were also objects of fascination and desire, and his claims to their material capacity to inhabit and transform his subjectivity evinced an air of the uncanny; this was not so much a rejection of biopsychiatric discourse as it was a surrealist rereading of claims to medicinal efficacy, the disordering and recombinatory nature of such an engagement with psychiatric signifiers suggesting the delirious logic of a dream. Like a dreamer, Paul did not confront the injunction to adhere head on. Rather, he beheld it obliquely, from the un-homely vantage point of Freud's "Other Scene."

Attempting to think through the relationship between Foucauldian models of subjectivation and psychoanalytic theories of the Unconscious is at once disquieting and productive. At first glance, these two modes of analysis seem incommensurable, not least because they lay divergent claims to the status of what might be called the soul. Nevertheless, the complexity of cases like Paul's demands a multifaceted and unorthodox theorization of subjectivity—one that acknowledges the degree to which the subject of antipsychotic adherence is apprehended and interpellated by the techno-scientific apparatus of psychiatry while simultaneously reaching beyond its grasp. The nature of this unconscious beyond, following psychoanalytic thinkers from Freud to Lacan, emerges from an oneiric space of multiplicity, imaginal passion, and misrecognition that obfuscates the unity, autonomy, and conscious intention that defines the classical, Cartesian individual just as profoundly as analytics that privilege discursive regimes of power. This beyond, and its purchase

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[111] Ellen Corin, "The 'Other' of Culture in Psychosis: The Ex-Centricity of the Subject," *Subjectivity: Ethnographic Investigations*, 276.

[112] Ellen Corin, "The 'Other' of Culture in Psychosis: The Ex-Centricity of the Subject," *Subjectivity: Ethnographic Investigations*, 277.

in the here and now, is manifest in dreams, prapraxes, and other manifestations of the return of the repressed.

The *psyche*, for psychoanalytic thinkers and their interlocutors, is therefore not a product of the capillary action of power, but rather defined by the uneasy relationship between the rational, waking self and a mysteriously emergent symbolic remainder that escapes the external censorship of the family, institutions of care, and society as such, as well as their internalized counterpart, which Freud and his descendants call the super-ego. By contrast, the forms of life encompassed by the psyche would seem to be larger and more capacious than those likewise contained by the Foucauldian subject, and they are defined both by their ability to respond and adhere to the commands of institutions of care, as well as by the scandalous heterogeneity of their intrinsic capacity to circumvent such calls to obedience. As Judith Butler writes, the psychoanalytic model of the psyche is not entirely commensurate with that of the Foucauldian subject specifically because it "includes the unconscious."[113] Instead, as Butler writes: "the psyche is precisely what exceeds the imprisoning effects of the discursive demand to inhabit a coherent identity, to become a coherent subject. The psyche is what resists the regularization that Foucault ascribes to normalizing discourses."[114]

What to make of the kind of patient that Paul embodies—the one who offers the ethnographer a glass of water, transfigured into a publican's pint of ale? Might we call such a patient the subject of the psyche? As Paul soon told me toward the end of our first conversation, he'd taken water from the cooler in the day room and combined it with a hearty portion of ethanol from one of the many hand sanitizing stations that were placed around St. Dymphna's Ward. He was "partying" with his medications, he claimed, and with any other substance he could get his hands on, marking a lyrical sort of misreading of the intended purpose of these various medical technologies, all of which call patients into a specific kind of position qua medical authority. Following Butler on the nature of subjectivation, psychiatric or otherwise:

> […] there is always the risk of a certain *misrecognition*. If one misrecognizes the effort to produce the subject, the production itself falters. The one who is hailed may fail to hear, misread the call, turn the other way, answer to another name, insist on not being addressed in that way. Indeed, the domain of the imaginary is demarcated by Althusser as precisely the domain that makes *misrecognition* possible.[115]

Per Butler's reading of Lacan, Paul's predisposition to misrecognize the institutionally determined purpose of scientific objects like haloperidol or ethanol—

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[113] Judith Butler, "Subjection, Resistance, Resignification: Between Freud and Foucault," *The Psychic Life of Power*, 86.

[114] Judith Butler, "Subjection, Resistance, Resignification: Between Freud and Foucault," *The Psychic Life of Power*, 86.

[115] Judith Butler, "Subjection, Resistance, Resignification: Between Freud and Foucault," *The Psychic Life of Power*, 95.

again, to "transform the cultural signifiers" of a scientific social order[116]—might well be derived from the specific structure of his (waking) relationship to the imaginal space of the dream or the Unconscious.

It is important to note, after all, that Butler's meditations on the uneasy theoretical intersections between Foucauldian and psychoanalytic models of the subject, especially as they relate to the overlapping conditions of the subject's constitution and dissolution, would all seem to be predicated on what psychoanalysts would call the "neurotic" position. Specifically, this position depends upon a model of the psychoanalytic subject wherein the conscious and unconscious dimensions of the psyche are divided; inherent to Freud's "psychical apparatus" is a barrier of "censorship," or a structure of symbolic disavowal that separates the experience of wakefulness from that of sleep, ultimately producing the metamorphic effects of symbolic condensation and displacement that are called the *traumarbeit*, or "dream work."[117] Paul would seem to represent another order of psychic structure, however. Namely, Paul would seem to occupy the psychoanalytic position of psychosis, in which, as Lacan tells us, "the unconscious is present but not functioning."[118] It is this same position, of course, which Butler identifies as nothing less than the "dissolution of the subject," as such.[119]

In the silence following Paul's invocation of his psychoanalytic mentor, he posed another question to the consultation team. "What do you see when you look at me? What do you make of me?"

Each of the clinical staff answered him, speaking directly to the sense of unreality that characterized Paul's initial encounter with the Gardai as well as his sense of jarring contact with the inhuman and otherworldly.

"I see a human being," they answered, one after another, as if making a collective appeal to a mutually intelligible sense of reality, to a commonality of being.

Clumsily, and bereft of clinical training or a professional obligation to appeal to the reality principle, I answered: "I think you're interesting."

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Paul's experiments continued in the coming weeks, as did the practical and conceptual disruptions they posed to the rest of St. Dymphna's Ward. He never rejected the injunction to adhere, but he nevertheless troubled straightforward assumptions about the ways in which the subjectivizing apparatus undergirding

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[116] Ellen Corin, "The 'Other' of Culture in Psychosis: The Ex-Centricity of the Subject," *Subjectivity: Ethnographic Investigations*, 277.

[117] cf., the sixth chapter of Freud's seminal *The Interpretation of Dreams*, called "The Dream Work," pages 311-546.

[118] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 143.

[119] Judith Butler, "Subjection, Resistance, Resignification: Between Freud and Foucault," *The Psychic Life of Power*, 103.

psychiatric appeals for antipsychotic consumption might operate in apprehending and constituting an obedient patient. Paul's idiosyncratic mode of relating to his medications—indeed, to chemical substances more generally—was often perplexing. It never failed, however, to suggest the possibility of a new language, incipient and struggling into being, with which to explore the entanglement of the materiality of mind-altering substances and the complexities of psychotic subjectivities themselves.

Though Paul was hardly the first resident of St. Dymphna's Ward to note that the differences between the licit substances he was prescribed and the illicit ones that ostensibly lead to his psychotic episode were largely arbitrary, he was one of the few to claim that he enjoyed exploring the embodied effects of the antipsychotics he was given on the ward. Unlike most of the patients who were accused of drug-seeking behavior, Paul never asked for benzodiazepines, but he nevertheless took pleasure in a kind of chemical bricolage. The antipsychotics that he chewed up or gargled were affecting him, of course, but so was the heady tincture of drinking water and ethanol that he had offered me during our first meeting.

While a fascinating approach to engaging with psychiatric treatment, such a form of experimentation clearly undercuts normative definitions of epistemic community as founded in a shared and ultimately replicable Baconian practice. Indeed, Paul's inquiry into the nature of his medications—in addition to other substances like cannabis and ethanol—flaunts the experimental conventions to which Dr. Lynch and his colleagues adhere when they engage in pharmacological trial and error, as well as the potential for the broader legibility of such conventions within a shared clinical and institutional milieu. These explorations disturb expectations of experimental commensurability not only because they subvert the juridical authority of the prescribing psychiatrists, but also because they foreground Paul's own experience of the medications in question. Operating outside of the psychiatric logic that governs clinical appeals for adherence, Paul seems to exemplify the anarchic scientific spirit espoused by Paul Feyerabend. Unencumbered by the kind of therapeutic training that might "inhibit intuitions" over the course of his experimentation in favor of an ideology of decontextualized "objectivity," the experiential dimensions of Paul's work go some distance toward blurring the boundaries between the traditions of psychopharmacology as a "domain of research" and "the rest of history," or the social and institutional contingencies that shape, constrain, and define this tradition.[120]

This is not to say that Paul's discoveries are illegible to intellectual traditions working beyond the domain of psychiatry. His reflections on the nature of the materiality of medication uncannily recall the work of Jane Bennett, a political theorist and scholar of Science and Technology Studies whose work attempts to imagine what it would mean to encounter an inhuman object on its own material terms. In the assemblage of human and non-human actors that is thought to have precipitated and then ameliorated Paul's psychosis—an assemblage that includes controlled substances, drug dealers, gardai, inpatient wards, nurses, psychiatrists, haloperidol, olanzapine, and an anthropologist—the power of the material looms.

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[120] Paul Feyerabend, *Against Method*, 11.

Following Giles Deleuze and Latour, Bennett cautions against using the language of the "object" to explore this power. A material actant like marijuana or haloperidol is agentive in that it "intervenes" from an ontological space beyond subject and object, and thereby beyond easy definitions of non-distributed or solitary affective power. It becomes an "operator," according to Bennett, when "its particular location in an assemblage […] makes things happen, becomes the decisive force catalyzing an event," or establishes a set of contingencies within which other, occasionally human, forms of agency can be understood.[121] In short, the operant material force of a drug put Paul into the psych ward, but it could also eventually get him out.

More broadly, the vitality, the vibrancy of the matter in question, seems to inhere in its potential to escape or even "thwart our desire for conceptual and practical mastery," undoing the best laid plans or the good intentions of those who seek to master it.[122] As Bennett's work suggests, an analysis of the power of the *thing*, as opposed to the subject or the object, opens the possibility of a new realm of political and philosophical discourse. Specifically, it problematizes normative, often "Euro-American," "bourgeois," and "theocentric" notions of subjectivity as a basis for political ethics. Herein also lies the affective potential of different arrangements of matter to thwart attempts at mastery, leading to the "irreducibly strange dimension" or "*out-side*"-ness of the material.[123] This is the very "wildness" that establishes matter's status as an "absolute" that "names the limits of *intelligibility*."[124]

Bennett's polemic thusly also demands further reflection regarding the degree to which it is possible, outside of the space of a thought experiment, for a given subject to think past the cultural, institutional, and ideological conditions of possibility that shape his or her capacity to encounter the world of materiality which lurks, by Bennett's own definition, in an ontological space just beyond the limits of effability. Or what of the man or woman in the grips of a psychotic episode who may suffer from what R.D. Laing calls "ontological insecurity," or the condition of feeling "more real than unreal" and "precariously differentiated from the rest of the world" so as to subvert easy assumptions regarding "identity and autonomy"?[125] Questions of language arise, yet again. Critical theorists of all types, from political theorists working under the rubric of Science and Technology Studies to psychological anthropologists and beyond, must ask: how, and under which conditions, is it possible to imagine another world or to invent a new language? Who can encounter such limits to intelligibility and return, much less with a form of testimony that can be received by others? The answer may well lie in Paul's first appeal to the absent psychoanalyst.

In *The Subject of Addiction*, Loose situates chemical dependency in relation to the three classical diagnostic structures that inform Lacanian practice. Just as the neurotic, psychotic, and perverse positions must be understood as emergent from

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[121] Jane Bennett, "The Force of Things," *Vibrant Matter*, 9.

[122] Jane Bennett, "The Force of Things," *Vibrant Matter*, 15.

[123] Jane Bennett, "The Force of Things," *Vibrant Matter*, 3.

[124] Jane Bennett, "The Force of Things," *Vibrant Matter*, 3.

[125] R.D. Laing, *The Divided Self*, 43.

the relationship of the subject to the Other—defined in *The Psychoses* as "the locus in which speech is constituted"[126] and later as the Unconscious itself, insofar as "the unconscious is the Other's discourse"[127]—addiction indexes a certain set of symptoms that define the subject's position with respect to the symbolic order (the raw materials that animate and move through this aforementioned "locus" of speech) and its inverted manifestations in the space of dreams. If, for Loose, neurosis "addresses the Other with a question," and the foreclosure of the symbolic that characterizes Lacanian definitions of psychosis means that "there is no relationship to the Other," then "addiction seeks administration" and, ultimately, "independence of the Other."[128] That Paul's psychiatrists did not deem him an addict by the standards of the DSM-V or the ICD-10 matters far less than the extent to which his invocation of his previous mentor's psychoanalytic discourse *about* addiction reveals his own attempts to frame his epiphany about the permeability of his body with respect to psychoactive substances and the rest of the material world. In short, and in the midst of an overwhelming, revelatory experience, this is the language with which Paul would seem to grapple with the limits of language as such.

How, then, might we bring this order of expression to bear upon Paul's predicament, both experiential and diagnostic? Lacan himself at times refers to prior methods of psychiatric classification regarding psychotic phenomena like hallucinations, classically conceived as "a *perceptum* without an object,"[129] or patients' refusals to abandon egocentric and paranoid beliefs like "delusions of reference,"[130] but the presence of such symptoms is not enough to guarantee a diagnosis of psychosis. If the psychoanalytic symptom is typically (neurotically) structured like a language, wherein the symptom can be understood as a signifier standing in for a barred (repressed) signified,[131] then the psychotic symptom is something else. Lacan writes:

> What is the psychotic phenomenon? It is the emergence in reality of an enormous meaning that has the appearance of being nothing at all—in so far as it cannot be tied to anything, since it has never entered into the system of symbolization—but under certain conditions it can threaten the entire edifice.[132]

In other words, and at the level of the subject's relationship with the Other, a strange and ineffable event that defies the descriptive capacity of the symbolic order intrudes upon the ordinary conventions of inner experience and social life. If the

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[126] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 274.

[127] Jacques Lacan, "Seminar on 'The Purloined Letter'," *Écrits*, 10.

[128] Rik Loose, *The Subject of Addiction: Psychoanalysis and the Administration of Enjoyment*, 216-217.

[129] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 446.

[130] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 18.

[131] Jacques Lacan, "The Function and Field of Speech and Language in Psychoanalysis," *Écrits*, 223.

[132] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 85.

Unconscious is truly "present but not functioning" in psychosis,[133] it is because it has erupted into the everyday and exists "at the surface" of waking life.[134]

The profundity of this experience cannot be overstated, nor can its bewildering, often shattering, effects upon the subject's sense of a stable identity and cohesive community. As Freud notes in texts as early as *The Interpretation of Dreams*, the Unconscious dramatizes and explores the myriad and sometimes hidden possibilities of one's own being, especially as this being concerns the meanings of one's relationships to others.[135] Following Freud, Lacan offers that the Unconscious is not only the discourse of the Other, but also "the locus from which the question of [the subject's] existence may arise […]."[136] These questions of uncertain being are ultimately ontogenetic in origin for Lacan, and they emerge in a developmental period prior to the incipient subject's full entry into language. This is a time when first encounters with the other are fraught with ambiguity and pre-linguistic confusion regarding that other's desires, intentions, and judgments, and Lacan designates the unknown dimension of these earliest relations as "Mother's Desire."[137]

Lacan continues to propose that the capacity of a developing subject to enter into a state of symbolic mediation qua the uncertain intentions and desires of this originary other—in short, to access, internalize, and deploy socioculturally appropriate forms of signification, nomination, and social relation that can contain and reshape the threatening ambivalence of "Mother's Desire"—be called the "Name-of-the-Father."[138] The Name-of-the-Father, in turn, instantiates the inchoate subject's first encounter with the law of social relations. It acts as an originary metaphor of interpersonal mediation for the nascent subject, and it organizes this subject's early relationships, as well as the attendant repression of certain forms of desire and their direct signification, founding the unique nature of the subject's future psychic life and later relationships in the process. Indeed, we may think of the prohibitions inherent to the Name-of-the-Father as they relate to foundational psychoanalytic concepts like a child's Oedipal desire for the mother, and this comparison is especially useful given the degree to which the prohibitions that the Name-of-the-Father entails do not fully answer the questions of being posed by Mother's Desire, but rather serve to partially delimit the field of possible answers in relation to the Other. This question of being therefore persists, echoing in the space of the Other, where it "envelops the subject, props him up, invades him, and even tears him apart from every angle," but this alone is not enough to indicate a psychotic decompensation.[139]

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[133] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 143.

[134] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 11.

[135] cf., "The Dream of Irma's Injection," "The Dream of the Burning Child," and multiple other analyses for further enumeration of the extent to which Freud understands dreams to open but never answer questions of identity and the ambiguous meanings of interpersonal relationships.

[136] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 459.

[137] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 465.

[138] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 465.

[139] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 459.

Rather, for Lacan, the onset of psychosis occurs when, "from the field of the Other, there comes the interpellation of an essential signifier that is unable to be received."[140] When the Name-of-the-Father fails to answer the questions of being which persist in the Unconscious—*Who am I? What do you want from me?*—the subject has no language with which to engage this earliest uncertainty in its moment of contemporary manifestation. Whereas the repression of specific forms of desire and their direct signification can precipitate their return in the form of neurotic symptoms or the space of the Unconscious, psychosis is the "imaginary cataclysm" that follows the "foreclosure" of a stabilizing psychic structure like the paternal metaphor of the Name-of-the-Father.[141] As Lacan writes of foreclosure:

> At issue is the rejection of a primordial signifier into the outer shadows, a signifier that will henceforth be missing at this level. […] It's a matter of a primordial process of exclusion of an original within, which is not a bodily within, but that of an initial body of signifiers.[142]

Those experiences, encounters, meanings, and forms of relation that escaped primitive symbolization then "appear in the real" in the form of delusions and hallucinations.[143] With this proliferation of psychotic phenomena, the very nature of the subject's relationship to language and the world that it is supposed to describe changes radically; the signifier has been decoupled from the signified and "invades" the subject,[144] initiating a chain reaction at the level of the broader symbolic order. The psychotic subject is "inhabited" and "possessed" by language,[145] but this system of signification risks becoming so idiosyncratic as to be impenetrable to the other. The epistemological foundations of a mutually intelligible world begin to shake.

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It was late summer when it happened, and the day of the Dublin airshow. The sun was warm, and the sky was unusually clear as the aircraft flew slowly east from the western reaches of the city and toward the Port of Dublin and the Irish Sea. Their procession followed the path of the River Liffey, and the shadows of their wings traced the equatorial line that divides the Catholic north side of the city from the posher, Protestant south. Retired military models followed sleek, black helicopters from the United Kingdom's Royal Air Force and grand airbuses whose flight paths would never normally cross the city center. Thousands of people

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[140] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 306.

[141] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 321.

[142] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 150.

[143] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 81.

[144] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 218.

[145] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 250.

thronged the quays of the Liffey at midday just to look up. The papers reported that the spectacle was arranged as a part of The Gathering, a year-long, government-backed tourism initiative aimed at enticing members of the contemporary Irish diaspora back to the island. Innumerable imagined returns heralded by a parade in the sky.

It was a Sunday, so Paul sat relaxing and smoking marijuana in his apartment near the Four Courts, three long city blocks from the northern edge of the river. The air was humming with the noise of the nearby crowds and the steady droning of the aircraft passing overhead when it began to dawn on him that he could hear something else. With ears sharpened by years of vocational training in sound engineering, he began to discern a voice within the larger cacophony of the afternoon, and then voices. It was in this moment that Paul began to dream with his eyes open.

They were not precisely angels, nor were they aliens, but they came from somewhere very far away, reaching out to him across time and over an incalculable distance. It was a question of dimensional difference rather than light-years, Paul decided, as they could speak to him, could move and act through his body, but not appear. In this speech, and in this movement, they showed him the falseness of the boundaries he perceived between his body and the world. He could see now that he was porous, continuous with the clutter of his sun-drenched living room—the curtains billowing at the window, the television in the corner, the low contours of the couch he was sitting on, the cool tile of the floor, the joint smoldering in the ashtray on the table in front of him. There was a danger in this last thing, they warned him, and he looked toward the kitchenette, cans of beer standing haphazardly by the electric kettle on the counter. These substances bled across the fictive boundary of his body as well, and at times they overwhelmed him. They could interfere with the larger plans that the faraway ones had for him. Something momentous would happen soon, he realized. The world would not precisely end, but it would change beyond recognition, and he had a part to play. He would either do something very good or very bad, but he could not say which, and they would not tell him. He was overwhelmed in his uncertainty. He needed help, some assistance in discernment.

Pulling off his clothes, he walked into his bedroom and shrouded himself in a sheet. He left his apartment and walked south toward the Liffey and the crowds. He stopped a block short of the river at Chancery Street, however, and turned and walked west along the side of the Luas line, the light rail overloaded with people who had come to watch the flying machines. After two more blocks he passed the imposing colonnade of the High Courts and arrived at the Bridewell Garda Station. He walked into the station, let the sheet fall to the floor, and offered himself naked to the law.

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Under normal circumstances, according to Lacan, unconscious phenomena are "fragile on the ontic plane."[146] They typically appear in the lacunae of disrupted speech or the uncanny staging of a dream, and their manifestations mark the fleeting, ciphered return of the repressed that typifies the neurotic position. Psychosis, on the other hand, would appear to represent a sort of theoretical state of exception. If the Unconscious is indeed "at the surface" following a psychotic decompensation, the passage of its activities from the subjective space of psychotic experience and into the intersubjective field of social life is not difficult to trace. Psychiatric approaches to engaging and treating delusions and hallucinations might suggest that they arise from a sort of epistemological error, but the testimonies of psychotic subjects and the forms of listening opened by the discourse of psychoanalysis suggest that people experiencing such disturbances in reality are not merely working with bad cognitive or even sensory "data." Rather, nested within the "enormous experience" of Paul and others like him are implicit claims regarding the organization of reality, claims which might be called ontological in nature.

Such claims also invite an anthropological interrogation of the difference between psychiatric and psychoanalytic forms of clinical engagement with psychotic phenomena. Whereas standard psychiatric protocols aim to facilitate a patient's return to insight, often by challenging hallucinatory experiences or delusional speech, a psychoanalytic mode of listening foregrounds both the structure *and* the content of psychotic phenomena. Per Lacan:

> Psychoanalysis […] gives a curious endorsement to the psychotic's delusion because it legitimates it in the same sphere as the one in which analytic experience normally operates and because it rediscovers in his discourse what it usually discovers as the discourse of the unconscious.[147]

Reflecting upon such a mode of listening is useful for the ethnographer. Paul's moment of epiphany, which he recounted in fragmentary form over the course of our many conversations following his intake interview, is therefore instructive for a host of reasons. Most notably, it speaks directly to the structural and experiential dimensions of psychotic phenomena, while also enumerating the deeply ethical concerns indexed by the questions of being that can be located in the Unconscious, fragilely ontic or otherwise.[148] Hallucinations and delusions may mark the limits of epistemological commensurability within a given social order, but they still pose a series of questions for the subject of psychosis, as well as for those that he or she encounters in the space of social life, regarding the degree to which the forms of existential inquiry that emerge from the locus of the Unconscious necessarily play out in the field of relations that involves the other.

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[146] Jacques Lacan, *The Four Fundamental Concepts of Psychoanalysis, 1964: The Seminar of Jacques Lacan, Book XI*, 33.

[147] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 132.

[148] Jacques Lacan, *The Four Fundamental Concepts of Psychoanalysis, 1964: The Seminar of Jacques Lacan, Book XI*, 33.

A hallucination is never merely "a perceptum without an object" when examined in this light. Rather, the psychotic subject exists in a world where "everything has become a sign."[149] Following Lacan's famous example of the paranoiac who is struck by the sight of a red car in the street, the "delusional intuition" that guides the psychotic thought process regarding the relationship between points of signification insists that the car "has a meaning, but the subject is very often incapable of saying what it is."[150] He or she can only further intuit, as Paul did when he began to detect an unsettling salience in the noises of the crowds and the droning of the aircraft on the afternoon of his epiphany, that this world of signs and these indeterminate meanings were addressed *to him*. The semantic content of this address often remains uncertain, precisely because it finds its point of origin in the foreclosure of the subject's full access to the descriptive resources of the symbolic order. With the loss of a stable relationship to the Other, a host of imaginary others proliferates in the subject's field of perception, and these strange, sometimes fantastic beings speak to the subject in the form of auditory hallucinations.[151]

What to make, then, of Paul's hallucinations and the revelations they deliver? They seem to speak directly to these questions of being that are normally situated in the space of the Unconscious, but beyond the ordinary interrogation of identity and relationality that Lacan describes, Paul offers further elaborations. The questions *Who am I?* and *What do you want from me?* remain, but they are joined by a another query: *Who am I in relation to these other substances, this assemblage of objects and fields of suspension, that I engage by smoking or drinking or breathing or swallowing? How am I to live in relation to them?*

In light of this framing, the word "addiction" would seem to take on a formally neologistic character. Though not a part of a system of resignification that is as extensive or developed as the language invented by Daniel Schreber in *Memoirs of My Nervous Illness* and discussed, at great length, by Lacan in a number of his works, the slippage between normative psychiatric definitions of addiction as mere chemical dependency and the degree to which this signifier comes to stand in for Paul's sense of embodied continuity with material objects and chemical substances is essential. As Lacan writes of the relationship between an original foreclosure of the Name-of-the-Father, auditory hallucinations, and the development of neologisms: "In the locus where the unspeakable object was rejected into the real, a word made itself heard […] coming to the place of what has no name […]."[152] A disruption in the metonymic chain of signification that undergirds the non-psychotic use of language, the neologistic signifier is free-floating and decoupled from a contextualizing chain of semantic reference. "Hallucinations," Lacan notes again, "inform the subject of the forms and usages that constitute the neo-code […]."[153]

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[149] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 9.

[150] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 9.

[151] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 87.

[152] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 448.

[153] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 450.

These hallucinations—received by Paul as transmissions from extra-dimensional entities—go some distance toward placing him within a new order of signification. They do not directly answer the questions of being that emerge from the Unconscious following his psychotic decompensation, but in their strangeness and their urgency they suggest another world approaching. Inspiration and eschatology converge in Paul's descriptions of the ways in which these communications affected him, the words of his inhuman interlocutors penetrating and inhabiting his body, threatening to move him like a divine automaton. Though his role does not seem to be strictly Christological in nature, the faraway ones promise Paul a vital part in the transformations that precede the coming world, and in his growing certainty regarding their intentions, a metamorphosis proceeds at the level of the structure of his subjectivity. Lacan writes:

> It is the lack of the Name-of-the-Father in that place which, by the hole that it opens up in the signified, sets off a cascade of reworkings of the signifier from which the growing disaster of the imaginary proceeds, until the level is reached at which signifier and signified stabilize in a delusional metaphor.[154]

In the aftermath of an original foreclosure, the loss of the paternal metaphor and its tethering to a social law, and the concomitant psychotic decompensation, delusion acts as a form of support for the subject in crisis, reorienting him or her within a new schema of symbolic coordinates. The disruption of such a reorientation to the subject's place within a larger social order is nevertheless profound.

It is worth noting that Paul makes one last effort to contain the enormity of his experience following this epiphany; namely, he seeks out the support of the law, hypostatized and made manifest in an institutional form whose symbolic function it is to safeguard and preserve the social order from which he has been abstracted. It is not clear whether or not Paul knew the gardai would transport him to the hospital and begin the legal process of involuntary commitment following his arrival at the station, but perhaps he was guided by the very experimental ethos that structures his relationship to the injunction to adhere and to psychoactive substances more broadly. Instead of addressing himself exclusively to psychiatric discourse about his medications, or more specifically to the larger apparatus of psychiatric subjectivation into which these agential objects are integrated, Paul seemed to attempt the reconstitution of a form of social relations that was not predicated upon the tablet form. Rather, while fundamentally acknowledging the agency of the drug-as-object, Paul fought to ensure that he was not with the object and at its mercy. In the absence of the Other, and at the mercy of a world of signs an inhuman presences, he continues to attempt to address himself to a world of human others. I like to think that he posed the same question to the gardai that he posed to Dr. Lynch's consultation team the following morning. "What do you make of me?"

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[154] Jacques Lacan, "On a Question Prior to Any Possible Treatment of Psychosis," *Écrits*, 481.

Paul was not the only patient who came to St. Dymphna's Ward with a question for the institution as such, but the existentiality of his attempts to position himself with respect to the order of the gardai station and the ward, albeit on his own terms, marked his experimental engagements with these medico-juridical spaces with a special poignancy. It was common for chronically re-admitted patients to request a so-called "respite" from Dr. Lynch and the rest of the ward staff during times of crisis, extreme stress, or relapse, but patients diagnosed with psychotic spectrum disorders like Matthew or Paul frequently approached the terms of their confinement with a unique synthesis of supplication and critique. While the effects of psychotic experience upon their integration into a larger social order were indeed often shattering, they deployed diverse, creative forms of appeal for institutional support, and their language was as likely to be characterized by religious overtones as it was to be framed in terms of patients' rights or couched in the kind of experiential expertise—a kind of "situated knowledge" of medicines and treatment protocols and their respective effects—that lifelong psychiatric service users usually develop and aim back at their clinicians.

Following an analysis of Pauls' attempts to reconstitute himself via a bodily offering to the law, the question must be asked: to what degree do psychotic persons seek out an institutional representation of the Name-of-the-Father in the inpatient psychiatric unit? In "The No/Name of the Institution," Ian Whitmarsh analyses the degree to which the capacity of institutions to produce subjects via the propagation of norms and disciplinary practices necessarily encodes the subversion of the same norms into the subjects in question.[155] Whitmarsh argues for a conceptual homology between the power of a given institution to impose a set of productive constraints upon a developing subject and its structurally mediated ability to name (and thus delimit) such a subject's place within a larger system of social and symbolic organization. Though the psychotic subject is not precisely the kind of subject that Whitmarsh analyzes, his analysis of the extent to which institutions of carcerality and care can embody the stabilizing law of the paternal metaphor (as well as the ambivalence that its injunctions index) allows for a deeper reading of patients' attempts to gain access to the spaces of productive containment that these institutions can easily come to represent.

Likewise, the resonance of such appeals with older forms of institutional containment and care so often associated with the classical Irish asylum or the monastic cell plainly disturbed the ward's clinical staff, but the psychotic capacity to inhabit these anterior, untimely postures of compliance without fully bending to the institution's will also demands further reflection. Though not every psychotic experience is necessarily distinguished by a confrontation with the fantastic, inhuman, or supernatural, the frequency with which religious or spiritual signifiers come to the fore is striking. This frequency is all the more fascinating given the waning cultural significance of religious institutions in Ireland, but stories about divine encounters and spiritual revelation were so common among patients on the ward that the staff seemed largely inured to the profundity of the ontological claims

[155] Ian Whitmarsh, "The No/Name of the Institution," *Social Thought and Commentary*, 2014.

nested within these stories. Perhaps more pointedly, and despite the pluralistic overtures made by Dr. Lynch when dealing with particularly religious patients, the discourse of psychiatry was largely incommensurable with psychotic rearticulations of a more orthodox and institutionally stable Catholic theology.[156] And yet, patients still called upon the name of God, or something like it, with an undeniable regularity.

One such patient, a man named Ray, came to occupy just such a position in my ethnographic imaginary. While his stories seemed to trouble the boundary between theophany and manic elation, his immediate concerns were often prosaic, circling around his desire for community and his ambivalence about the kind of psychiatric care he was receiving at the day hospital he was supposed to frequent.

"Sometimes I get to thinking that I'm Jesus," he said during our first interview, some twelve hours after appearing in the emergency room, where he had reported suicidal thoughts after the psychiatrist on call tried to turn him away. "But I couldn't be Jesus. I think I'm only a messenger."

"Like a prophet?" I asked.

"Maybe a prophet or something, but I'm not…I don't prophesy to anyone. All I want is a job and a kid and a family and a wife."

Despite his dissatisfaction with the services provided by the community psychiatry team at the day hospital, Ray claimed to feel at home in St. Dymphna's Ward. I came to understand this curious preference for the locked ward in relation to Ray's avowed loneliness and through the lens of one of the most fundamental dimensions of his unusual (and at least partly mad) experiences. Namely, Ray seemed to be caught within a cycle of institutional returns that was markedly different from the usual rhythms of relative stability and periodic hospitalization that shape the ebb and flow of the lives of many men and women living with chronic mental illnesses.

I interpreted Ray's affinity for the inpatient unit as a request for a very specific and arguably anachronistic form of care, particularly in light of Dr. Lynch and his colleagues' warnings regarding the potentially pathogenic nature of spending too much time in the ward. At the intersection of his professions of divine inspiration and painful isolation, I heard a request for asylum, for community, for subjective containment. In the ruins of the total institution, I heard an echo of Michel de Certeau's own invocation of an ancient prayer intoned by early Christian mystics: "May I not be separated from thee."[157] The spirit of the old hospitals began to take shape.

The consultation team expressed their collective skepticism regarding Ray's claims to feeling unwell, much less suicidal, the morning that I met him. In the minutes before he joined us for his allotted portion of morning rounds, they

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[156] cf. the story of Amina in Stefania Pandolfo's *Knot of the Soul*. In the chapter "Testimony in Counterpoint," Pandolfo examines the extent to which traditional Islamic cures of the djinn comingle with and contradict psychiatric diagnoses and treatment protocols in the aftermath of one woman's experience of crisis and fragmentation. Amina goes first to an Islamic shrine to ward off paranoia, a sense of unreality, and feelings of persecution. It is only in the intersection of these multiple orders of cure that Amina obtains a form of containment.

[157] Michel de Certeau, *The Mystic Fable*, 1.

reflected that they had seen Ray in the midst of a mixed episode (when he was "high" or "elated" to use his own words), and it had ended with him driving the wrong way down one of the freeways outside of Dublin. Many of the staff had known Ray for years through his repeated returns to the ward, and he had seemed positively calm by comparison during breakfast that morning. Based on a conversation with his community psychiatric nurse and the doctor overseeing his treatment at the nearby day hospital, they suspected that he had showed up to the emergency room requesting to be admitted the night before because his mother had once again forbade him from staying in her flat. Additionally, he was open in his dislike for the housing provided to the chronically ill and disabled by the Health Services Executive and Dublin City Council. In the midst of an ongoing national moral panic surrounding suicide, however, they reasoned that Ray knew even a dubious reference to wanting to take his own life would get him admitted.

A tall, imposing man with the bearing of a rugby player, Ray's face suggested a youth and an openness that his stature belied. He entered the consultation room with a set of what he called demands, though the opener was more of a statement. When Dr. Lynch asked what was ailing him, Ray produced a list. The first item read: "I have no friends." The second, as predicted, was a petition for better housing, though Ray acknowledged that the waiting list for state-subsidized flats was long. The third and fourth were requests to receive treatment at Dr. Lynch's outpatient clinic rather than the day hospital and to remain at the slightly lower doses of lithium and haloperidol that the staff of St. Dymphna's ward had elected to give him while he was under their care. Ray complained that the classes and activities available to patients at the day hospital, part of an overarching program of occupational therapy, were boring and that his fellow patients were equally dull from overmedication. The patients in St. Dymphna's ward appeared to be less sedated, he observed, and he broke into a grin, exclaiming, "I want *you* to be my doctor, Dr. Lynch!"

Dr. Lynch smiled and said that he would do his best to consider all of Ray's requests. With brief introduction, he indicated to Ray that I might like to speak with him later, and Ray exited with the promise to find me after lunch. Before calling the next patient in, the team returned to the question of whether or not Ray was gaming them, weighing his alleged suicidality and the new threat that accompanied his list of demands—"If I don't get what I want, I'm going to the continent. I'll get in my car and drive!"—against the ever-present need for open beds. Uncharacteristically, the ward was only half full the day after Ray was admitted, and Dr. Lynch and his colleagues decided to acquiesce to the only request that they could conceivably grant, specifically the unspoken plea for shelter that lay, barely hidden, within Ray's list of demands.

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Ray knew what to do when he began to suspect that his pint had been poisoned. That the most basic quantum of social life and communal exchange in

Dublin should become an object fraught with risk and evil intention was reason enough to escape. He promptly left the north Dublin pub where he had been drinking for the evening and drove roughly 50 kilometers north, where a wordless call drew him to an abandoned nunnery.

"I saw the Holy Spirit out in Drogheda," he told me. "When I was high, you see, I was guided by the Lord."

In the shadow of the shuttered institution, he found a great, white bird—a dove, but impossibly large—hovering silently above him like a hummingbird. A deeper understanding descended upon him, and under the guidance of the Spirit he spent the night walking 20 more kilometers to the coast. Once there, he felt impelled to go to England, though the trip was not an easy one. He met many people while crossing the Irish Sea who did not want to hear about his audience with the divine presence, and he argued with them like a biblical prophet, increasingly isolated in his convictions.

He was briefly imprisoned in the United Kingdom, during which time his dual sense of certainty and fragmentation reached their zenith. He casually described a surreal scene from his time in jail wherein an argument with his cellmate about the existence of God was punctuated by the near dissolution of his body. As he sat on the toilet in the cell, he told me, he began to masturbate until an intuition prompted him to press a mole on his thigh "like a button." A door to another world seemed to open, and a fish appeared in the water of the bowl beneath him.

"A carving, scratched into the porcelain?" I asked, confused.

"No," he replied flatly. "It was a fish. A real fish."

It was another sign from God, he explained, and a sort of celestial joke. The fish appeared to demonstrate God's creative power, but it was also a reference to the evolutionary perspective his cellmate had been arguing during their debate about the creation of the world. God was more than complex enough, he clarified, to operate through the mechanism of Darwinian evolution. Like a "martyr of the unconscious," which is to say "a witness" to its unadulterated power following a psychotic decompensation,[158] Ray could only offer a testimony to the fantastic things that he had seen, all of which had proven God's intervention into the world. It was beyond him how anyone could fail to see that this was the case.

Ultimately, Ray was released from the British jail and returned to Dublin, where he received several different diagnoses including schizoaffective disorder and, most recently, bipolar disorder. He could recount the story of this first decompensation with a sense of relative distance, but the memories were still very real. His vision of the Spirit had frightened him, he said, but it had also filled him with a powerful sense of purpose and an unshakeable and still-enduring faith in the existence of God. It did nothing for his solitude and isolation.

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[158] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 132.

When dealing with new patients that they fear may abuse the hospitality of the ward, staff members at St. Dymphna's often invoke the specter of the old asylums, namely that of the sprawling, nearby, and newly defunct St. Brendan's Hospital at Grangegorman. When dealing with older patients, many of whom spent years in Grangegorman prior to national deinstitutionalization, staff members reminded them of the importance of safeguarding their newfound freedom by adhering to their psychopharmaceutical regimens in order to stay out of the hospital. If the asylum has been largely buried in much of the west, the grave is shallow in Ireland, if occupied at all. It was in this larger context, at the mouth of the tomb, that Ray saw the Spirit, received treatment, and made his appeal for something else.

As it turned out, Ray was not, in fact, suicidal. He sheepishly admitted as much halfway through our first interview. He had lied his way into inpatient care because, as he reiterated, he felt at home in St. Dymphna's Ward. Moreover, Ray felt that he could make friends in the inpatient unit due to the unspoken understanding that he could expect from his fellow patients. There was no need to come clean about his history of mental health diagnoses because it was already a given. If he wanted to complain about the side effects of his medications, he could do so without fear of social stigma. If he got lonely in his room, he could walk to the day room and find the other inpatients watching television, playing cards, or smoking cigarettes and drinking tea. Even in the face of the isolation that he had felt for years in his state subsidized housing and at the day hospital—his inability to connect with others despite his conviction that the Stone Roses were singing to him from the radio—Ray seemed to believe that all of this might fall away if he was allowed to stay in the ward, or at the very least remain under the care of Dr. Lynch's service. Only a part of this, I think, had to do with the more measured approach that Dr. Lynch and his colleagues took to calculating the appropriate dosages of antipsychotic medications.

Though spoken from a space of madness or mysterious, ecstatic encounter—or perhaps because it hailed from such an origin—I began to understand Ray's position with respect to the psychiatric institution qua inpatient care as a form of critique. The object of this critique was not merely the day hospital that he despised, but the structure of community mental health as such. This critique is somewhat ironic from an American perspective. Ray benefits enormously from universal healthcare and receives sophisticated psychiatric treatment from community nurses and state subsidized housing because of his status as a person living with and receiving treatment for mental illness, but he is still plagued by questions regarding his place within a larger social world, regarding his relation to the other. In short, Ray seems to be complaining that he finds no community in the context of community mental health, and at least some of the figurations of his thinking, mad or mystical or otherwise, suggest the desire to renew the mission of something like a total institution.

Following de Certeau and Pandolfo, I want to argue for a productive resonance between the status of the (not quite) empty institution and those subjects that do not always speak with an "I," be they schizophrenic or saintly or both, but rather with many voices. The experience of this subject, the one who occupies a

conceptual space which might be called "ex-stasis," "reiterates at the level of biographical experience all the vocabulary of the Church Reformation: division, wounds, sickness, lying, desolation, and so on."[159] De Certeau continues on the nature of the mystic's relationship with the ruins of a once-mighty institution of pastoral care, a relationship which can only develop in the twilight of the establishment's existence:

> Individual bodies tell the story of the institutions of meaning. The end of the world is postulated in all of the spiritual poetics. Their bright and daring trajectories streak the night sky, from which they have been removed by pious collectors of mystic traces. They are written on that black page from which we must relearn to read them.[160]

Or, more plainly, and as I said when opening this reflection, Ray's returns may simply be an attempt to reconstitute a totality and to contain the experience of an overwhelming encounter with the non-human via mediation by community. "May I not be separated from thee."[161]

When I think about Ray's experiences from a classically anthropological perspective, the Holy Spirit calls him to return to the generic institution in the multiple forms of the abandoned nunnery, the psych ward, and perhaps even jail, because he is looking for divinity in the Durkheimian sense, or in the form of a collective representation which can give meaning and coherence to what Ellen Corin calls the "staggering world" of psychosis.[162] Following de Certeau on the illegibility of mystical speech, however, and drawing further inspiration from other scholars of impossible utterance like Michel Foucault and Reinhart Koselleck, I am called to push further, to attempt to think about what it would mean to listen to speech from or even to inhabit this staggering world. I wonder, here, if it possible for the anthropologist, much less the psychiatrist or the scholar of public health, to hear such a attempt to reclaim psychiatric space? Or, as Ray asked me during our second interview, just prior to his discharge from St. Dymphna's Ward, "Do you think I'm a holy man, or do you think I'm crazy?" Have we, as Koselleck asks in *Futures Past*, lost the capacity to hear the speech of prophecy and all its inherent judgment in our current historical moment? Have the "semantics" of our present historical time, or the Foucauldian monologue of reason about unreason that is psychiatry, left us with an inability to decipher the invisible writing on de Certeau's "black page"?

At the very least, and despite all of the horrors of the old hospitals, despite the nearly anomic loss of faith by mainstream Irish society in institutions of care, particularly those historically associated with the Catholic Church, I want to leave a space for Ray's perspective on the social good of the total institution. I also want to acknowledge that Dr. Lynch and his colleagues, despite their trepidation in the face of the specter of institutionalization, were able to hear Ray, after a fashion, and

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[159] Michel de Certeau, *The Mystic Fable*, 14.
[160] Ibid.
[161] Ibid., 1.
[162] Ellen Corin, "Living Through a Staggering World: The Play of Signifiers in Early Psychosis in South India," *Schizophrenia, Culture, and Subjectivity*.

honor his request for community and perhaps for containment, if only for a little while. As with Matthew and Paul before him, I want to be able to reject the terms of Ray's final question for me—*Am I a holy man, or am I crazy?*— and answer "why not both?"

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In *The Knot of the Soul*, Stefania Pandolfo conceives of the psychotic capacity to encounter the discourse of a given cultural or therapeutic tradition and imagine it otherwise as a form of "counterpoint" to the hegemonic status of institutionalized forms of apprehension, subjectivation, and care. Drawing upon the thinking of Theodor Adorno, she writes:

> Counterpoint is the violent trace of an existential condition marked by an 'indescribable tension.' It is the product of an 'opposition,' a struggle, which puts into play 'the nuances and contrasts of the soul divided against itself, and against the world.' For contrary to medieval polyphony, where, Adorno writes, there is no dominant theme and the subject exists only in relation to a collectivity, modern counterpoint remains true to the bourgeois idea of the sovereign subject and its emancipatory aspirations, all the while demonstrating its impossibility.[163]

Joining Lacan, Corin, and others who explore the "ex-centricity" of the psychotic subject with respect to normative engagements with cultural and epistemological formulations surrounding personhood, relationality, and therapeutic encounters, the concept of psychotic counterpoint allows for a unique form of critique of such conventional assumptions, as well as the institutions and norms they undergird. In much the same way that hallucinations constitute "the invention of reality," which acts as a "support for what the subject is experiencing" in the space of a psychotic decompensation,[164] the speech of the mad can draw upon the fragmentary resources of the prosaic and everyday to describe another possible world.

When the ethnographer listens for the counterpoint, the subjectivizing discourse of psychiatric approaches to adherence and the proliferation of clinical space are transformed. Under the auspices of Paul's antipsychotic experiments and Ray's request for asylum, new forms of medicated subjectivity take shape. Not only do these counterpoints articulate the horizon of a psychiatric discourse or therapeutic epistemology, but they also produce a poetics of engagement with both the form and the materiality of medication. Though questions of efficacy may be

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[163] Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, and Islam*, 67.

[164] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 142.

confined to the black box of experimental procedure,[165] and though the materiality of the medications in question may indeed name a limit of intelligibility at the level of object-agency,[166] the alchemical qualities of psychotic processes like hallucination and delusion—operating in their capacity to resignify a form emptied of meaning—render habitable a world otherwise dominated by the logic of the clinic. More than this, they "reconstruct the cosmos" in which the question of care can be asked at all.[167]

Psychosis, in this sense, is not so much an illness as it is a form of knowledge, albeit one that is most often gained by a passage through the confusion, isolation, and terror that arises from the disintegration of the self and the potential for the dissolution of social ties. In the face of a national anomie regarding the moral authority of institutions of care, and in spite of an extant debate within the larger clinical community of Irish and British mental health providers about the nature of psychotic experience and appropriate forms of treatment, the patients of St. Dymphna's Ward experimented with new forms of life in relation to their medications and the hospital itself. Paul's science and Ray's appeals, after all, are emergent from their own medicated subjectivities, and they speaks directly to a poignant, intimately experienced disturbance at the horizon of the psychiatric subject and the larger world of objects, institutions, and others that is usually thought to exist beyond it.

In the fashioning of these new forms of relating to medical technologies, institutions, and one another, patients like Paul and Ray reveal the ontologically plural stakes of psychotic experience and the psychiatric mise-en-scène.[168] How to describe such a world, resignified? How does one inhabit a cosmos in the process of reconstruction? None of the patients in St. Dymphna's Ward ever told me directly, but in the poetics of their speech there is an invitation to something like communion.

"Look at that," Paul said laughing, as we emerged from the spare office that the ward staff lent me for interviews. He pointed down the hall and toward the locked doors separating the inpatient unit from the rest of the hospital, and through the reinforced glass of the windows we could see an old man approaching with a golden box in his hand. It was round—a pyx, I realized.

"Will you take the sacrament?" I asked, but he wasn't listening, and his wide eyes stared past the man as the nurses buzzed him into the ward.

"I don't know why we bother with the Eucharist," Paul mused, spreading his arms as if to encompass the hallway, the nurses' station, the day room, the tablets and the cups of tea that his fellow patients were consuming with their lunch.

I stared back at him, and he turned, answering the question I did not ask.

"All of this is the body of Christ."

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[165] Compare to Dr. Lynch's meditations on the limits of psychiatric knowledge regarding medicinal efficacy in Chapter 2.

[166] Jane Bennett, *Vibrant Matter*, 3.

[167] Jacques Lacan, *The Psychoses, 1955-1956: The Seminar of Jacques Lacan, Book III*, 252.

[168] cf., Pierre Charbonnier, Gildas Salmon, and Peter Skafish, *Comparative Metaphysics: Ontology after Anthropology*, 2017.

Chapter 4: Stigma, Symptom, and Space: the Problem of Community in Community Mental Health

> The ordinary practitioners of the city live "down below," below the thresholds at which visibility begins. They walk—an elementary form of this experience of the city; they are walkers, *Wandersmänner*, whose bodies follow the thicks and thins of an urban "text" they write without being able to read it. These practitioners make use of spaces that cannot be seen; their knowledge of them is as blind as that of lovers in each other's arms. The paths that correspond in this intertwining, unrecognized poems in which each body is an element signed by many others, elude legibility.
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> -Michel de Certeau, *The Practice of Everyday Life*, 93.

Paul was only a few days from being discharged when Elijah threatened to eat him. The two men had been sitting near one another in the day room, Dr. Lynch told me, when Paul tried to strike up a conversation with the ward's newest arrival. A precariously housed immigrant from Nigeria who had spent time in the inpatient unit before, Elijah shared Paul's belief that he had experienced a series of divinely inspired revelations prior to his admission to St. Dymphna's Ward, but unlike Paul he valued solitude and quiet during his time in the hospital. He did not often sit with or speak to other patients or the clinical staff, and when he did he usually confined himself to extended recitations of the Bible. Elijah communicated his displeasure with Paul in no uncertain terms, the nurses had reported to Dr. Lynch, when he looked him in the eye and whispered: *If you continue to bother me, I will tear you limb from limb and devour you.*

Tensions could run high when patients entered the ward and just before they left, Dr. Lynch explained, and Elijah was in a particularly bad humor when the gardaí had escorted him to the hospital, far worse than the last time he had been hospitalized. "All this before the two of them were able to talk through their respective positions on prophecy," Dr. Lynch continued with a laugh. "We might have witnessed something like *The Three Christs of Ypsilanti*."

Despite the potential for a deeper recognition of patients' needs by the clinical staff, questions regarding the other's intentions clearly still abounded in the ward. This was especially true when patients had to deal directly with one another, and never more so than when the vicissitudes of psychotic phenomena forced a negotiation between the intrapsychic and the intersubjective experience of psychosis. The intrusion of hallucinations and delusions from the interior scene of a given patient's psyche into the shared, social space of the ward was relatively

common, but it often required the intervention of the staff. Despite their almost uniformly biopsychiatric epistemological orientations, the ward staff had more than enough experience managing discordant psychotic processes to understand and anticipate the intensities that could arise when multiple decompensations resulted in two or more patients confronting one another in the grips of what a psychoanalyst might qualify as ego dissolution and the literalization of an ordinarily figurative threat like the one that Elijah leveled at Paul.

The space of the ward, in this sense, is both a contested resource and a potential theater of both conflict and reintegration for men and women living with psychotic mental illnesses. The proliferation of extra-institutional but nonetheless clinical space that the discourse of adherence produces[169] also extends the range of this overdetermination into zones that might otherwise be characterized as public or even private. In the experimental enactment of a medicated subjectivity, however, psychiatric outpatients are nonetheless capable of engaging with the institutional and epistemological terms that serve to partially ground their relationships to medication and institutionally mediated space within the mutually intelligible discourse of a shared universe. The intimacy of these practical yet poetic relationships to medication and extra-institutional space can constitute a kind of ritual for many outpatients to the extent that their relationships to medication often have no small part in determining to what extent participation in a broader social world beyond the hospital is possible.

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In the aftermath of an acute phase of illness, and following what was usually a concomitant increase in privileges surrounding their mobility in and beyond St. Dymphna's Ward, patients would often clamor for day-leave or request permission to leave the inpatient unit to meet visitors in the hospital cantina or share a smoke on the street outside. Some patients who earned their doctors' permission to leave the ward would even congregate together in the hospital café, carefully tucking the wristbands that identified them as psychiatric inpatients inside the sleeves of their sweaters or jackets. Such patients evinced or occasionally outright expressed a deep desire for community. Occasionally they found it in the space of the ward, but hospital stays were normally relatively short, and it was not uncommon to hear patients' stories about broken promises to see one another "on the outside" when they eventually returned to St. Dymphna's. At issue seemed to be an enduring and often overwhelming sense of stigma associated with hospitalization and psychotic mental illness more generally.

How, then, to follow patients out of the ward and into the broader network of community mental health, tracking their respective relationships with antipsychotic adherence and ambiguously clinical extra-institutional spaces? In short, it was very difficult. My search took me to the far reaches of the city of Dublin, to a community

[169] cf., the relationship between the psychiatric injunction to adhere and the proliferation of clinical space in Chapters 1 and 2.

mental health group run by psychiatric service users in consultation with psychoanalysts affiliated with the New Lacanian School's (NLS) Dublin chapter, into the homes of the patients who trusted me enough to offer such an invitation, and finally back to St. Dymphna's Ward to speak with a patient who simply never left. Hovering over all of these encounters was a pervasive sense of social dislocation—not always the "spoiled identity" of a stigmatic position,[170] but a nearly universal instinct to conceal what others would not or could not understand.

My work with the community mental health group that I call *Solas* was illuminating in this regard. Organized around tea, biscuits, and conversation, *Solas* was much like any other Irish social club save for the fact that all of its members were living with a psychotic spectrum disorder. Once a month, group members met in the recreation room of a Catholic church on the south side of Dublin to eat, drink, play music, and chat with their fellows about the news, friends and family, and their personal lives. Along with several practicing psychoanalysts and a former group member who described herself as "in recovery" from bipolar disorder, I served refreshments, made small talk, and stood by to act as a sort of sounding board if any of the group members needed advice, wanted to vent to a sympathetic ear, or were in crisis. In spite of the ostensive purpose of the group, the subject of mental illness almost never came up during the first five to six months of my year-and-a-half long tenure as a volunteer host. *Solas* ran another community mental health group that catered toward an intensive form of group therapy and purportedly regularly included participation by members in a state of active decompensation, but these meetings were closed to anyone but active members and the clinician who presided over the meeting, again almost uniformly a psychoanalyst affiliated with the NLS.

Clinicians like Dr. Lynch and the other members of his consultation team were eager to recommend participation in these groups. Indeed, though they fell short of employing the language of "counter-hegemony" or "de-medicalization," they professed to see such groups, as well as the broader network of community mental healthcare in Dublin, as an integral part of their patients' re-entry into life beyond the ward, ultimately arguing that the supplementary forms of social support they offered for persons in recovery addressed needs that their predominantly psychopharmacological treatments could not.[171] Despite my curiosity, and despite my numerous conversations with both group members and each of the presiding psychoanalysts themselves, I never received an official explanation for the partnership between *Solas* and the NLS. The psychoanalysts who worked with the organization offered a characteristically Lacanian feint and declined to speak for *Solas*'s board of directors; they did, however, offer the observation that Lacanian psychoanalysis might be better suited than many other therapeutic modalities to encountering the experience of psychosis without judgment or an ethos of intervention, befitting an organization run by and for psychiatric service users. Each of the analysts emphasized the necessity of engaging group members beyond the rubric of their various biopsychiatric diagnoses, and they were adamant in their

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[170] cf., Erving Goffman's classic *Stigma* for an analysis of the effects of the deviation from norms on social identity and integration within larger society.

[171] Nancy Scheper-Hughes, "Three Propositions for a Critically Applied Medical Anthropology," 64.

commitment to giving group members the space to make their own decisions regarding treatment when and if the subject of mental healthcare or medication did come up.

When they spoke with group members who were in distress, the analysts explained, they did not challenge the delusions or hallucinations that came to light during conversation but rather treated them as formulations that were integral to understanding the group members' larger relationships to the problem of a mutually commensurable experience of reality. In response, they customarily asked group members questions about these experience that were designed to re-orient them toward the other without inspiring paranoia and hopefully helping them to devise strategies for finding shared meaning in social relationships. The writings of Stijn Vanheule,[172] a Lacanian psychoanalyst who specializes in theorizing and treating psychosis, and who is widely read within the Dublin chapter of the NLS and beyond, are helpful in distilling a contemporary clinical approach to thinking about psychosis:

> Metaphorically speaking, neurotic symptoms are displaced signifiers that appear in unexpected contexts, and as a result, to paraphrase Freud (1919), they provoke the feeling that one is not the master in one's own house. Psychotic experiences, by contrast, come with perplexity, and often also with dismay. They are manifestations of unthinkable signifiers, with which one, at least initially, feels no link. […] Practically this implies that we don't aim at installing free association. After all, there is no repressed that should be brought to the fore. The position the analyst takes is different and aims at helping the subject find an answer in response to perplexing or maddening situations. This response might be diverse. It could consist of finding an identification to believe in, developing a habit or practice to hold onto, or formulating a rule to adhere to. Structurally, the answer we have to invent by means of psychoanalytic work at least temporarily fills the gap of foreclosure.[173]

Membership in *Solas* itself was often a potent point of reference for such stabilizing identification. Though the facilitators were quick to note that participating in a group meeting was by no means isomorphic with the experience of an analysand upon a psychoanalyst's couch, they were committed to bringing the same ethos of listening to *Solas*. They both also seemed grateful, on a personal level, for the opportunity to democratize dimensions of the practice of Lacanian analysis, providing a form of this specific type of clinical support to people who might otherwise go without.

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[172] cf., Vanheule's *The Subject of Psychosis*, a much-celebrated book that was published in 2011, just prior to the beginning of my fieldwork in Dublin, which provides an excellent historical reading of the three major periods of Lacan's evolving thinking on the nature of psychosis.

[173] Stijn Vanheule, "Conceptualizing and Treating Psychosis: a Lacanian Perspective," 393-394.

Over time, as group members became increasingly comfortable with my presence at meetings, they talked more and more openly about their mental health. Such conversation took many forms. Some complained about the side effects of their medications (they made you thirsty, they rotted your teeth, they made it impossible to enjoy a pint), while others talked about feelings of depression and isolation. Many group members commented directly on the difficulty of dealing with the stigma so often associated with psychotic spectrum disorders and spoke wistfully about the dream of a complete recovery and the cessation of medication. Most of them were nevertheless realistic about the difficulties involved in weaning themselves off of psychotropic drugs. One member, an especially friendly middle-aged man whom I'll call Dermot, used a particularly ironic turn of phrase to describe the difficulties of living in the aftermath of diagnosis and in daily relation to the antipsychotic medications that so often served as perpetual reminders of illness and otherness. When Dermot and his friends talked about "the war," they were alluding to the challenges inherent to living full and rewarding lives *in spite of* their status as psychiatric subjects. They spoke with admiration about fellow group members who had stopped (or claimed to have stopped) taking their medications altogether, and they were exceptionally proud of those of their friends who were able to hold steady jobs and did not rely upon disability checks or public assistance for housing. Participation in *Solas* seemed to serve as something of a lifeline for this group of friends, but their camaraderie and mutual support was not a panacea.

"I think I'm having a panic attack," Dermot confided in me halfway through a meeting some nine months into my time volunteering with *Solas*. "I don't understand it," he continued through gritted teeth, sweat beading his brow. "It's just an ordinary night with the group…why is this happening now?" His voice never rose above a whisper.

Handing him a glass of water from my place behind the recreation room's service counter, I offered to breathe slowly and deeply with him. He didn't have any of the tablets that he occasionally took when he was overwhelmed by anxiety, and he didn't feel comfortable asking any of his friends if they were carrying. His humiliation was palpable, and at first I struggled to understand why he had shared his agitation with me at all, until the performative dimensions of group participation began to dawn on me. I occupied a strange position within the group: I was not Irish, nor was I a clinician, but I had stated my interest in studying psychotropic drugs and the lived experience of psychotic mental illness during my first introduction to the group members many months before. Perhaps equally importantly, my time with *Solas* had an expiration date. Perhaps for all these reasons, I had begun to notice, I had become a sort of Goffmanian "wise person" for some group members. As Goffman writes, borrowing "a term once used by homosexuals" to describe their heterosexual allies:

> […] the "wise" [are] persons who are normal but whose special situation has made them intimately privy to the secret life of the stigmatized individual and sympathetic with it, and who find themselves accorded a measure of acceptance, a measure of courtesy membership in the clan. Wise persons are the marginal men before whom the individual with a fault need

> feel no shame nor exert self-control, knowing that in spite of his failing he will be seen as an ordinary other.[174]

I was not, to Dermot's knowledge, a psychiatric service user, but I could be relied upon for sympathy and support because of my proximity to presumed expertise, and it seemed likely that my own status as an outsider to mainstream Irish culture made confiding in me all the more palatable. He could confide in me without undermining his performance of "sanity" for his fellow group members. He could continue to fight "the war" while receiving a modicum of support from a fringe participant.

In spite of the best intentions of group members and facilitators, an intense pressure to move into an un-medicated state of "recovery" seemed to animate most of *Solas*'s most active and enthusiastic members.[175] As such, it was comparatively rare for group members to publically commiserate with one another about mental and emotional distress. Contrary to Goffman's observation that the first source of support and solidarity for a stigmatized person usually comes from other individuals who are similarly stigmatized, members of *Solas* ordinarily reacted to public displays of strange or symptomatic behavior with embarrassment or outright annoyance.[176] Dermot himself reproached another group member during an outburst that suggested the energy and frustration of manic elation with a simple but especially cutting question: "Are you taking your tablets?" Under the eyes of the rest of the group, it was enough to silence the errant member and restore a modicum of calm to the evening. I looked around the room, doing my best to hide my surprise at the degree to which group members seemed comfortable policing one another's behavior. People looked down into their tea cups or withdrew into newspapers to hide their faces. Some even got up to walk outside for a cigarette. Nearly everyone in the room was consuming an array of substances that could easily be understood as psychoactive, I noted, but the mere mention of an antipsychotic descended with the force of public censure. The man who was admonished did not return to the group for several months.

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I encountered similar difficulties when trying to recruit patients from St. Dymphna's Ward's outpatient clinic for more home visits and further interviews. Though many of the men and women I met in the ward were happy to have me

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[174] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, 28.

[175] cf., Neely Myers's *Recovery's Edge*, in which she explores the degree to which clinical and social pressure to "recover" from serious mental illness can be as detrimental to patient well-being as the discourse of chronicity, trapping patients in an absolutist system of unrealistic expectations for a return to full functionality without relapse while ultimately equating the re-emergence of mental illness with a moral failing on the part of the patient.

[176] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, 28.

shadow their outpatient follow-up appointments with Dr. Lynch or his junior psychiatrists following their discharge from the hospital, the vast majority of them declined to invite me into their homes. Their trepidation was disappointing but ultimately understandable.

"I'm sorry, love," Theresa explained after one such appointment, "but how would I explain you to my neighbors?" Despite her decades-long battle with alcoholism and long history with Dr. Lynch, virtually no one outside of her immediate family (and other inpatients in St. Dymphna's Ward) knew that she had been receiving intensive psychiatric care for her addiction and labile moods.

One of the few outpatients to grant me an interview—a man in his late thirties whom I'll call George—displayed a similar desire to keep his history of mental illness as private as possible. George boasted a lucrative career in digital security, lived in a well-appointed condominium close to the Liffey, and by all accounts was successfully managing his schizoaffective disorder with a combination of the typical antipsychotic flupenthixol, an anticonvulsive medication called tegretol, and a low dose of antidepressants. More telling than his limited commentary on what adherence entailed were his thoughts on how other people, even his intimates, might perceive him in light of his diagnosis. He took his medications religiously, he said, but he also hoped to work with Dr. Lynch to slowly lower the dosages over time, and he had yet to share his medical history or the fact that he took psychotropic drugs with his girlfriend of several months. When I asked him why not, he said simply: "I wouldn't want to scare her off."

"I'll let you sit near the door," George offered, as we settled down across from one another in his dining room, my recorder resting on the glass tabletop between us.

"Why's that?" I asked naively.

"Because that's where the doctor sits in the clinic—closest to the door because it's safest. I don't want you to be afraid of me," he answered, looking down at his hands.

Comments like George's complicated my questions regarding how to think and write about a psychopharmaceutical practice of everyday life. Far from being uniformly banalized, outpatient antipsychotic adherence was often fraught with feelings of shame and exception, even between members of the same community mental health group. A sort of affective antipode to Paul's unsettling enthusiasm for his medications, the deeply stigmatic significance that many outpatients associated with their medications also served to undermine the degree to which the discourse of adherence was supposed to produce and support patient insight. Patients were supposed to take their medication because they understood that it would make them well; they were not supposed to fixate on what seemed to be a sort of indexical relationship between illness and cure, given concrete form in the antipsychotic tablet. When considered in conjunction with the strikingly high rates of patients like Matthew, Ray, or Theresa returning to St. Dymphna's Ward following a lapse in the consumption of medication—much less in relation to Dr. Lynch's dismal estimation of rates of adherence when not directly observed by an agent of psychiatric power—the biopsychiatric project of outpatient antipsychosis, much less community mental health, seems anything but straightforward.

In his discussion of the extent to which the multiplication of contemporary discourses of organization and governance has led to "contradictory movements that counterbalance and combine themselves outside the reach of panoptic power,"[177] de Certeau offers some clarity. He writes:

> The city becomes the dominant theme in political legends, but it is no longer a field of programmed and regulated operations. Beneath the discourses the ideologize the city, the ruses and combinations of powers that have no readable identity proliferate; without points where one can take hold of them, without rational transparency, they are impossible to administer.[178]

A species of institutional unconscious thus emerges from the discursive polysemy and collective weight of individual errors that characterizes outpatient mental health. Even beyond the kinds of therapeutic communities that take such a discourse of the unconscious seriously, epidemiological predictions regarding rates of medicinal consumption clash with clinicians' own diminished expectations regarding patients' capacities for rational action. Patients love their medications and they fear them. They obsess over them and they forget them. The psychodynamic significance of these relationships to the tablet comes to the fore yet again. The institutionalized system of ordered relations to antipsychotic drugs barely contains a confoundingly pluralistic system of signification in which a pervasive sense of rupture and unreality returns. Patients are variously overwhelmed by a sense of embodied porousness or threaten to devour one another in such a space, and medications are as likely to symbolize imprisonment and shame as they are to instantiate the promise of the Eucharist.

With this multiplicity of symbolic associations in mind, and while attempting to parse the integration of adherence into a larger, often highly ritualized milieu of consumption and sociality, I draw upon the unlikely conceptual resource of Gananath Obeyesekere's work on the mythopoetics of cannibalism. Far from writing out a sensationalist account of the devouring other, Obeyesekere is interested in the degree to which various societies mark idiosyncratic forms of "consubstantial community," or "a commensal community eating of a consecrated substance, based on the literal meaning of 'consubstantial' as 'having the same substance or essential nature.'"[179] Such a formulation relies upon the psychoanalytic logic of introjection, I argue, though Obeyesekere does not render the relationship between these two concepts explicit. Introjection, following the work of Freud and his contemporary and colleague Sándor Ferenczi, is the intrapsychic process by which a lost or rejected object of primordial relation becomes a powerful source of unconscious identification and, ultimately,

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[177] Michel de Certeau, *The Practice of Everyday Life*, 95.

[178] Michel de Certeau, *The Practice of Everyday Life*, 95.

[179] Gananath Obeyesekere, *Cannibal Talk: The Man-Eating Myth and Human Sacrifice in the South Seas*, xvi.

internalization and replication over the course of infantile maturation.[180] One takes on the qualities of what one eats, in this sense, and the collective transformation afforded by a shared meal is no less significant.

For Lacan, introjection is less a question of early object relations than a matter of internalization of symbolic cultural content as received in an encounter with the other. Introjection, he writes, "is always accompanied by a symbolic denomination. Introjection is always the introjection of the speech of the other, which introduces an entirely different dimension from that of projection."[181] In light of the shame and fear associated with antipsychotics, to say nothing of their indexical relation to the illnesses they are nominally supposed to treat, could a group like *Solas* find something like consubstantial community in the shared consumption of antipsychotics? Is it possible for community mental health patients to transcend the shared, stigmatic signification of their medications and bring about something like the ritual introjection of "sanity"? Can the poetic elaboration of extra-institutional clinical spaces via patients' engagements with the project of medicated subjectivity stabilize the boundary between internal and external experience? Beyond their chemical qualities, can tablets stave off the symbolic quandaries imposed by the dissolution of the ego? I found myself drawn back to St. Dymphna's Ward in my attempts to answer these questions.

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Joseph was twenty when I met him during the first week of my fieldwork in St. Dymphna's Ward, and he suffered from an extremely severe case of obsessive-compulsive disorder, or OCD. This case was so severe that Joseph had been hospitalized for approximately three to four months prior to my formal affiliation with the hospital, for all nine months of my intensive fieldwork in the ward, and for some time after my departure according to my ongoing communications with Dr. Lynch. Joseph remained in St. Dymphna's Ward for so long because of the severity of his disorder, because he often actively resisted treatment, and because his mother seemed unambiguously invested in institutionalizing him. His relationship to medical intervention was marked by anxiety and defiant resistance, but he was especially frightened of medication.

As the name obsessive-compulsive disorder suggests, documents like the DSM-V and its international counterpart, the ICD-10, define OCD as being characterized by obsessive, intrusive thoughts and an often-concomitant compulsion to perform highly specific rituals. These rituals seem to help mitigate anxiety produced by the obsessive thoughts, and in some cases it appears that patients believe, to varying degrees, that the performance of these rituals actually prevents the content of these obsessive thoughts from becoming reality. OCD is often treated with a combination of therapies aimed at behavioral intervention (usually a mix of cognitive behavioral therapy and some form of aversion therapy)

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[180] Sigmund Freud, *Group Psychology and the Analysis of the Ego*, 51.

[181] Jacques Lacan, *Freud's Papers on Technique, 1953-1954: The Seminar of Jacques Lacan, Book I*, 83.

as well as with SSRIs for their antidepressant and anxiolytic properties. The ward's staff had employed all of these tactics in attempting to treat Joseph for the duration of my time working at the hospital, but in the last two or three months of my ethnographic research, they were reaching the end of their collective tether.

I spoke with Dr. Lynch on the day that Joseph was prescribed quetiapine (or Seroquel), an atypical antipsychotic sometimes used to ameliorate the symptoms of treatment-resistant OCD, and together we processed his ambivalence regarding this newest intervention. "He's ready for *you* now, Michael," he winced, a dry reference to the fact that my IRB clearance specified that I would only speak with patients who had been prescribed antipsychotics. With great weariness, he continued: "We have nearly exhausted our other resources."

Prior to meeting Joseph, my knowledge of OCD was limited to a rather stereotypical association of the disorder with a generalized fixation on cleanliness and repetitive hand washing and what I imagined to be relatively rare and exotic presentations like trichotillomania or religious scrupulosity. Joseph, on the other hand, had become so preoccupied with the impossibility of washing himself in a symmetrical or ritualistically appropriate fashion that he had stopped bathing altogether. Staff were divided on how long it had been since he had taken a proper shower, but by their count they were only able to coax him into semi-supervised bathing sessions once every few weeks, and even then only with the promise of limited day leave or other privileges. Such a case of OCD was exceedingly, mercifully rare, Dr. Lynch told me, but it was not unheard of.

Even more troubling than Joseph's aversion to washing when he could not do so perfectly—and one gets the sense here that the demands exacted by Joseph's compulsions regarding rituals of grooming and hygiene were simply so complex that they paralyzed him—was his penchant for retracing his steps. This was a harmless, if occasionally annoying, ritual in the setting of St. Dymphna's Ward—essentially it meant that you could usually find Joseph walking up and down the halls of the ward, sometimes forward and sometimes backwards, often in such a way as to seem like he was practicing a waltz with an invisible partner—but it became increasingly dangerous and intolerable to his mother and to law enforcement when he retraced his steps down a major thoroughfare like O'Connell Street, one of the central commuter arteries of the city of Dublin. It was actually Joseph's attempt to repeat a particularly long journey—to get it right, in a sense—along the median of one of Dublin's busier streets that got the municipal *gardai* involved, got him delivered to the psychiatric emergency room, and prompted his mother to file paperwork in collaboration with the police to have him committed as a danger to himself and others.

Simply put, by the time we began our formally sanctioned conversation, the corporeal manifestations of Joseph's illness were spectacular, florid, overdetermined. His body was a site of contention—at once the primary territory of a disciplinary investment by the hospital as institution of care, and in the space carved out by his resistance to this discipline, his primary weapon in the war against much of the staff. The nature of Joseph's compulsions was somewhat clear to me at this point, but I had yet to begin to understand the content of his obsessions. I will say more on this later. For now, I want to try to think through the ways in which

several different theoretical languages can be used to attempt to understand Joseph's illness and the treatment it requires, as well as his experience of self in a state of suffering, all within a larger social, historical, and institutional milieu.

Here I want to propose my first "reading" of Joseph's self, namely the way that this figure emerges as an epiphenomenon of specific types of care. It would be easy, after all, to mark Joseph's body as the sole object of medical intervention. Under the sign of a biopsychological and behavioralist strategy of treatment, the staff wanted Joseph to adhere to a "care plan" that involved taking his medication, washing his body and his clothes, and disposing of all the detritus that accumulated about his person—the candy bar wrappers, the old tissues, the banana peels that he tucked into his pockets, under his bed, and into the locker in his room until they rotted or produced a smell and were disposed of by increasingly irate members of the hospital staff. Such a body actively resists incorporation into a Foucauldian apparatus of subjectivation, however, given the degree to which it renders literal the symbolism of the ungovernable.

This kind of biopolitical reading can only take us so far, however, especially when we attempt to think a self or a subject in relation to the body that I have been describing—a body that takes on the characteristics of the abject, a body that variously enthralls and inspires discomfort, and occasionally even something approaching horror, in those who behold it. How can we think about a body that functions, to some degree, like a social contaminant? How can we think about a self or subject that is so unreasonable, so averse to the recuperative, disciplinary strategies of the institution of care, that it begins to inspire unreason in its caretakers? It is the perceived abject nature of this self that I want to explore now, namely the ways in which this self, via the medium of its body, overcomes its own boundaries and *con*founds others' senses of the same.

In *Purity and Danger*, Mary Douglas famously defines dirt as "matter out of place." Coming into contact with hair or fingernails is usually acceptable when they are attached to a living person, for example, but they become grotesque substances when they are cut off from the body—when they are removed from their proper place in the universe relative to the body—beyond all rational contemporary understandings of what constitutes cleanliness. Rather, popular notions of the clean and the unclean resonate on a subtly moral symbolic register, and the orifices of the body are likewise understood to represent doorways demarcating the boundary between the profanity of the outside world and the sanctity of the interior world—a sanctity that can all too quickly become profane when blood or bile or excrement is externalized. Grooming rituals, again more often devoted most directly to a social rather than microbial definition of cleanliness and care, proliferate around these openings, fortifying the integrity of the body, and these rituals are among the first, earliest performances of social convention in which we are trained, most often by parents or caretakers.

Joseph's body, as well as, I want to argue, the self that inhabits it, were matter out of place on the ward. His various hospital caretakers spoke with the greatest frustration, and at times even anger, when they talked about being forced to supervise his performance of these earliest forms of social convention. Largely exceedingly patient men and women, they were nonetheless deeply disturbed by

being called into what seemed to many of them a perverse form of familial relation. Worse for many of them than the ways in which the sensorial impact of Joseph's body exceeded its traditional boundaries—its smells, its sights, the tactility that it suggested—was the extent to which many of them seemed to feel intimately implicated in the care they tried and failed to give him. "I'm not his *mother*. I'm not his *father*. Why do I have to do this? He's an adult."

The disorder that Joseph embodied, which he seemed to directly cultivate via his resistance to psychopharmaceutical and behavioral care plans, extended to the constellation of objects that he accumulated rather than discarding or otherwise ritually purifying. Tissues, wrappers, pieces of food, unwashed clothing—all of these objects took on a quality of the occult. They became emblematic of the scattered, disorganized self emergent from Joseph's illness. They indexed, I believe, the failure of the therapeutic process to call a biomedical subject into being, a species of self that might be said to accrete around the internalization of a "right disposition" or a self that is located in the practice of self-care, normatively understood. The objects that Joseph accumulated, I learned, were the things he was carrying with him over the course of his multiple attempts to "finish" the ritual of retracing that landed him in the back of a police car, in the emergency room, and eventually in the inpatient ward. They marked what seemed to be a strategy of homeostasis. Joseph wished to refrain from washing himself or his clothes, from throwing away a tissue or a banana peel, because he wished to suspend himself in the conditions of the interrupted ritual. His twenty-first birthday came and went, but he told me that he felt he was stuck in the moments before the ritual began, that he had not truly aged. The ritual interrupted, the profane detritus he accumulated, his dirty hair and clothes—I began to think of these features as another type of attempt at establishing a technology of the self.

For Dr. Lynch, they were hallmarks of a treatment that was not only failing but was in fact producing the opposite of its intended effects. When Dr. Lynch attempted to negotiate Joseph's discharge into the community mental health system on the grounds that he was refusing treatment and perhaps even becoming more intensely unwell, his mother delivered a letter of complaint from a local representative affiliated with the political party Sinn Fein advocating for Joseph's right to receive the best possible care at his local public hospital. In an ironic turn that resonated on the level of both politics and the symbolic resource of collective social history, Joseph responded to his enduring captivity, and to hospital administrators' refusals to allow him to return to the ward from day leave with the pies that his mother curiously kept baking for him, by comparing himself to the Blanketmen of the infamous Long Kesh Prison hunger strike—an event considered by many to mark the zenith of the Troubles in Northern Ireland and punctuated by IRA affiliated prisoners' collective refusal to wash, to wear clothing, and ultimately to eat, all while painting the walls of their cells with excrement in the name of receiving official recognition as political prisoners loosely affiliated with the aforementioned political party Sinn Fein. The interpenetration of contemporary political claims upon the status of a body in a state of illness and the symbolic resonance of that body with others within a shared social and historical milieu—and the degree to which the former and the latter were ultimately opposed within the

space of St. Dymphna's Ward—was actually lost on no one, but it did nothing to blunt the surreal irony of the situation.

From my perspective, however, Joseph's self-professed affinity for the Blanketmen recalled the work of Allen Feldman on the hunger strikes in *Formations of Violence*, especially the extent to which the symbolic, perhaps even psychodynamic, significance of prisoners' attempts to thwart the disciplinary powers of the prison as its own form of an institution of care relied upon their commitment to transforming their bodies from the sites of subject-making to symbolic weapons opposed to the disciplinary aims of the state. The Blanketmen's physical transformations—arguably more extreme versions of the ones Joseph had undertaken for slightly more parochial and mysterious reasons—emerged from a radical refusal of normative forms of self-care. It did not take long, according to Feldman, for the self in question to disappear, to overcome its symbolic boundaries and bleed into the space around it, for the interior of the body to become the exterior of the prison cell through the smearing of excrement on the walls. The self, the subject, became unbounded and spatialized, in a sense. It became a territory.

Joseph was remarkably candid when I asked him why he felt compelled to repeat his journeys around town, retracing his steps sometimes down the middle of a busy street. It began when he was about 11, he said, and riding a bus through the city center with his mother. A man of East Asian descent sat down across the aisle from them and sneezed carelessly, forgetting to cover his mouth. Recalling recent news bulletins about the rise of a potential SARS pandemic in East Asia, news that clearly became entangled with an inchoate array of fantasies about a poorly understood and flatly imagined ethnic other, Joseph was overcome with the sense that this man represented a potential vector of transmission for disease. He began compulsively washing his hands as soon as he returned home, and over the course of the following months he became increasingly preoccupied with the threat of contamination by germs. He was able to acknowledge that these conclusions were up for debate. In all likelihood, the man who sneezed on him on the bus had not just come from Hong Kong, nor was it likely that he suffered from Severe Acute Respiratory Syndrome. Joseph could appreciate how specious these associations might sound to a casual observer. However, the extremely slim possibility that the man had exposed him to a frightening illness overwhelmed him, and he set about attempting to ritualistically reconstitute the symbolic borders of his person, the stable and closed nature of which could no longer be taken for granted.

Over time, the nature of his fixations and the compulsions that followed changed. His fear at the possibility of infection broadened to include not only biological agents of contamination but also psychological states or interpersonal events. He began to worry that he was vulnerable to taking on unpleasant personality traits or the social stigmas that burdened people he encountered on the streets. If someone looked lonely or angry or like they didn't have many friends, Joseph worried that these qualities could be transmitted through a sneeze or a word or physical contact and overtake him. Intersubjective exchange became fraught with danger. The other threatened to overwhelm, to annihilate the self. Hand washing alone would not save him. In fact, quite the opposite. He began to attempt to remain in a state analogous to the one he was in at the moment of these

threatening encounters—unwashed and clothed in the remnants of the day in question—and he began to seek out the opportunity to retrace his steps without incident. In an attempt to guarantee the unity of the self, to demarcate the boundary between himself and a world of others, the self actually became all the more porous and distributed across a spatial as well as temporal register.

I do not seek to challenge his doctors' diagnosis of OCD, to try to tease out a tension between the neurotic or psychotic subject position, though the staff of St. Dymphna's ward increasingly debated the usefulness of the diagnosis of OCD toward the end of my time in Dublin, and we were all struck by the extent to which Joseph seemed to enjoy his symptoms, by the extent to which his illness was ego-syntonic or continuous with his sense of self, rather than being characterized by the ego-dystonia that is so often associated with OCD. Rather, I want to take advantage of a model of the self that must be understood as always already split and multiple, elaborated to some degree *through* the symptom and not in opposition to it. As Joseph said when I asked him whether or not he intended to keep trying to complete the ritual that landed him in the inpatient ward: why not? This is a part of me, and I'm tired of having to apologize for myself.

I'll repeat: I believe that Joseph enjoyed his symptoms. He understood them to be a part of himself, perhaps *because* rather than *in spite of* the extent to which they distributed his personhood across the streets of Dublin city center and through various registers of time. I'm thinking here of the model that Lacan gives us for thinking through the relationship between the self and a nascent sense of embodied wholeness in the space of the mirror stage. The self here is a "mirage of maturation and power," a specular image of totality marking discrete borders between the incipient Ego, the other, and the world.[182] I do not mean to suggest that Joseph's mirror is broken, but the image is on the move—sometimes present, sometimes in transit.

[182] Jacques Lacan, "The Mirror Stage as Formative of the *I* function as Revealed in Psychoanalytic Experience," *Écrits*, 76.

Epilogue: Antipsychosis in the Intimate Clinic

> Philosophy borders madness. It lingers there, sometimes, extracting itself more or less successfully. But the successes that are too successful cancel out philosophy, as the Principle of reason that ought to guide it becomes a pure Principle of identity. If philosophy is the "reassurance given against the anguish of being mad at the point of greatest proximity to madness," this assurance is always put into question, perpetually destabilized.
> -Frédéric Neyrat, "Critique of Pure Madness," *Atopias*, 3.

Paul and I finally had our drink a few months after he was discharged from the inpatient ward, the day after Lou Reed died. We sat in his living room drinking lukewarm pint cans of Saint Etienne and listening to "Coney Island Baby," the conversation drifting lazily between the track listings, a chance encounter on the street with one of his friends from the ward, and of course his meds. He was nominally still on the all of the same medications, though the haloperidol now came in a slightly slower-acting tablet form, and he was still committed to adhering, albeit on his own terms.

The haloperidol and the procyclidine sat in half-empty blister packs on his kitchen counter next to a rack of the beer we were drinking, packets of tea, a jar of instant coffee, and an electric kettle. I noted the similarity of this assemblage to a laboratory setting, the spread of substances all commonly understood to alter consciousness laid out in a neat row, and Paul reiterated his earlier claim that the drugs his psychiatrists prescribed him were tools, useful for maintaining his stability on his own terms but ultimately not so different from the illicit psychotropic substances that lead to his most recent breakdown. While he remained on the haloperidol, as well as the procyclidine to manage the former's potential for producing unpleasant neuromuscular side effects, he abstained from the olanzapine and lorazepam unless he had trouble sleeping. He was short on money while waiting for his disability payments to be processed, and gesturing toward a kitchen cabinet that housed the cache of excess pharmaceuticals, he admitted that he was considering trying to sell them for their hypnotic effects. I asked how his medications were making him feel now that he was taking them at a lower dose and in the more diffuse institutional context of community care. The haloperidol was managing the immediate, phenomenal experience of psychosis including his delusions and hallucinations, but he said that he was still conceptually committed to the idea of extra-dimensional life and the possibility that he was being observed and manipulated by these beings, that his body was open and, indeed, continuous with the world.

Paul's status as a psychotic subject, as well as his partial training in Lacanian analysis and ongoing experimentation with his medications, make for a curious sort of engagement with the problem of extra-institutional adherence. From a space between madness and philosophy, Paul is able to generate a unique form of conceptual counterpoint to the ways in which medications follow patients from the hospital and into the broader community. The status of matter in Bennett's thinking as an "out-side" and a limit to intelligibility also recalls the place of the Real in Lacanian analysis. This is not to say that the Real is synonymous with the material; rather it constitutes an order of experiential reality that is not only beyond symbolization but actively resists it. Following Paul's own attempts to symbolize his experiences with medications, I would like to suggest that the Real can, at times, become available through frictive contact with the material. Following Freud's thoughts on trauma, a body of work that marks a continuity between the penetration of the primitive organism by environmental stressors and calamitous near misses with an automobile or a train collision, the force of the material threatens illusions of mastery and reveals the terrifying, inhuman agency of the world beyond (and sometimes within) the subject.

The symbolic foreclosure that characterizes the Real also suggests the ways in which the psychotic subject is drawn into the full presence of the material world as an out-side to human agency and design. In a sense, and despite the fact that psychotic subjectivity is characterized by the méconnaissance of delusions and hallucinations, men and women like Paul seem to have access to a dimension of the vibrancy that Bennett is writing toward, a vibrancy that the non-psychotic, in turn, misrecognize. So when Paul says that haloperidol "tastes like order," I'm reminded of Bennett's thoughts on the affective agency of material actants. The material "mood" of the drug, to borrow another of Bennett's characterizations, is slow and sleepy, producing the ordered, relatively docile bodies prized by inpatient psychiatry. Ostensibly, these medications are supposed to restore "sanity," but its more accurate to say that their Real effects impact the subjectivities of adherent men and women in terms all their own.

Gaston Bachelard calls the house the space that "shelters" the dreamer,[183] that localizes a series of habits—or, as he calls them, the "passionate liaisons of [the] bod[y]"[184]—transforming this series of repetitive actions into a state of *in*-habit-*ing*. I want to argue that these habits, these repeated practices, have the capacity to transform space with the same poetic intensity with which the psychotic subject sees and (re)interprets the world and the objects that he or she encounters in it. Space, I want to argue, is the theater of materiality—whether the Real of Lacan, the agentive object of Latour, or the biopsychiatric drug—just as it is shaped and patterned by a practical engagement with this materiality. Transformed on an intimate and subjective level by the activity of adherence itself, however ambivalently undertaken, I see the space of the classically defined clinic reinterpreted, hallucinated, and, in a few miraculous cases, renewed and repurposed.

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[183] Bachelard, *The Poetics of Space*, 6.

[184] Bachelard, *The Poetics of Space*, 14.

This is the space of the intimate clinic, as I would like to call it: the penetration by the psychiatric logic of adherence of both personal, bodily, and propertied space-as-such, and the inchoate, multifaceted, and profoundly porous space of psychotic subjectivity by the larger material, social, and conceptual infrastructure of community mental health. In this space we find a reinterpretation, conscious and intentional or otherwise, of clinical authority. Borrowing again from Corin, the propensity of the psychotic subject to encounter and, to some degree, reinterpret this psychiatric logic cannot be overstated. "Psychotic patients appropriate and modify collective representations, beliefs, and symbols in an idiosyncratic manner," Corin writes, telegraphing the méconnaissance that characterizes the psychotic encounter with the world.[185]

This misrecognition inheres, I argue, in the poiesis of psychotic subjectivity—a subjectivity that takes for granted Bachelard's poetic capacity to see that "the duality of subject and object is iridescent, shimmering, unceasingly active in its inversions"[186] and, furthermore, to "sense the concordance of world immensity with intimate depth of being." He continues:

> …we [originally, the poet, for our purposes the psychotic subject] discover that immensity in the intimate domain is intensity, an intensity of being, the intensity of a being evolving in a vast perspective of intimate immensity. It is the principle of "correspondences" to receive the immensity of the world, which they transform into intensity of our intimate being. They institute transactions between two kinds of grandeur.[187]

The stakes of antipsychotic adherence, in this sense, are at once deeply subjective and grandly global.

The aporia of these effects, and their intersection with the tangled interplay of psychotic encounters with others and the world, both misrecognized and Real, produces a fascinating space for experimentation and intimate relation with the psychopharmaceuticals in question, a space both literal and conceptual that I have started calling the "intimate clinic." In the intimate clinic of Paul's living room, in a network of vibrant material actants, a species of adherence was being parsed, explored, and enacted. The intensity of the symptoms had diminished, it would seem, but a psychiatrist would likely say that full insight was elusive. It is here, I argue, in the gap between the intended effects of Paul's antipsychotics and his continuing experimental negotiations with their materiality, that a new way of understanding the relationship between the psychotic subject and the world, as well as the stakes of a trans-disciplinary dialogue, emerges.

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[185] Corin, "The 'Other' of Culture in Psychosis," 287.

[186] Bachelard, "Introduction," *The Poetics of Space*, xix.

[187] Bachelard, "Intimate Immensity," *The Poetics of Space*, 193.

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