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# Hunting the Real: Psychosis and Race in the American Hospital

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It has been consistently observed that black Americans receive psychotic disorder diagnoses at higher rates than white Americans. While this finding has proven robust across time and setting, with other demographic variables accounted for, reasons for the disparity remain obscure. This paper aims to provide a psychoanalytic and historical framework for thinking about this correlation. Rather than categorizing black liberation as insane (a well-worn trend within American psychiatry) or dismissing the elevated rates of insanity as mere racist fabrication, here, I propose to listen to what speaks through insanity for what it may reveal about the historical and present realities of being black in America. To do so, I will first outline Francoise Davoine and Jean-Max Gaudilliere's framework for thinking about psychosis alongside historical trauma and then turn to clinical experiences at a city hospital in the Bronx.

Over the last three decades, it has been consistently observed that black Americans[1] receive psychotic disorder diagnoses at higher rates than white Americans (Anglin et al., 2010; Olbert et al., 2018; Schwartz & Blankenship, 2014). While this finding has proven robust across time and setting, with other demographic variables accounted for, reasons for the disparity remain obscure. Here I will briefly outline possible explanations, and then turn to a framework for thinking about the relation between race and psychosis that I find particularly productive. I will argue that elevated rates of psychosis among black Americans may reflect the catastrophic experiences carried by this particular population that have been disavowed in the social inscription of American history and that a clinical approach sensitive to historical and political factors may be critical to recovery.

One explanation for the link between black race and psychosis in America is clinician bias. Research has pointed to clinicians' mistrust of African American patients (Eack et al., 2012), the under-diagnosis of mood disorders in African American populations (Barnes, 2004), and misinterpretation of socially

[1] *As I am interested in the impact of the historical and social position of those defined as "black" in America (which cuts across ethnic origin), I will refer primarily to "black Americans". Some of the research has focused exclusively on African Americans, so I will use this term when appropriate.*



disruptive behavior (Schwartz & Blankenship, 2014) as potential mediators to the disproportionate diagnostic patterns. Even when using structured interviews with clear-cut diagnostic criteria, race has been shown to influence clinicians' diagnosis of schizophrenia, independent of symptoms (Neighbors et al., 2003).

But reasons for the disparity also surpass individual prejudice. In his book, *The Protest Psychosis*, Metzl (2010) charts how the very diagnostic classification of psychosis has shifted historically in response to anxieties in the medical establishment inspired by black liberation, beginning with slavery and the protest thereof by black slave leaders and others. In 1851, American surgeon and pro-slavery defender Samuel Cartwright developed two categories of insanity specifically for slaves. The first, Dreptomania, described the "symptom" of attempting to run away, and the second, Dyaesthesia Aethiopis, described the "rascality" and "disrespect for the master's property" that resulted when slaves did not have white men overseeing their every action (p. 30). The "treatment" Cartwright recommended was, not surprisingly, brute violence: "whipping, hard labor, and in extreme cases, amputation of toes" (p. 30).

Cartwright's work influenced early twentieth century researchers, who argued that rates of insanity rose dramatically in black Americans after emancipation, a supposed but demonstrably false relationship. For instance, in 1913 psychiatrist Arrah Evarts wrote an article in the Psychoanalytic Review in which she linked psychosis in "colored" patients to the pressures of freedom: "This bondage in reality was a wonderful aid to the colored man. The necessity of mental initiative was never his, and his racial characteristic of imitation carried him far on the road. But after he became a free man, the conditions under which he must progress became infinitely harder" (Metzl, 2010, p. 31). The association between blackness and dementia praecox (a biological category for psychosis at the time) was further used by the Eugenics movement as justification for sterilization. A key advocate was Eugenicist and Chief Justice Harry Olsen of the Chicago municipal court, who argued that American society deals with the "defective insane" via "race betterment … segregating and sterilizing defective stocks so that they may not reproduce their kind" (Metzl, 2010, p. 33–4). Put

simply, the medical treatment of psychosis is directly tied to the cruelest aspects of our racial history.

Metzl (2010) documents how shifting trends within mental health over the following decades, along with anxieties consequent to a changing racial climate, led to a reorganization of the diagnostic category of schizophrenia. As psychoanalytic conceptions of psychosis and its treatment came into fashion in the 30s and 40s, the diagnosis schizophrenia became associated primarily with upper-middle-class white housewives; black Americans suffering from psychosis during these decades were in large part diagnosed as antisocial. Legal and medical innovations in the 1950s (such as the increased use of insanity as a defense in



criminal court, and advancements in the chemical treatment of psychosis) along with overcrowding in asylums then led to a shift from treating asylum patients to suppressing and controlling them. With this turn toward coercion, and concurrent with the rise of militant racial justice movements, came a reorganization of the category of schizophrenia in the DSM-II to address primarily aggressive black men.

Where the DSM-I had considered schizophrenia a "reaction," suggesting "individual extensions of normal personality," the newly introduced DSM-II named schizophrenia an "exogenous disease" (p. 96); it began using male pronouns to describe its subject and highlighted hostility and aggression. Medical research on schizophrenia began focusing on black subjects for the first time, and associating schizophrenia with Black Power. The most egregious example, and Metzl's title, came from psychiatrists Walter Bromberg and Frank Simon, who described a new form of schizophrenia called the "protest psychosis": "a condition in which the rhetoric of the Black Power movement drove 'negro men' to insanity" (Metzl, 2010, p. 100). Similar arguments appeared in various forms in many mainstream research articles in the 1960s and 1970s.

Over the next several decades, de-institutionalization further produced black men as psychotic subjects par excellence. Metzl (2010) writes:

> *The process [of de-institutionalization] did not only dictate which patients the state set free, it also determined which patients it held on to. The later and much smaller group—most all of whom were men—[were argued to have] suffered from a particularly violent form of schizophrenia, one that required their continued incarceration ... As a*

*result, these men became the institutionalized bodies that de-institutionalization left behind. (p. 136)*

In short, both the diagnostic categories and the clinicians who implement them associate psychosis with blackness, and more specifically with black people fighting for freedom.

While much of the correlation between blackness and psychosis can be explained by clinician bias and structural racism within our diagnostic categories, recent empirical research pushes our thinking further. Using nuanced techniques such as race-blind symptom descriptions, newer studies suggest a relation between black race and risk of psychosis may exist in America, even with individual and structural biases accounted for (Arnold et al., 2004; Bresnahan et al., 2007). Rates of psychosis do not appear elevated in black populations outside of the US and Europe (Anglin et al., 2010),[2] suggesting a correlation between the experience of being black in America and elevated

[2]*While this research has been important in refuting an essentialist reading of the relation between black race and psychosis, it is important to note that it ends up relying on an essentialist conception of blackness, where people across different societies and geographies are assumed to be part of an overarching category of "black" people, as if the term referred to an ontological reality and not a context-specific social construction.*



expression of psychosis. This paper aims to provide a psychoanalytic and historical framework for thinking about this correlation. Instead of dismissing black liberation as insane or dismissing the elevated rates of insanity amongst black Americans as mere racist fabrication, I propose to listen to what speaks through insanity for what it may reveal about the historical and present realities of being black in America. To do so, I will first outline Francoise Davoine and Jean-Max Gaudilliere's framework for thinking about psychosis alongside historical trauma, and then turn to my experiences on internship at a city hospital in the Bronx.

In their book, *History Beyond Trauma*, Davoine and Gaudilliere (2004) theorize madness not as a flight from reality (as it is commonly framed) but as an investigation of aspects of reality that have been subject to erasure. Focusing primarily on war trauma, they elaborate a type of catastrophic experience at the edge of the personal and historical that is mis- or dis-remembered by an entire society, often for political reasons. For Davoine and Gaudilliere (2004),

such events and their continuous erasure erode the fundamental securers of social and subjective existence. This is on two registers. First, there is a "rupture of the symbolic order, of the place in which alliance, the guarantee of promises and treaties, and hence the social link, is founded" (p. 45). Normal modes of trust and relationality have been destroyed, leading language and history to falter in their anchoring functions. Second, there is a "disorganization of the orientation points of the Imaginary" (p. 45). Time and space fall into disarray, destroying the capacity for "specular identification" through which one comes to have a self (p. 45).

Madness, for Davoine and Gaudilliere, becomes then both the effect and expression of a horror that has been forgotten: "What we are dealing with … is a normal craziness that bears witness to a normality that is crazy, trivialized, dehistoricized, and denied" (p. 47). They continue: "In the gap opened up by those patients who rightly lament that they have no self, no 'me,' … [t]hey … bear witness to the stories that have been erased from history … whose disaster they reveal at the price of their own identity" (pp. xxi-xxii).

For Davoine and Gaudilliere (2004), this witnessing of a failure to inscribe historic catastrophe points the way toward resolution: "In speaking to the wall, to the TV, or the universe, madness challenges its interlocutor to find the place of otherness to which it can speak" (p. 7). The analyst's role, then, "far from diagnosis of deficit," becomes to "bring into existence zones of nonexistence wiped out by a powerful blow that actually took place" (p. xxvii). Davoine and Gaudilliere (2004) articulate this project as a battle, and one that does not leave the analyst unscathed: "the analytic act in cases of madness may be compared to an arrow of language repeatedly shot at the Real Thing in order to force it to enter the realm of speech" (p. 206). More specifically, they argue that such



patients find resonances in our own histories and make use of them to locate points of overlap from which experience without witness can find the other necessary to be spoken, and even more importantly, to be heard.

Using Davoine's and Gaudilliere's model, I turn to my experiences as a psychology intern on the inpatient psychiatry units of a city hospital in New York, where I treated primarily poor and working-class men of color-experiencing psychosis. As I was able to witness only momentary glimpses into the breakdowns patients were experiencing and giving voice to, my presentation will be associative, drawing from literary and historical references. My goal is not to offer a conclusive elaboration of what psychosis can tell us about blackness in America, but simply to point to a way of listening that may

allow us to take seriously a form of expression often dismissed as nonsense and medicated into silence.[3] I will present my observations in three parts, relating themes in the order they returned to memory.

## Destruction

It is difficult to reenter the hospital—to walk myself through the two double doors to which I held the key, never knowing what I would find inside. Swallowing fear every time, because no kind of safety was ensured. The day I left the inpatient units, I dreamt of a mass murder I had barely escaped, leaving many to die. Indeed, when I think of the hospital, it is the threat of destruction pulsing through the halls that first returns.

This seems multiply determined. Current qualifications for inpatient hospitalization make acts of violence or violent urges close to mandatory for admission. Insurance-driven short stays then created more acute patient populations, less stability, and less relational trust within the unit. A deprived environment exacerbated tensions, as well as symptoms. Lastly, and perhaps most insidiously, there was little containment offered. The hospital did not supply staff who could intervene on violence on the unit—instead, when violence erupted, there would be a "blue light," and support staff would show up minutes later, after enough time for significant damage to have occurred. The responding staff were often police officers who were unfamiliar with the unit, and could be aggressive themselves, making matter worse. In addition, the limited containment possibilities that did exist (blue lights, physical and chemical restraints, and confinement) were recorded, and affected the hospital's reputation, creating pressure

[3] *It is worth noting that psychoanalysis in America was historically thought to be inappropriate for the treatment of psychosis as well as of those with significant socio-economic stressors. To the contrary, I argue that working psychoanalytically can reveal links to historical trauma, often especially relevant to those cast out of the social order.*



to abstain from intervening with an escalating patient until the situation was already out of hand.

All this contributed to a sense of destructiveness that often paralyzed the unit. Staff hated patients for threatening their safety. Patients hated staff for threatening theirs. Attention went toward suppressing anger on all sides,

getting rid of it, expelling threats, often loading projectively into the bodies of black men. (We would sometimes count the days until a particularly terrifying patient was off the unit). What was eclipsed was any space to listen to what the destructiveness had to say.

Winnicott (1989) writes of destructiveness as primary to human subjectivity; not opposed to creativity, love, and life, but rather one and the same, an inherent drive toward engagement with the world. He points to the baby's first kick at the uterine wall and the infant's "spontaneous gesture" as earliest examples. What develops out of this primary destructivity is for Winnicott completely dependent on how it is received: "The fate of this unity of drive cannot be stated without reference to the environment. The drive is potentially 'destructive' but whether it is destructive or not depends on what the object is like" (p. 245). If the environment is able to meet the child's intensity, receive his destructiveness and provide opposition that contains while registering his power, the child can discover what is "me" and what is "not me," and through this experience both himself and his environment as real and usable. Alternatively, if the environment cannot tolerate the destructiveness natural to existing, if instead it retaliates or collapses, the process of discovering "me" and "not me," fantasy and reality, is foreclosed. Instead, the child becomes either compliant or unable to contain destructive aggression within fantasy.

One does not have to look far to see evidence of the particular refusal of black destructiveness in the US, from the pathologization of militant Black liberation movements discussed previously to the countless shootings of black men assumed to be a "threat" simply by going about their daily living. In *Beloved*, Morrison (1987) writes of white terror of black destructivity and its consequence:

> *White people believed that whatever the manners, under every dark skin was a jungle. Swift unnavigable waters … red gums ready for their sweet white blood. In a way … they were right. The more colored people spent their strength trying to convince [white people] … how gentle they were, how clever and loving, how human, the more they used themselves up to persuade whites of something Negroes believed could not be questioned, the deeper and more tangled the jungle grew inside. But it wasn't the jungle blacks brought with them to this place … it was the jungle white folks planted in them. (p. 234)*

Here it is white fear and refusal of black destructivity that creates a "jungle," demanding a compliance insidious to subjective life. Returning to the hospital

with this idea in mind, the level of violence on the unit can be understood as a hopeful, although tragically unmet, symptom—an attempt to find an environment that will finally register its presence, have the strength necessary to contain it, and thus allow it to exist.

One black Guyanese-American patient I'll call Loki brought to us a particularly tragic history of foreclosed destruction. Loki arrived agitated, violent, and high on K2; a constant trickster, his initial pranks suffered from his level of intoxication. In our first meeting, he "pretended" he was open to talking with me, followed me into a meeting room and then began laughing at my having fallen for his interest. I told him I supposed I'd fall for that one every time; he thought this was hilarious, and decided to try to trick me every day. Mostly this consisted of attempting to manipulate me into buying him a snack.

One day, Loki performed a darker prank. Staff on the unit were gathered in morning report, and Loki was very angry—his psychiatrist was refusing to meet with him due to threats Loki had made early on in his stay, and Loki knew he would not be able to leave until this circumstance was remedied. Our staff meeting was held behind a large glass window, and Loki screamed on the other side. He finally yelled, "If you do not talk to me I will bash my head into the window!" and with this, he ran at the glass, at what seemed like full speed, and slammed his head. I was hysterical, thinking he was going to snap his neck. He then did it again, screaming, "Look what you are making me do! Look what you are making me do!" The most disturbing aspect of this event, as we waited for the police to arrive, was witnessing the nursing staff on the other side of the glass standing by and simply watching Loki hurt himself. He was a small man, easily containable, and yet no one stepped in. In hindsight, I imagine the nurses were enraged at him, having dealt with his mischief and yelling for days, maybe also furious with the mostly white medical staff on the other side of the glass for leaving them with the mess; perhaps they enacted their anger by letting Loki attack himself.

Later that day, when talking with Loki about what had transpired and the terror it evoked, he smiled at me and said, "you shouldn't have worried, didn't you think I would use my head to hurt my head?" He explained that as he was acting out a suicidal act, he was in reality making sure his head and neck were safe (apparently he had put his hood up a certain way, and used his shoulders to protect his spine).

A couple of days later he asked me if I wanted Kool-Aid.

"Kool-Aid?"

He started laughing, “You know my father was killed in Jonestown, right?”

I hadn’t. I looked it up.

I was aware that there has been a mass-murder-suicide in Guyana in 1978, in which 918 people had died, most from drinking cyanide-laced Kool-Aid at the command of cult leader Jim Jones. What I had not known was how linked this horrific event was to racial politics in the US at the time. In her book, White Nights,



Black Paradise (2015), Sikivu Hutchinson charts how White American Jim Jones founded the People’s Temple in Indianapolis on an activist platform, dedicated to racial justice. The church moved its headquarters to Oakland in the 70s, where Jones’ focus on social welfare programs, housing and health care attracted a largely black followership. Jones repeatedly declared his own blackness, emulated black preachers, and offered a vision of racial utopia free from white supremacy, segregation and oppression. The move to Jonestown in Guyana was the culmination of such a vision—the desire to escape all the hate, injustice, and danger, and find a place where finally there would be safety and freedom.

In reality, the racial oppression and anti-black violence imagined to be evacuated by the move ran a particularly devastating course. Beneath the illusion of racial equality, Jonestown was run almost exclusively by Jones and white women, demanding total submission from a majority black followership. The act of murder-suicide, presented as a necessary response to the threat of racist annihilation, in fact, annihilated roughly 600 African-Americans.

And then I hear the echoes: “Look what you are making me do! Look what you are making me do!” Loki screams at the white male attending, a man in power professing to help but instead keeping him captive. “Look what you are making me do!”, as he pretends to suicide, at the hands, at the command, of the “White Knight” (Hutchinson, 2015) in charge. In tricking us, he also flips positions—commandeering his captives to bear the terror of a suicidal rage they are both complicit in and cannot contain. Playing all parts, Loki performs a history of violent deception—the seductive offering of a utopia free from racial oppression and conflict, that in reality produced deadly compliance. It is this trick of erasing destruction, which erases, too, the possibility for subjective engagement, that Loki points to and attempts to convey.

## Deprivation

Every morning during community meeting patients offered a list of reasonable complaints—the plumbing in two bathrooms is not working, the food is terrible, there are not enough activities. Staff would agree, and most of the time have no solution. More broadly, patients often arrived homeless, without employment, and were discharged to whatever shelter among the boroughs had openings, with an appointment at a far away psychiatric clinic in a month. In short, in the face of great need, we had close to nothing to offer.

The deprivation did not stop at patients. Staff were overworked, expected to do more than was possible, and without resources needed to perform basic tasks (such as printing paper). As an intern, I experienced the staff as having little capacity to help metabolize experience or think about our training needs. In a particularly challenging moment, immediately before my second rotation, the



head psychologist and supervisor went on sudden medical leave, leaving me and another intern to carry the unit on our own, breaking APA internship requirements. Few times have I felt as greedy, and as ungenerous, as I did that year.

"I know what it is to be without milk that belongs to you "says ex-slave Sethe of Morrison's *Beloved* when she has given up on the social world, "to have to fight and holler for it, and to have so little left" (p. 236). The novel depicts the violence of slavery as theft of the most basic human resources, largely figured through oral imagery. Sethe is pinned down and nursed by students of her plantation owner, robbed of both her daughter's food and her capacity to give. "They took my milk!" she repeats throughout the text. Another character is forced to wear an iron bit in his mouth, making both speech and taking in nourishment impossible. Sethe's husband, having witnessed Sethe's nursing, lives out his suffering by the dairy churn, representing the terrible scene with butter smeared all over his face. In short, the foundational elements of subjective life—giving, receiving, and speaking—are taken away. As the hospital's barren landscape illustrates, the deprivation so brutally and literally rendered in *Beloved* is no stranger to the present day, with a recent study reporting the median black family's wealth to be 2% that of the median white family's and projected to fall to zero by 2082.[4]

As if calling on Morrison's oral imagery, patients at the hospital often asked staff to bring them treats—a coffee, a donut, a juice. Something, anything. It would be tempting to respond, I think for selfish reasons; the deprivation we

were witnessing and to a small degree experiencing was a daily reality for many on the unit, and to bring a coffee, a donut, a juice, would allow one to think it was, or could be, otherwise. The risk in such a response was covering over the deprivation, thereby refusing to confront and so to metabolize something of its experience.

One particularly insistent bargainer I'll call Sherwin made his demands less concrete—he did not want coffee, he wanted love. Brought in manic, after swinging a knife around at the train station and demanding a white woman marry him, Sherwin spent his days on the unit continuing his search. He would seek out light-skinned female staff, propose to them, and when they turned him down shouting, "It's because I'm black!"

Overtime, Sherwin's requests became less agitated and more fanciful—each encounter seemed to enact a ritual, although for whom and to what end remained unclear. One day, in a rare moment of privacy in the art room, Sherwin began to talk about his life. He told me of his father, a committed member of a Black nationalist organization, who had radicalized Sherwin as a child, expected much of him, and then was in and out of jail during Sherwin's adolescence. He spoke of his mother, who was light-skinned, also in and out of Sherwin's childhood, seemingly in response to conflict with his father. As

[4]*Institute for Policy Studies, "Dreams Deferred: How Enriching the 1% Widens the Racial Wealth Divide." January 2019: https://ips-dc.org/racial-wealth-divide-2019.*



Sherwin was speaking, another white staff member entered the space, and his open, wandering prose came to a sudden halt. He put on a large, flirtatious grin, told our visitor she was beautiful and asked her to marry him—she gave the shy smile most staff offered and left.

"What just happened?" I asked.

"What do you mean?"

"You completely transformed when Ms. Smith came into the room."

"You have to make white women think you want them. It's the only way to be safe," he replied.

I was struck by this statement, as it seemed to flip the history it brought to mind, in which black men were lynched by mobs and then courts under the accusation of having raped white women. Here it was not desire for white

women, but the absence of it that threatened safety. I wondered how Sherwin was right. In the following days, I observed his interactions with light-skinned female staff and attended to my own response when Sherwin performed his marriage dance. I noticed a particularly disturbing aspect: while I think the mimicry of this historical and often deadly exchange made all white women on the unit uncomfortable, there was also a pleasure in it—in feeling one's desirability and so too one's purity (after all, the answer was "no"). Indeed, the female staff on the unit, for all their complaints, were drawn to Sherwin. It is this perverse underbelly of deprivation—the pleasure in withholding, a faint echo of the glee Morrison depicted in students extracting milk from an enslaved woman—to which Sherwin's proposals gave voice.

Near the end of his stay, following countless requests that I meet him at Starbucks after he left, after many refusals and much curiosity about his request, Sherwin broke down crying. He turned away from me and whispered, "I am your n** baby and you are leaving me at the church steps." I was speechless. My mind went to Sherwin's light-skinned mother's departure, an articulation in his personal history of the social legacy of white female rejection of black masculinity. A rejection that Sherwin performed in his proposals, highlighting the use of black male desire in order to evacuate while also experiencing white female desire. But there seemed to be more in his words—why the church? Where and when was this scene? He left the next day, giving me a note with his address, in case I changed my mind about meeting again; I struggled to say goodbye amidst the questions his breakdown opened up.

## Broken Mirrors

The last observation I'll share from the hospital is a frequent delusion I encountered among young black men of being a famous model. I was surprised by the recurrence of this particular delusion, perhaps especially in



men. One patient, who reported himself "half white and half black," would spend sessions performing poses and asking which race I saw in each. Another patient spoke about his modeling in great detail—the clothes he wore, his fans. One session, about a week into our work together, he asked me if I had ever played a first-person shooter video game, where your hands are out in front of you. I had. He then said, "I feel like that all the time. My hands are in front of me, and I have no idea what is behind them, I have no idea what I look like."

Loss of one's image has been a trope in conceptualizing the psychic violence done to black Americans, and more specifically black men, since the early twentieth century, entering popular discourse through Ellison's (1947) *Invisible Man*. "I am invisible … simply because people refuse to see me" Ellison wrote. "When they approach me they only see my surroundings, themselves, or figments of their imaginations—indeed, everything and anything except me" (p. 3). This invisibility is also a structural reality, most clearly represented in the mass incarceration and subsequent political and financial disenfranchisement of young black men.

Davoine and Gaudilliere (2004) point to the devastating impact of a lost image on the body. Without representation, bodily experience cannot be inhabited as one's own. "Emotions and sensations" become "impossible to trust," often "anaesthetized" into what Davoine and Gaudilliere (2004) call "zones of petrification" (pp. 48–9). Ellison echoes the anesthetization at stake in the experience of invisibility: "You ache with the need to convince yourself that you exist in the real world, that you're part of all the sound and anguish" (p. 4). Along similar lines, Morrison articulates the path to freedom as re-imagining and so too re-investing in the body:

> *The only grace they could have was the grace they could imagine … if they could not see it, they would not have it.*
>
> *… [I]n this here place, we flesh; flesh that weeps, laughs; flesh that dances on bare feet in grass. Love it. Love it hard. Yonder they do not love your flesh. They despise it … You got to love it. (pp. 102-4)*

I am reminded of Coates' (2015) plea to not forget the body, to understand that "racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth. You must never look away from this" (p. 10).

One young man on the unit whom I'll call Joseph spoke exclusively of his body. It hurt. He experienced a series of odd and painful physical sensations, almost without pause. Following medical work-ups, his experience was marked as a somatic delusion; he was placed on multiple anti-psychotic medications, all with little success. Hopeless for relief, Joseph mostly kept his pain a secret.



Indeed, it was only during his second admission on the unit, following an attempt to cut into his body to stop the pain, that he finally revealed to me his physical suffering. Most days he sat home alone in his mother's apartment, attempting to think the pain away, wondering why on earth he had been

saddled with it. “Pain behavior can point to a painful place,” writes Wittgenstein, “but the subject of pain is the person who gives it expression” (in Davoine and Gaudilliere, 2004, p. 302). I, like Joseph, wonder after the contents of his pain—what was he working to express, that found its way into the most basic of signals? Pain. Pain in the body. What was he expressing on behalf of others, historic and present, who themselves were unable to feel?

One session Joseph and I sat together on the windowsill, and he communicated to me as he could the bodily sensations that passed through him for forty minutes. It was devastating. I felt by the end drained of hope. Joseph then turned to me, lit up and said, “I feel like we just killed a deer!” I was both moved and confused by this image, which somehow felt right. In hindsight, I am struck by the resonance with Davoine and Gaudilliere’s comparison of the psychoanalytic treatment of psychosis to hunting: “an arrow of language repeatedly shot at the Real Thing in order to force it to enter the realm of speech.” Perhaps it was this traumatic real that Joseph was marking that we had, momentarily, shot into speech; this traumatic real that our psychotic patients keep alerting us to, that has yet to find its way into history, both individual and social.

## Conclusion

> *All survivors bear witness to the impossibility of surviving alone … without an other present, or, if necessary, hallucinated.*
>
> *(Davoine and Gaudilliere, 2004, p. 210)*

At the opening of the first museum in the US to memorialize victims of lynching, founder Bryan Stevenson articulated his vision as the confrontation of a shadow: “[C]ast across the American landscape … [, t]his shadow cannot be lifted until we shine the light of truth on the destructive violence that shaped our nation, traumatized people of color, and compromised our commitment to the rule of law and to equal justice.”[5] Indeed, aspects of our history and present reality of racist violence that cannot be addressed do not disappear, but set up residence as shadows, gaps, or in Davoine and Gaudilliere’s term “zones of petrification”—bits of catastrophic experience without representation. Their presence signals a threat to the foundational elements of social relations—the capacity to trust, to communicate, to be truthful. Ignored or denied by many, these gaps are left to those who

[5](April, 2018). Why Build a Memorial to Victims of Racial Terror? Retrieved from: https://museumandmemorial.eji.org/memorial.



cannot help but notice. As Davoine and Gaudilliere (2004) point out, it is often the children or grandchildren of the traumatized who take them up, unable to not register the shadows that cloud their caregivers' minds.

But how does one make sense of a shadow that no one else professes to see? Following Davoine and Gaudilliere (2004), I contend that madness can be an effort at such sense-making—an attempt to represent what has been disavowed from the social world, in order to find one's way back into it. One way, then, to understand the elevated rates of psychosis in black Americans is as reflecting the kind of knowledge carried by this particular population, knowledge that has been denied or erased in the social inscription of American history.

Each in their own terms, Loki, Sherwin and Joseph grapple with shadows. Loki screams about coercion, Sherwin performs his marriage dance, Joseph bears inexplicable pain. All three invoke experiences that seem both of and beyond them, calling in more or less explicit ways on historical tropes. If we conceptualize these symptoms as purely individual, they become evidence of a faulty mind. But if we think of them as at once personal and historical, as a personal expression of contact with a historical shadow, they become "instruments of research" (p. 78) to be respected, taken seriously, and eventually joined.

Such a shift has consequences for analytic work. First, it places history and social context more squarely at the center of how we listen. Paradoxically, symptoms that appear most detached from the social world are here thought of as most intimately connected to it. I have had fantasies since leaving the hospital of having courses on the history of American slavery on the units, or workshops to construct family maps, infusing the environment with the spirit of investigation, and the importance of social and personal history. Second, the framework here espoused demands of clinicians a particular kind of availability and assumption of responsibility. It requires us to tune in to the ways our patients live in and call on us—how we dream them, the parts of our own histories and experiences they evoke, and, perhaps most challenging, what they notice in us, which will inevitably become part of the investigative process. For it is in the meeting of two people who may each know something about catastrophe and so too one another, not in the sense of merger but in the sense of existing within the shared and intersecting paths of human history, that

shadows can begin to be translated into a common language, freeing their explorers from the impossible task of surviving them alone. It is at this threshold of the representable that we face both risk and possibility; if we dismiss the mad, we further alienate those who dare to investigate historical catastrophe, but if we listen, we have the opportunity to join in the research, thereby fostering the development of a more just society.



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