

Rapid #: -19073033

CROSS REF ID: **959861**

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TYPE: Book Chapter

BOOK TITLE: The Collected Schizophrenias: Essays

USER BOOK TITLE: The Collected Schizophrenias: Essays

CHAPTER TITLE: High-Functioning

BOOK AUTHOR: Esmé Weijun Wang

EDITION:

VOLUME:

PUBLISHER: Graywolf Press

YEAR: 2019

PAGES: 43-58

ISBN: 9781555978273

LCCN:

OCLC #:

Processed by RapidX: 5/17/2022 2:02:30 AM

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High-Functioning

At midday I entered the Chinatown Mental Health Clinic's guarded front doors, wearing a careful expression as I clipped into the waiting room. Inside the tiny space sat an elderly Chinese couple on a bench. The woman was clutching her head, and I considered how it takes so much—too much—energy to act as though our addled minds are all right. Few of the psychiatric facilities I've stayed in house those with the luxury for such performances. I was reluctant to stare, but felt monstrous for turning away from her pain, which was exactly what I did when I approached the partition and stated my purpose through the porthole to the woman behind the glass: "I'm a member of the local speakers' bureau, and I'm here to tell my story."

To the clinic I wore a brown silk Marc Jacobs dress with long sleeves, carefully folded up to the elbows. Buttons up to the dip between my collarbones, finished with a tied bow. No jewelry, save for a silver bangle and my wedding ring. Black wedge heels. Flat scars crisscrossed my bare ankles like dirt tracks. I wore an organic facial moisturizer that smelled like bananas and almonds, Chanel's

Vitalumière Hydra foundation in 20 Beige (discontinued), and a nubby Tom Ford lipstick in Narcotic Rouge (also discontinued, replaced by the inferior Cherry Lush).

My makeup routine is minimal and consistent. I can dress and daub when psychotic and when not psychotic. I do it with zeal when manic. If I'm depressed, I skip everything but the lipstick. If I skip the lipstick, that means I haven't even made it to the bathroom mirror.

In 2017, every morning I take a small and chalky pink pill; every night I take one and a half of the same pill. Haloperidol is, Dr. M reasons, what has kept me functioning without either delusions or hallucinations for the last four years, though for most of 2013 I struggled with what Sylvia Nasar, in *A Beautiful Mind*, calls schizophrenia's "dislocation of every faculty, of time, space, and body."

My official diagnosis didn't change to schizoaffective disorder for years. The disorder had been suspected, but not recorded, because schizoaffective disorder has a gloomier prognosis and more intense stigma than bipolar disorder does, and even psychiatrists can be swayed by the perceived severity of a different *DSM* code. Psychiatry also operates by treating symptoms and not a root cause, and so my psychopharmacological treatment was not impacted by the dramatic change in my chart. In *Blue Nights*, Joan Didion remarks, "I have not yet seen that case in which a 'diagnosis' led to a 'cure,' or in fact to any outcome other than a confirmed, and therefore an enforced, debility." My new diagnosis bore no curative function, but it did imply that to be high-functioning would be difficult, if not impossible, for me.

My talk for the Chinatown clinic was one that I adjusted for a variety of audiences: students, patients, doctors. It began with this line:

"It was winter in my sophomore year at a prestigious university." That phrase, "prestigious university," was there to underscore my kempt hair, the silk dress, my makeup, the dignified shoes. It said, *What I am about to disclose to you comes with a disclaimer*. I didn't want my audience to forget that disclaimer when I began to talk about believing, for months at a time, that everyone I love is a robot. "Prestigious university" acts as a signifier of worth.

Other signifiers: my wedding ring, a referent to the sixteen-year relationship I've managed to keep; descriptions of my treatment plan as if it were a stable, infallible Rosetta stone, when in fact the plan constantly changes in response to my ever-changing brain chemistry; the mention of the small online business, based on digital products and freelance work, that I started in early 2014. With these signifiers, I am trying to say that I am a wife, I am a good patient, I am an entrepreneur. I am also schizoaffective, living with schizoaffective disorder, living with mental illness, living with mental health challenges, crazy, insane—but *I am just like you*.

Whom "you" refers to depends on which talk I am giving. One of the clinic's group leaders, Henry, told me that I'd first be speaking to an audience of "high-functioning schizophrenics." Most of them, he told me, had been meeting there every week for ten years. I couldn't tell if this was said with pride as he guided me into the small meeting room.

There were fewer than ten people inside, not including Patricia, the head of the speakers' bureau. Almost all of them were, like I am, Chinese, save for one elderly white woman whose eyes cast about the room like hyperactive Ping-Pong balls. Before the talk began, Henry passed around photographs from a field trip. No one handed the photographs to me, the outsider. Without seeing the snapshots, I could only guess at the destination of a field trip for "high-functioning schizophrenics": maybe city hall, or perhaps a jaunt to

Muir Woods. The group quietly admired the photographs. Some of them spoke with the lilting disorganization that I associate with people who live relatively well with schizophrenia, given that they were spending time at the clinic—but who would immediately be labeled by many as crazy, to be pitied and even avoided.

Before the presentation began, Henry brought out a party-sized bag of Lay's. He searched the corners of the room for napkins and paper plates as a handsome twentysomething pried open the bag with his big hands. Nobody seemed terribly interested in engaging with me, and I was too busy reviewing my papers for this, my first talk in a clinical setting, to initiate contact. Patricia introduced the presentation by briefly speaking about the different kinds of stigma. A few people interrupted her with meandering commentary and needed to be gently rerouted by Patricia or Henry. The quiet ones avoided eye contact and said nothing.

With this group, I deviated from my script. When I told the story of my diagnosis and recovery, I exchanged complex language for simpler terminology. I removed the term "avolition." I leaned into descriptions of experiences that I thought they'd understand—including, in Mandarin, my mother's explanation for why she lied to my first psychiatrist about our family history of mental illness: "We don't talk about these things." In the final moments, I quoted from an email she sent after I resigned from my full-time editing position, having realized that the job was triggering psychotic episodes: "Fly free. I love you." The talk was designed to be inspiring. I was trying to *light up* the room with hope.

When I finished, two people were crying. Patricia, tear-streaked, showed me her arm: goose bumps. "I thought I had it bad," said the other woman who was crying, and my heart stammered in my chest. *I was her*, but I didn't want to *be her*. I was the one at the head of the table, visiting. She was the one who had come to this clinic every

week for the last decade. Not much was changing for her—but everything, I had to believe, was possible for me.

During my first inpatient experience at a psychiatric hospital, I met two patients who were treated as markedly different from the rest of us: Jane and Laura. Jane was middle-aged and chatty; Laura was the only other Asian person on the ward, and spoke to no one. We patients rarely spoke of our diagnoses—at the time, I was diagnosed with bipolar disorder, with traits of borderline personality disorder—but everyone knew that Jane and Laura were the two with schizophrenia.

Jane was friendly, and frequently rolled up in her wheelchair to share disjointed monologues about the psychiatrists' "mind control experiments," ramblings paranoid enough to be considered psychotic, yet realistic enough to be unsettling to my vulnerable mind. In less coherent periods, her stories dissolved into the verbal nonsense known as "word salad," in which one word only tenuously relates to the one that came before it, and the assortment of them means nothing at all. These problems with communication caused her to be excluded, by doctors' decree, from otherwise mandatory group therapy sessions.

I never interacted with Laura, but I remember her yelling as she was pulled out of the hall bathroom, interrupted during an attempt to vomit up her medications. "They're poison!" she screamed as two nurses yanked at her long, skinny arms. "They're trying to poison me! They're trying to kill me!"

A natural hierarchy arose in the hospital, guided by both our own sense of functionality and the level of functionality perceived by the doctors, nurses, and social workers who treated us. Depressives, who constituted most of the ward's population, sat at the top of the chain, even if they were receiving electroconvulsive therapy. Because we were in the Yale Psychiatric Institute (now the Yale New Haven

Psychiatric Hospital), many of those hospitalized were Yalies, and therefore considered bright people who'd simply wound up in bad situations. We had already proved ourselves capable of being high-functioning, and thus contained potential if only we could be steered onto the right track. In the middle of the hierarchy were those with anorexia and bipolar disorder. I was in this group, and was perhaps even ranked as highly as the depressives, because I came from Yale. The patients with schizophrenia landed at the bottom—excluded from group therapy, seen as lunatic and raving, and incapable of fitting into the requirements of normalcy.

High-functioning patients had the respect of the nurses, and sometimes even the doctors. A nurse who respected me would use a different cadence; she would speak to me with human understanding. One gave me advice, saying that I needed to “dye my hair back”—it was clownishly red at the time—and “get down to normal living.” As condescending as such words seem to me now, they were more than what was offered to those like Jane and Laura, who received only basic care. Forget about life advice—there was no hope for them beyond low-grade stability. Expectations are often low to begin with; in *A Beautiful Mind*, Nasar remarks that “unlike manic-depression, paranoid schizophrenia rarely allows sufferers to return, even for a limited period, to their premorbid level of achievement, so it is believed.”

The psychiatric hierarchy decrees who can and cannot be high-functioning and “gifted.” A much-liked meme on Facebook once circulated on my feed, in which a chart listed so-called advantages to various mental illnesses. Depression bestows sensitivity and empathy; attention-deficit/hyperactivity disorder allows people to hold large amounts of information at once; anxiety creates useful caution. I knew immediately that schizophrenia wouldn't make an appearance. Creative genius is associated with madness, but such

genius, as explored in Kay Redfield Jamison's *Touched with Fire*, is primarily linked to depression or bipolar disorder. An exception is outsider artist Henry Darger, whose influential 15,145-page work *In the Realms of the Unreal* is both brilliant and the work of an obsessive, troubled mind that may or may not have been afflicted with schizophrenia—either way, Darger's inability to function in “normal” life is inextricable from his art.

With such unpleasant associations tied to the schizophrenias, it is no wonder that I cling to the concept of being high-functioning. As in most marginalized groups, there are those who are considered more socially appropriate than others, and who therefore distance themselves from those so-called inappropriate people, in part because being perceived as incapable of success causes a desire to distance oneself from other, similarly marginalized people who are thought to be even less capable of success.

An example of such distancing can be seen in Jenny Lawson's book *Furiously Happy: A Funny Book about Horrible Things*, which is often recommended to me as a hilarious memoir that embraces those with mental illness. Lawson, the beloved blogger behind *The Bloggess*, has been diagnosed with a variety of disorders, including depression and avoidant personality disorder. Yet she explains early in *Furiously Happy* that she is on antipsychotics—not because she is psychotic, she assures us, but because it decreases the length of her depressive episodes. “There is nothing better than hearing that there is a drug that will fix a terrible problem,” she writes, “unless you also hear that the drug is for treating schizophrenia (or possibly that it kills fairies every time you take it).” But that line distressed me: for Lawson, my psychiatric condition, and the medications I take for it, put me on par with a fairy-killer; but if I were taking Haldol as a “side dish” for depression, I'd remain on the proper side of the mentally unwell.

Lawson, I'd like to believe, is trying to be honest rather than

mean-spirited. Schizophrenia and its ilk are not seen by society as conditions that coexist with the potential for being high-functioning, and are therefore terrifying. No one wants to be crazy, least of all truly crazy—as in psychotic. Schizophrenics are seen as some of the most dysfunctional members of society: we are homeless, we are inscrutable, and we are murderers. The only times I see schizophrenia mentioned in the news are in the context of violence, as in *Newsweek's* June 2015 opinion piece titled “Charleston Massacre: Mental Illness Common Thread for Mass Shootings.” In this article by Matthew Lysiak, psychosis is linked to mass shooters such as Jiverly Wong, Nidal Hasan, Jared Loughner, and James Holmes. In the paragraph on Holmes, his treating psychiatrist is described as having written—and here I imagine a voice dripping with doom—that Holmes “may be shifting insidiously into a frank psychotic disorder such as schizophrenia.” Immediately following that line, the piece reads, “On July 20, 2012 Holmes walked into an Aurora, Colorado movie theater and killed 12 people, injuring 70 others.”

In a 2008 paper, Elyn R. Saks recalls, “When I was examined for readmission to Yale Law School, the psychiatrist suggested I might spend a year working at a low-level job, perhaps in fast food, which would allow me to consolidate my gains so that I could do better when I was readmitted.” While fighting with my insurance company over disability benefits, I tried to explain that I can’t work at McDonald’s, but I can run a business based on freelance work. Place me in a high-stress environment with no ability to control my surroundings or my schedule, and I will rapidly begin to decompensate. Being able to work for myself, while still challenging, allows for greater flexibility in my schedule, and exerts less pressure on my mind. Like Saks, I am high-functioning, but I’m a high-functioning person with an unpredictable and low-functioning illness. I may not

be the “appropriate” type of crazy. Sometimes, my mind does fracture, leaving me frightened of poison in my tea or corpses in the parking lot. But then it reassembles, and I am once again a recognizable self.

A therapist told me in my midtwenties, when my diagnosis was still bipolar disorder, that I was her only client who could hold down a full-time job. Among psychiatric researchers, having a job is considered one of the major characteristics of being a high-functioning person. Most recently, Saks has spearheaded one of the largest extant studies about the nature of high-functioning schizophrenia. In it, employment remains the primary marker of someone who is high-functioning, as having a job is the most reliable sign that you can pass in the world as normal. Most critically, a capitalist society values productivity in its citizens above all else, and those with severe mental illness are much less likely to be productive in ways considered valuable: by adding to the cycle of production and profit. Our society demands what Chinese poet Chuang Tzu (370–287 BCE) describes in his poem “Active Life”:

Produce! Get results! Make money! Make friends! Make changes!

Or you will die of despair.

Because I am capable of achievement, I find myself uncomfortable around those who are visibly psychotic and audibly disorganized. I’m uncomfortable because I don’t want to be lumped in with the screaming man on the bus, or the woman who claims that she’s the reincarnation of God. I’m uncomfortably uncomfortable because I know that these are my people in ways that those who have never experienced psychosis can’t understand, and to shun them is to shun a large part of myself. In my mind, there is a line between

me and those like Jane and Laura; to others, that line is thin, or so negligible as not to be a line at all.

When asked, "What do people who live successfully with schizophrenia have in common?" for an awareness-raising social media campaign, Dr. Ashish Bhatt answered, "Often those persons who live successfully with schizophrenia are ones who have positive prognostic factors, which include good premorbid functioning, later age of symptom onset, sudden symptom onset, higher education, good support system, early diagnosis and treatment, medication adherence, and longer periods of minimal or absent symptoms between episodes."

Some of these factors and characteristics are determined by fate; others, however, have proved to be susceptible to human intervention, giving many people with schizophrenia—particularly young ones—a better chance to live high-functioning lives. In 2008, the National Institute of Mental Health launched a research initiative called RAISE (Recovery After an Initial Schizophrenia Episode), designed to explore the efficacy of certain kinds of early-intervention treatments. These types of treatments, known as Coordinated Specialty Care (CSC) treatments and supports, comprise a combination of tools, including case management, medication and primary care, cognitive-behavioral therapy, family education and assistance, and supported employment and education. Introducing this holistic approach to treatment takes into account a greater variety of factors that improve the odds for recovery. And, unlike in many other types of first-episode psychosis intervention, clients are encouraged to help guide their own treatment—thus contributing to higher rates of compliance and a greater sense of autonomy. Feeling some degree of control over their lives is particularly important for a population of people who are vulnerable to having

none. As Dr. Lisa Dixon, director of OnTrackNY, told the *New York Times*, "We wanted to reinvent treatment so that it was something people actually want."

After the RAISE initiative determined that CSC treatment improved outcomes for people in the early stages of schizophrenia, early psychosis intervention programs began to appear around the country. As of 2016, such programs existed in thirty-seven states. At Stanford, the Prodrome and Early Psychosis Program Network started in 2014; in San Francisco, where I live, the Prevention and Recovery in Early Psychosis Network also addresses first-episode psychosis. Many provide services free of charge.

"Yet you *look* very put-together," Dr. M told me. I'd told her that, as a part of therapy, I was working on improving my hygiene. Showering became a challenge shortly after I began to hallucinate in college; my first experience with hearing voices occurred when a phantasm in the dorm showers intoned, "I hate you." This might have unnerved me enough to make me anxious about showering forever after. But because I care about my appearance, because I used to be a fashion blogger and writer, because I worked, for a time, at a fashion magazine and then as a fashion editor at a start-up company, I pass for normal more easily than do my comrades in the schizophrenias. When I browse the virtual aisles of La Garçonne, I am considering a uniform for a battle with multiple fronts. If schizophrenia is the domain of the slovenly, I stand outside of its boundaries as a straight-backed ingenue, and there is no telltale smearing beyond the borders of my mouth.

To some degree, the brilliant facade of a good face and a good outfit protects me. My sickness is rarely obvious. I don't have to tell new people in my life about it unless I want to. Although I no longer fret about when to disclose my psychiatric condition, I'm still aware

of the shift that occurs when it happens. At a writers' residency, one woman responded to my disclosure with "I'm surprised to hear that. You don't seem to have those . . . tics and things." I reflexively smiled at this backhanded compliment. I suspect that she found comfort in being able to place me in a category separate from my brethren whose limbs and faces jerk from tardive dyskinesia, a horrific side effect of antipsychotic use that remains even if the medication is stopped. At a literary party, a wealthy patron who knew of my diagnosis told me that I should be proud of how coherent I am. In both anecdotes, I thanked the well-meaning women involved.

There are shifts according to any bit of information I dole out. Some are slight. Some tilt the ground we stand on. I can talk about the fact that I went to Yale and Stanford; that my parents are Taiwanese immigrants; that I was born in the Midwest and raised in California; that I am a writer. If the conversation winds its way to my diagnosis, I emphasize my normalcy. See my ordinary, even superlative appearance! Witness the fact that I am articulate. Rewind our interaction and see if you can spot cracks in the facade. See if you can, in sifting through your memory, find hints of insanity to make sense of what I've said about who I am. After all, what kind of lunatic has a fashionable pixie cut, wears red lipstick, dresses in pencil skirts and tucked-in silk blouses? What sort of psychotic wears Loeffler Randall heels without tottering?

My trajectory as a fashion writer began in 2007 with a blog called *Fashion for Writers (FFW)*. At the time, big-name bloggers such as Susie Bubble, a.k.a. Susanna Lau, were developing cachet with the *Devil Wears Prada* old guard—Susie once even included *FFW* in her "blog roll" of links—which seemed to gesture toward the democratization of a historically elite industry. I could not afford the high-end stylings of Jane Aldridge, the wealthy Texan behind *Sea of Shoes*, but I had enough pocket money for 1930s dresses

from Etsy and an enormous white faux-fur coat that earned me the nickname "Abominable Snowman" in graduate school. The oldest *FFW* posts, created while I was still a lab manager, mixed inane style commentary (e.g., pontificating on the return of pussy-bow secretary blouses) and clumsy "outfit of the day" photos taken with my digital camera propped up on books and, eventually, locked onto a cheap tripod.

In graduate school I invited a college friend, fellow writer and clotheshorse Jenny Zhang, to join *FFW*. We were both Chinese American, twentysomething women working to get our MFAs in blindingly white Midwestern towns, and Jenny, who had majored in ethnic studies, aimed the blog in a more political, and more interesting, direction. Eventually, Jenny took over *FFW* entirely before ending it in favor of greener pastures. Meanwhile, I moved on to work at a dubiously operated fashion and lifestyle magazine before settling in at a start-up that sold and produced vintage-inspired fashion, where I honed my copywriting chops and editing skills as I finished my debut novel. I sank my discretionary income from the start-up job into vintage, ultrafeminine silk chiffon and georgette and organdy dresses the color of candy floss, adorned with bows and tied up with satin ribbons; for a while, my Twitter profile read, "Taiwanese American. Weaponized glamour," the latter being a reference to Châédria LaBouvier's work on the concept of "using beauty and style in direct, political ways that subvert dehumanizing expectations." Her thoughts on weaponized glamour are perhaps best known in her writing about Chimamanda Ngozi Adichie; Adichie, as a black woman author who writes about politics, who is dark-skinned and a feminist, is not an expected model of beauty to some, but is defiantly glamorous nonetheless.

I went to the Alexander McQueen exhibit *Savage Beauty* at the Met in 2011 because it was a significant occasion for people in

the fashion industry, however peripheral. *Savage Beauty* reflected art as madness, darkness, beauty, death. McQueen's 2010 suicide hung over everything, throwing long shadows on the walls and the dresses. He'd ended his life not long after the death of his mother, and then the death of his friend Isabella Blow.

The piece that most beguiled and frightened me was a blank-faced, pure-white mannequin in a suit of inky feathers. In this ensemble, plumage forms massive shoulders that could be wings; the body displays a nipped, severe waist. There is nothing charming about this aviary costume. Encounter this creature in the shadows, and death has surely come to claim you. McQueen said about his clothing, "I want to empower women. I want people to be afraid of the women I dress," which is another truth about fashioning normalcy: the way I clothe myself is not merely camouflage. It is an intimidation tactic, as with the porcupine who shows its quills, or the owl that puffs its body in a defensive offensive: *dress like everyone should be terrified of you.*

And yet there are things that good costuming can't hide. For one season, I saw shadowy demons darting at me from all angles, and I couldn't control my response, which was to jump to the side or duck or startle at things that no one else could see. If I was with someone, I'd pretend afterward that nothing had happened, and usually my companion or companions who knew of my diagnosis would generously pretend that I hadn't just ducked, rather dramatically, for no reason. But I was mortified. It didn't matter how pulled-together I seemed when I was dodging specters that no one else could see. I knew that I looked crazy, and that no amount of snappy dressing could conceal the dodging. Because such movements were a necessary concession to my craziness, I responded by trying even harder to seem normal when I wasn't being assailed by hallucinations. I went dancing. I drank Jameson on the rocks and

ate potato skins in Irish bars and pizza joints. I did all the normal things I could think of.

At the Chinatown clinic, I was led downstairs into a different room to give a second talk. This one was brighter, cleaner, and clearly the clinicians' domain. A water cooler stood burbling in one corner. The tables had been moved to flank the walls, allowing space for an assembly of folding chairs in the middle. The clinicians begin to wander in—men and women in business casual who found seats and stared into the middle distance. There was one man who sat in the back and actively scowled; his face read, *I can't believe I have to come to this goddamn thing.* He made me nervous, but it was also true that all of them, even the friendly-seeming ones, made me nervous.

Being faced with this many clinicians took me back to my first psychiatric hospitalization, when a battalion of psychiatrists, social workers, and psychologists made their daily rounds throughout the unit to interrogate us about how we were doing. The flock of officious questioners stopped by when I was sitting on the threadbare sofa near the television, or listlessly pushing around puzzle pieces at a table. Rarely did I experience such a radical and visceral imbalance of power as I did as a psychiatric inpatient amid clinicians who knew me only as illness in human form. During that first hospitalization, I learned that clinicians control when inpatients are granted privileges, such as being able to go downstairs for meals or outside to smoke for ten minutes twice a day. Most important, it was my team of clinicians who decided when I could go home. I became accustomed to playacting for the benefit of doctors: *Look! I'm happy! I'm fine!* In response to "Are you thinking about hurting yourself or others?" there was only one proper answer, which, regardless of what I said, was always followed by suspicious, persistent questioning. Knowing that it was time for me to talk about being crazy in

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

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

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

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

Yale Will Not Save You

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

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