People form in idiosyncratic ways. Perhaps it was not surprising that, as a meteorologist's daughter, I found myself, in that glorious illusion of high summer days, gliding, flying, now and again lurching through cloud banks and eddies, past stars, and across fields of ice crystals. Even now, I can see in my mind's rather peculiar eye an extraordinary shattering and shifting of light, inconsistent but ravishing colors laid out across miles of circling rings; and the almost imperceptible, somehow surprisingly public moons of this Catherina wheel of a planet. I remember singing "Fly me to the moon" as I swept past those of Saturn and thinking myself terribly funny. I saw and experienced that which had been only dreams, or fitting fragments of aspiration.

Was it real? Well, of course not, not in any meaningful sense of the word real. But did it stay with me? Absolutely. Long after my psychosis cleared, and the medications took hold, it became part of what one remembers forever, surrounded by an almost Proustian melancholy. Long since that extended voyage of my mind and soul, Saturn and its icy rings took on an elegiac beauty, and I don't see Saturn's image now without feeling an acute sadness at its being so far away.
Speaking of Madness

Not long before I left Los Angeles for Washington, I received the most vituperative and unpleasant letter that anyone has ever written me. It came not from a colleague or a patient, but from a woman who, having seen an announcement of a lecture I was to give, was outraged that I had used the word "madness" in the title of my talk. I was, she wrote, insensitive and crass and very clearly had no idea at all what it was like to suffer from something as awful as manic-depressive illness. I was just one more doctor who was climbing my way up the academic ranks by walking over the bodies of the mentally ill. I was shaken by the ferocity of the letter, resented it, but did end up thinking long and hard about the language of madness.

In the language that is used to discuss and describe mental illness, many different things—descriptiveness, banality, clinical precision, and stigma—intersect to create confusion, misunderstanding, and a gradual bleaching out of traditional words and phrases. It is no longer clear what place words such as "mad," "daft," "crazy,"
“cracked,” or “certifiable” should have in a society increasingly sensitive to the feelings and rights of those who are mentally ill. Should, for example, expressive, often humorous, language—phrases such as “taking the fast trip to Squirrel City,” being a “few apples short of a picnic,” “off the wall,” “around the bend,” or “losing the bubble” (a British submariner’s term for madness)—be held hostage to the fads and fashions of “correct” or “acceptable” language?

One of my friends, prior to being discharged from a psychiatric hospital after an acute manic episode, was forced to attend a kind of group therapy session designed as a consciousness-raising effort, one that encouraged the soon-to-be ex-patients not to use, or allow to be used in their presence, words such as “squirrel,” “fruitcake,” “nut,” “wacko,” “bat,” or “loon.” Using these words, it was felt, would “perpetuate a lack of self-esteem and self-stigmatization.” My friend found the exercise patronizing and ridiculous. But was it? On the one hand, it was entirely laudable and professional, if rather excessively earnest, advice: the pain of hearing these words, in the wrong context or the wrong tone, is sharp; the memory of insensitivity and prejudice lasts for a long time. No doubt, too, allowing such language to go unchecked or uncorrected leads not only to personal pain, but contributes both directly and indirectly to discrimination in jobs, insurance, and society at large.

On the other hand, the assumption that rigidly rejecting words and phrases that have existed for centuries will have much impact on public attitudes is rather dubious. It gives an illusion of easy answers to impossibly difficult situations and ignores the powerful role of wit and irony as positive agents of self-notion and social change. Clearly there is a need for freedom, diversity, wit, and directness of language about abnormal mental states and behavior. Just as clearly, there is a profound need for a change in public perception about mental illness. The issue, of course, is one of context and emphasis. Science, for example, requires a highly precise language. Too frequently, the fears and misunderstandings of the public, the needs of science, the inanities of popularized psychology, and the goals of mental health advocacy get mixed together in a divisive confusion.

One of the best cases in point is the current confusion over the use of the increasingly popular term “bipolar disorder”—now firmly entrenched in the nomenclature of the Diagnostic and Statistical Manual (DSM-IV), the authoritative diagnostic system published by the American Psychiatric Association—instead of the historic term “manic-depressive illness.” Although I always think of myself as a manic-depressive, my official DSM-IV diagnosis is “bipolar I disorder; recurrent; severe with psychotic features; full interepisode recovery” (one of the many DSM-IV diagnostic criteria I have “fulfilled” along the way, and a personal favorite, is an “excessive involvement in pleasurable activities”). Obviously, as a clinician and researcher, I strongly believe that scientific and clinical studies, in order to be pursued with accuracy and reliability, must be based on the kind of precise language and explicit diagnostic criteria that make up the core of DSM-IV. No patient or family member is well served by elegant and expressive language if it is also imprecise and subjective. As a person and patient, however, I find the word “bipolar” strangely and powerfully offensive: it seems to me to obscure and minimize the illness it is supposed to represent. The description
"manic-depressive," on the other hand, seems to capture both the nature and the seriousness of the disease I have, rather than attempting to paper over the reality of the condition.

Most clinicians and many patients feel that "bipolar disorder" is less stigmatizing than "manic-depressive illness." Perhaps so, but perhaps not. Certainly, patients who have suffered from the illness should have the right to choose whichever term they feel more comfortable with. But two questions arise: Is the term "bipolar" really a medically accurate one, and does changing the name of a condition actually lead to a greater acceptance of it? The answer to the first question, which concerns accuracy, is that "bipolar" is accurate in the sense that it indicates an individual has suffered from both mania (or mild forms of mania) and depression, unlike those individuals who have suffered from depression alone. But splitting mood disorders into bipolar and unipolar categories presupposes a distinction between depression and manic-depressive illness—both clinically and etiologically—that is not always clear, nor supported by science. Likewise, it perpetuates the notion that depression exists rather tidily segregated on its own pole, while mania clusters off neatly and discreetly on another. This polarization of two clinical states flies in the face of everything that we know about the cauldronous, fluctuating nature of manic-depressive illness; it ignores the question of whether mania is, ultimately, simply an extreme form of depression; and it minimizes the importance of mixed manic-and-depressive states, conditions that are common, extremely important clinically, and lie at the heart of many of the critical theoretical issues underlying this particular disease.

But the question also arises whether, ultimately, the destigmatization of mental illness comes about from merely a change in the language or, instead, from aggressive public education efforts; from successful treatments, such as lithium, the anticonvulsants, antidepressants, and antipsychotics; from treatments that are not only successful, but somehow also catch the imagination of the public and media (Prozac's influence on public opinion and knowledge about depression, for example); from discovery of the underlying genetic or other biological causes of mental illness; from brain-imaging techniques, such as PET and MRI (magnetic resonance imaging) scans, that visually communicate the location and concrete existence of these disorders; from the development of blood tests that will ultimately give medical credibility to psychiatric diseases; or from legislative actions, such as the Americans with Disabilities Act, and the obtainment of parity with other medical conditions under whatever health-reform system is put into place. Attitudes about mental illness are changing, however glacially, and it is in large measure due to a combination of these things—successful treatment, advocacy, and legislation.

The major mental health advocacy groups are made up primarily of patients, family members, and mental health professionals. They have been particularly effective in educating the public, the media, and the state and national governments. Although very different in styles and goals, these groups have provided direct support for tens of thousands of individual patients and their families; have raised the level of medical care in their communities by insisting upon competence and respect through, in effect, boycotting those psychiatrists and
psychologists who do not provide both; and have agitated, badgered, and cajoled members of Congress (many of whom themselves suffer from mood disorders or have mental illness in their families) into increasing money for research, proposing parity for psychiatric illnesses, and passing legislation that bans job and insurance discrimination against the mentally ill. These groups—and the scientists and clinicians who make treatment possible—have made life easier for all of us who have psychiatric illnesses, whether we call ourselves mad or write letters of protest to those who do. Because of them, we now have the luxury of being able to debate the fine points of language about our own and the human condition.

Seated in a chair, with quick access to escape through the back door of the conference room, Jim Watson was twitching, peering, scanning, squinting, and yawning. His fingers, linked together on the top of his head, were tapping restlessly, and he alternately was paying avid, if fleeting, attention to the data being presented, snatching a look at his New York Times, and drifting off into his own version of planetary wanderings. Jim is not good at looking interested when he is bored, and it was impossible to know if he really was thinking about the science at hand—the genetics and molecular biology of manic-depressive illness—or was instead mulling about politics, gossip, love, potential financial donors for Cold Spring Harbor Laboratory, architecture, tennis, or whatever other heated and passionate enthusiasm occupied his mind and heart at the moment. An intense and exceedingly blunt man, he is not someone who tends to bring out the dispassionate side of people. For myself, I find him fascinating and very wonderful. Jim is genuinely
independent and, in an increasingly bland world, a true zebra among horses. While it could be argued that it is relatively easy to be independent and unpredictable if you have won the Nobel Prize for your contributions to discovering the structure of life, it is also clear that the same underlying temperament—intense, competitive, imaginative, and iconoclastic—helped propel his initial pursuit for the structure of DNA.

Jim’s palpably high energy level is also very appealing; his pace, whether intellectual or physical, can be exhausting, and trying to keep up with him, in discussions across the dinner table or walking the grounds of Cold Spring Harbor, is no mean task. His wife maintains she can tell whether or not Jim is in the house simply by the amount of energy she feels in the air. But however interesting he is as a person, Jim is first and foremost a scientific leader: director until only very recently of one of the foremost molecular biology laboratories in the world, Cold Spring Harbor Laboratory, and the first director of the National Center for Human Genome Research. In the past few years, he has turned his interest toward the search for the genes responsible for manic-depressive illness.

Because the scientific understanding of manic-depressive illness is so ultimately beholden to the field of molecular biology, it is a world in which I have spent an increasing amount of time. It is an exotic world, one developed around an odd assortment of plants and animals—maize, fruit flies, yeast, worms, mice, humans, puffer fish—and it contains a somewhat strange, rapidly evolving, and occasionally quite poetic language system filled with marvelous terms like “orphan clones,” “plasmids,” and “high-density cosmids”; “triple helices,” “untethered DNA,” and “kamikaze reagents”; “chromosome walking,” “gene hunters,” and “gene mappers.” It is a field clearly in pursuit of the most fundamental of understandings, a search for the biological equivalent of quarks and leptons.

The meeting where Watson was peering and twitching and yawning was focused specifically on the genetic basis of manic-depressive illness, with the intent of bringing together clinical psychiatrists, geneticists, and molecular biologists, all of whom are in one way or another actively engaged in the search for the genes responsible for manic-depressive illness, to share information about their research methods, findings, and the pedigrees of the affected families whose genetic material is being analyzed. Pedigree after pedigree was being projected onto the screen, some with relatively few ill family members, others containing large numbers of squares and circles that had been completely blackened in, indicating men or women who suffered from manic-depressive illness. Half-blackened circles and squares depicted depressive illness, and an s, cross, or slash flagged those individuals who had committed suicide. Each of these black or half-black symbols represented a life with periods of terrible suffering, yet, ironically, the more of these darkened squares and circles in a particular family, the “better” (that is, the more genetically informative and useful) the pedigree was considered to be. It seemed very likely, when I looked around the room, that among these scientists, and somewhere within these pedigrees, the location of the gene or genes responsible for manic-depressive illness was going to be found. It was a very exciting thought, because once the genes are located, early and
far more accurate diagnosis is likely to follow; so, too, is more specific, safer, less problematic, and more effective treatment.

The slides went off, the curtains were pulled back, and I looked out beyond Jim Watson, past the apple trees, and remembered a trip I had taken, years ago, down the Mississippi. Mogens Schou, a Danish psychiatrist who, more than anyone, is responsible for the introduction of lithium as a treatment for manic-depressive illness, and I had decided to skip a day's sessions of the American Psychiatric Association's annual meeting and take advantage of being in New Orleans. The best way to do this, we decided, was to take a boat ride down the Mississippi River. It was a gorgeous day, and, after having discussed a wide variety of topics, Mogens turned to me and asked me point-blank, Why are you really studying mood disorders? I must have looked as taken aback and uncomfortable as I felt, because, changing tack, he said, "Well, why don't I tell you why I study mood disorders?" He proceeded to tell me about all of the depression and manic-depressive illness in his family, how devastating it had been, and how, because of this, years ago, he had been desperately searching the medical literature for any new, experimental treatments. When John Cade's article about the use of lithium in acute mania first appeared in 1949, in an obscure Australian medical journal, Mogens pounced on it and began almost immediately the rigorous clinical trials necessary to establish the efficacy and safety of the drug. He talked with ease about his family history of mental illness and emphasized that it had been this strongly personal motivation that had driven virtually all of his research. He made it clear to me that he suspected my involvement in clinical research about manic-depressive illness was likewise personally motivated.

Feeling a bit trapped, but also relieved, I decided to be honest about my own and my family's history, and soon the two of us were drawing our pedigrees on the backs of table napkins. I was amazed at how many of my squares and circles were darkened, or darkened with a question mark placed underneath (I knew, for instance, that my great-uncle had spent virtually all of his adult life in an asylum, but I didn't know what his diagnosis had been). Manic-depressive illness occurred repeatedly, throughout the three generations I had knowledge of, on my father's side of the family; asterisks, representing suicide attempts, showed up like a starfield. My mother's side of the family, in comparison, was squeaky clean. It would not have taken a very astute observer of human nature to figure out that my parents are terribly different, but here was one very concrete example of their differences—and, quite literally, in black and white. Mogens, who had been sketching out his own family tree, took one look over my shoulder at the number of affected members in mine and promptly, laughingly, conceded the "battle of the black boxes." He noted that the circle representing me was solid black and had an asterisk next to it—how remarkable to be able to reduce one's suicide attempt to a simple symbol—so we talked for a long time about my illness, lithium, its side effects, and my suicide attempt.

Talking with Mogens was extremely helpful, in part because he aggressively encouraged me to use my own experiences in my research, writing, and teaching, and in part because it was very important to me to be able
to talk with a senior professor who not only had some knowledge of what I had been through, but who had used his own experiences to make a profound difference in the lives of hundreds of thousands of people. Including my own. No matter what struggles I had had with lithium, it was painfully clear to me that without it I would have been long dead or on the back wards of a state hospital. I was one of many who owed their lives to the black circles and squares in Schou’s family tree.

The fact that manic-depressive illness is a genetic disease brings with it, not surprisingly, very complicated and often difficult emotions. At one extreme is the terrible shame and guilt one can be made to feel. Many years ago, when I was living in Los Angeles, I went to a physician recommended to me by a colleague. After examining me, and after finding out that I had been on lithium for many years, he asked me an extended series of questions about my psychiatric history. He also asked me whether or not I planned to have children. Having generally been treated with intelligence and compassion by my various doctors up to that point, I had no reason to be anything but direct about my extensive history of mania and depression, although I also made it clear that I was, in the vernacular, a “good lithium responder.” I told him that I very much wanted to have children, which immediately led to his asking me what I planned to do about taking lithium during pregnancy. I started to tell him that it seemed obvious to me that the dangers of my illness far outweighed any potential problems that lithium might cause a developing fetus, and that I therefore would choose to stay on lithium. Before I finished, however, he broke in to ask me if I knew that manic-depressive illness was a genetic disease. Stifling for the moment an urge to remind him that I had spent my entire professional life studying manic-depressive illness and that, in any event, I wasn’t entirely stupid, I said, “Yes, of course.” At that point, in an icy and imperious voice that I can hear to this day, he stated—as though it were God’s truth, which he no doubt felt that it was—“You shouldn’t have children. You have manic-depressive illness.”

I felt sick, unbelievably and utterly sick, and deeply humiliated. Determined to resist being provoked into what would, without question, be interpreted as irrational behavior, I asked him if his concerns about my having children stemmed from the fact that, because of my illness, he thought I would be an inadequate mother or simply that he thought it was best to avoid bringing another manic-depressive into the world. Ignoring or missing my sarcasm, he replied, “Both.” I asked him to leave the room, put on the rest of my clothes, knocked on his office door, told him to go to hell, and left. I walked across the street to my car, sat down, shaking, and sobbed until I was exhausted. Brutality takes many forms, and what he had done was not only brutal but unprofessional and uninformed. It did the kind of lasting damage that only something that cuts so quick and deep to the heart can do.

Oddly enough, it had never occurred to me not to have children simply because I had manic-depressive illness. Even in my blackest depressions, I never regretted having been born. It is true that I had wanted to die, but that is peculiarly different from regretting having
been born. Overwhelmingly, I was enormously glad to have been born, grateful for life, and I couldn’t imagine not wanting to pass on life to someone else. All things considered, I had had a marvelous—albeit turbulent and occasionally awful—existence. Of course, I had had serious concerns: How could one not? Would I, for example, be able to take care of my children properly? What would happen to them if I got severely depressed? Much more frightening still, what would happen to them if I got manic, if my judgment became impaired, if I became violent or uncontrollable? How would it be to have to watch my own children struggle with depression, hopelessness, despair, or insanity if they themselves became ill? Would I watch them too hawkishly for symptoms or mistake their normal reactions to life as signs of illness? All of these were things I had thought about a thousand times, but never, not once, had I questioned having children. And despite the cold-bloodedness of the doctor who examined me and who told me I shouldn’t, I would have delighted in having a houseful of children, as David and I once had planned. But it just didn’t work out that way: David died, and Richard—the only man since David’s death that I wanted to have children with—already had three from a previous marriage.

Not having children of my own is the single most intolerable regret of my life. I do, however, and very fortunately, have two nephews and a niece—each wonderful and quite remarkable in his or her own way—and I enjoy, beyond description, my relationships with them. Being an aunt is an extraordinarily pleasurable sort of thing, especially if your nephews and niece are reflective, independent, thoughtful, droll, smart, and imagina-

tive people. It is impossible not to find their company delightful. My nephews, whose interests, like those of their father, have leaned toward the study of mathematics and economics, are quiet, witty, freethinking, gentle souled, and charming young men. My niece, considerably younger, is now eleven and, having already won a national writing award, is very determined to become a writer. One often finds her curled up in a chair, scribbling away, asking about words or people, tending to her many and various animals, or leaping mouth first into a family discussion to defend her point of view. She is fiery, sensitive, original, and disconcertingly able to hold her own against a very vociferously articulate pack of older brothers, parents, and sundry other adults. I cannot imagine the awful gap that would exist in my life without these three children.

Now and again, despite my strong commitment to the scientific efforts that are being made to track down the genes for manic-depressive illness, I have concerns about what finding the genes might actually mean. Clearly, if better and earlier diagnosis and more specific, less troublesome treatments result from the ongoing genetic research, then the benefits to individuals who have manic-depressive illness, to their families, and to society will be extraordinary. It is, in fact, only a matter of time until these benefits will be available. But what are the dangers in prenatal diagnostic testing? Will prospective parents choose to abort fetuses that carry the genes for manic-depressive illness, even though it is a treatable disease? (Interestingly, a recent study done at Johns Hopkins,
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which asked manic-depressive patients and their spouses whether or not they would abort an affected fetus, found that very few said that they would.) Do we risk making the world a blander, more homogenized place if we get rid of the genes for manic-depressive illness—an admittedly impossibly complicated scientific problem? What are the risks to the risk takers, those restless individuals who join with others in society to propel the arts, business, politics, and science? Are manic-depressives, like spotted owls and clouded leopards, in danger of becoming an “endangered species”?

These are very difficult ethical issues, particularly because manic-depressive illness can confer advantages on both the individual and society. The disease, in both its severe and less severe forms, appears to convey its advantages not only through its relationship to the artistic temperament and imagination, but through its influence on many eminent scientists, as well as business, religious, military, and political leaders. Subtler effects—such as those on personality, thinking style, and energy—are also involved because it is a common illness with a wide range of temperament, behavioral, and cognitive expression. The situation is yet further complicated by the fact that additional genetic, biochemical, and environmental factors (such as exposure to prolonged or significant changes in light, pronounced sleep reduction, childbirth, drug or alcohol use) may be at least in part responsible for both the illness and the cognitive and temperamental characteristics associated with great achievement. These scientific and ethical issues are real ones; fortunately, they are being actively considered by the federal government’s Genome Project and other groups of scientists and ethicists. But they are immensely troubling problems and will remain so for many years to come.

Science remains quite remarkable in its ability to raise new problems even as it solves old ones. It moves quickly, often beautifully, and as it moves it brings high expectations in its wake.

Sitting on one of the hard, uncomfortable chairs that are so characteristic of medical conferences, I was semi-oblivious to the world. My mind was on hold after having been lulled into a mild hypnotic state by the click, click, click of the changing of slides in a carousel. My eyes were open, but my brain was swaying gently in its hammock, tucked away in the far back reaches of my skull. It was dark and stuffy in the room, but beautiful and snowing outside. A group of my colleagues and I were in the Colorado Rockies, and anyone with any sense at all was skiing; yet there were more than a hundred doctors in the room, and the slides were going click, click, click. I caught myself thinking, for the hundredth time, that being crazy doesn’t necessarily mean being stupid, and what on earth was I doing indoors instead of being out on the slopes? Suddenly, my ears perked up. A flat, numbingly objective voice was mumbling something about giving an “update on structural brain abnormalities in bipolar illness.” My structurally abnormal brain came to attention, and a chill shot down my spine. The mumbling continued: “In the bipolar patients we have studied, there is a significantly increased number of small areas of focal signal hyperintensities [areas of increased water concentration] suggestive of abnormal tissue. These are
what neurologists sometimes refer to as ‘unidentified bright objects,’ or UBOs.” The audience laughed appreciatively.

I, who could ill afford any more loss of brain tissue—God knows what little chunks of gray matter had crossed the River Styx after my nearly lethal lithium overdose—laughed with somewhat less than total enthusiasm. The speaker went on, “The medical significance of these UBOs is unclear, but we know that they are associated with other conditions, such as Alzheimer’s, multiple sclerosis, and multi-infarct dementias.” I was right; I should have gone skiing. Against my better judgment, I pointed my head in the direction of the screen. The slides were riveting, and, as always, I was captivated by the unbelievable detail of the structure of the brain that was revealed by the newest versions of MRI techniques. There is a beauty and an intuitive appeal to the brain-scanning methods, especially the high-resolution MRI pictures and the gorgeous multicolored scans from the PET studies. With PET, for example, a depressed brain will show up in cold, brain-inactive deep blues, dark purples, and hunter greens; the same brain when hypomanic, however, is lit up like a Christmas tree, with vivid patches of bright reds and yellows and oranges. Never has the color and structure of science so completely captured the cold inward deadness of depression or the vibrant, active engagement of mania.

There is a wonderful kind of excitement in modern neuroscience, a romantic, moon-walk sense of exploring and setting out for new frontiers. The science is elegant, the scientists dismayingly young, and the pace of discovery absolutely staggering. Like the molecular biologists, the brain-scanners are generally well aware of the extraordinary frontiers they are crossing, and it would take a mind that is on empty, or a heart made of stone, to be unmoved by their collective ventures and enthusiasms.

I was, in spite of myself, caught up by the science, wondering whether these hyperintensities were the cause or the effect of illness, whether they became more pronounced over time, where in the brain they localized, whether they were related to the problems in spatial orientation and facial recognition that I and many other manic-depressives experience, and whether children who were at risk for manic-depressive illness, because one or both of their parents had the disease, would show these brain abnormalities even before they became ill. The clinical side of my mind began to mull about the visual advantages of these and other imaging findings in convincing some of my more literary and skeptical patients that (a) there is a brain, (b) their moods are related to their brains, and (c) there may be specific brain-damaging effects of going off their medications. These speculations kept me distracted for a while, as changing gears from the personal side of having manic-depressive illness to the professional role of studying and treating it often does. But, invariably, the personal interest and concerns returned.

When I got back to Johns Hopkins, where I was now teaching, I buttonholed neurology colleagues and grilled my associates who were doing the MRI studies. I scurried off to the library to read up on what was known; it is, after all, one thing to believe intellectually that this disease is in your brain; it is quite another thing to actually see it. Even the titles of some of the articles
were a bit ungluing: "Basal Ganglia Volumes and White Matter Hyperintensities in Patients with Bipolar Disorder," "Structural Brain Abnormalities in Bipolar Affective Disorder: Ventricular Enlargement and Focal Signal Hyperintensities," "Subcortical Abnormalities Detected in Bipolar Affective Disorders, Using Magnetic Resonance Imaging"; on and on they went. I sat down to read. One study found that "Of the 32 scans of the patients with bipolar disorder, 11 (34.4%) showed hyperintensities, while only one scan (3.2%) from the normal comparison group contained such abnormalities."

After an inward snort about "normal comparison group," I read on and found that, as usual in new fields of clinical medicine, there were far more questions than answers, and it was unclear what any of these findings really meant: they could be due to problems in measurement, they could be explained by dietary or treatment history, they could be due to something totally unrelated to manic-depressive illness; there could be any number of other explanations. The odds were very strong, however, that the UBOs meant something. In a strange way, though, after reading through a long series of studies, I ended up more reassured and less frightened. The very fact that the science was moving so quickly had a way of generating hope, and, if the changes in the brain structure did turn out to be meaningful, I was glad that first-class researchers were studying them. Without science, there would be no such hope. No hope at all.

And, whatever else, it certainly gave new meaning to the concept of losing one's mind.

Clinical Privileges

There is no easy way to tell other people that you have manic-depressive illness; if there is, I haven't found it. So despite the fact that most people that I have told have been very understanding—some remarkably so—I remain haunted by those occasions when the response was unkind, condescending, or lacking in even a semblance of empathy. The thought of discussing my illness in a more public forum has been, until quite recently, almost inconceivable. Much of this reluctance has been for professional reasons, but some has resulted from the cruelty, intentional or otherwise, that I have now and again experienced from colleagues or friends that I have chosen to confide in. It is what I have come to think of, not without bitterness, as the Mouseheart factor.

Mouseheart, a former colleague of mine in Los Angeles, was also, I thought, a friend. A soft-spoken psychoanalyst, he was someone I was in the habit of getting together with for a morning coffee. Less frequently, but enjoyably, we would go out for a long
lunch and talk about our work and our lives. After some time, I began to feel the usual discomfort I tend to experience whenever a certain level of friendship or intimacy has been reached in a relationship and I have not mentioned my illness. It is, after all, not just an illness, but something that affects every aspect of my life: my moods, my temperament, my work, and my reactions to almost everything that comes my way. Not talking about manic-depressive illness, if only to discuss it once, generally consigns a friendship to a certain inevitable level of superficiality. With an inward sigh, I decided to go ahead and tell him.

We were in an oceanfront restaurant in Malibu at the time, so—after a brief rundown on my manias, depressions, and suicide attempt—I fixed my eye on a distant pile of rocks out in the ocean and waited for his response. It was a long, cold wait. Finally, I saw tears running down his face, and, although I remember thinking at the time that it was an extreme response—particularly since I had tried to present my manias in as lighthearted a way as possible, and my depressions with some dispassion—I thought it was touching that he felt so strongly about what I had been through. Then Mouseheart, wiping away his tears, told me that he just couldn’t believe it. He was, he said, “deeply disappointed.” He had thought I was so wonderful, so strong: How could I have attempted suicide? What had I been thinking? It was such an act of cowardice, so selfish.

I realized, to my horror, that he was serious. I was absolutely transfixed. His pain at hearing that I had manic-depressive illness was, it would seem, far worse than mine at actually having it. For a few minutes, I felt like Typhoid Mary. Then I felt betrayed, deeply embar-

rassed, and utterly exposed. His solicitude, of course, knew no bounds. Had I really been psychotic? If so, he asked in his soft voice, with seemingly infinite concern, did I really think, under the circumstances, that I was going to be able to handle the stresses of academic life? I pointed out to him, through clenched teeth, that I had in fact handled those particular stresses for many years, and, indeed, if truth be told, I was considerably younger than he was and had, in fact, published considerably more. I don’t really remember much of the rest of the lunch, except that it was an ordeal, and that at some point, with sarcasm that managed to pass him by, I told him that he ought not to worry, that manic-depressive illness wasn’t contagious (although he could have benefited from a bit of mania, given his rather dreary, obsessive, and humorless view of the world). He squirmed in his seat and averted his eyes.

A boxed bouquet of a dozen long-stemmed red roses arrived at my clinic the next morning; an abject note of apology was tucked in at the top. It was a nice thought, I suppose, but it didn’t begin to salve the wound inflicted by what I knew had been a candid response on his part: he was normal, I was not, and—in those most killing of words—he was “deeply disappointed.”

There are many reasons why I have been reluctant to be open about having manic-depressive illness; some of the reasons are personal, many are professional. The personal issues revolve, to a large extent, around issues of family privacy—especially because the illness under consideration is a genetic one—as well as a general belief that
personal matters should be kept personal. Too, I have been very concerned, perhaps unduly so, with how knowing that I have manic-depressive illness will affect people’s perception of who I am and what I do. There is a thin line between what is considered zany and what is thought to be—a ghastly but damning word—“inappropriate,” and only a sliverish gap exists between being thought intense, or a bit volatile, and being dismissively labeled “unstable.” And, for whatever reasons of personal vanity, I dread the fact that my suicide attempt and depressions will be seen by some as acts of weakness or as “neurotic.” Somehow, I don’t mind the thought of being seen as intermittently psychotic nearly as much as I mind being pigeonholed as weak and neurotic. Finally, I am deeply wary that by speaking publicly or writing about such intensely private aspects of my life, I will return to them one day and find them bleached of meaning and feeling. By putting myself in the position of speaking too freely and too often, I am concerned that the experiences will become remote, inaccessible, and far distant, behind me; I fear that the experiences will become those of someone else rather than my own.

My major concerns about discussing my illness, however, have tended to be professional in nature. Early in my career, these concerns were centered on fears that the California Board of Medical Examiners would not grant me a license if it knew about my manic-depression. As time went by, I became less afraid of such administrative actions—primarily because I had worked out such an elaborate system of clinical safeguards, had told my close colleagues, and had discussed ad nauseam with my psychiatrist every conceivable contingency and how best to mitigate it—but I became increasingly concerned that my professional anonymity in teaching and research, such as it was, would be compromised. At UCLA, for example, I lectured and supervised large numbers of psychiatric residents and psychology interns in the clinic I directed; at Johns Hopkins I teach residents and medical students on the inpatient wards and in the outpatient mood disorders clinic. I cringe at the thought that these residents and interns may, in deference to what they perceive to be my feelings, not say what they really think or not ask the questions that they otherwise should and would ask.

Many of these concerns carry over into my research and writing. I have written extensively in medical and scientific journals about manic-depressive illness. Will my work now be seen by my colleagues as somehow biased because of my illness? It is a disconcerting thought, although one of the advantages of science is that one’s work, ultimately, is either replicated or it is not. Biases, because of this, tend to be minimized over time. I worry, however, about my colleagues’ reactions once I am open about my illness: if, for example, I am attending a scientific meeting and ask a question, or challenge a speaker, will my question be treated as though it is coming from someone who has studied and treated mood disorders for many years, or will it instead be seen as a highly subjective, idiosyncratic view of someone who has a personal ax to grind? It is an awful prospect, giving up one’s cloak of academic objectivity. But, of course, my work has been tremendously colored by my emotions and my experiences. They have deeply affected my teaching, my advocacy work, my clinical practice, and what I have chosen to study: manic-depressive illness in general and, more specifically, sui-
cide, psychosis, psychological aspects of the disease and its treatment, lithium noncompliance, positive features of mania and cyclothymia, and the importance of psychotherapy.

Most important, however, as a clinician, I have had to consider the question that Mouseheart so artfully managed to slip into our lunchtime conversation in Malibu: Do I really think that someone with mental illness should be allowed to treat patients?

When I left the University of California in the winter of 1986 to return to Washington, I was eager to continue teaching and to obtain an academic appointment at a university medical school. Richard, who had gone to medical school at Johns Hopkins, thought I would love it. At his suggestion, I applied to the Department of Psychiatry for a faculty appointment, and I started teaching at Hopkins within a few months of moving back East. Richard was right. I loved Hopkins straightaway. And, as he predicted, one of the many pleasures I found in being on the Hopkins faculty was the seriousness with which teaching obligations are taken. The excellence of clinical care was another. It was only a matter of time. The issue of clinical privileges was bound to come up.

With the usual sense of profound uneasiness that for me accompanies having to look through official hospital appointment forms, I stared at the packet of papers in front of me. In imposing capital letters THE JOHNS HOPKINS HOSPITAL was written across the top of the page. Scanning downward, I saw that it was, as I had expected, an application for clinical privileges. Hoping for the best, but expecting the worst, I decided to tackle all of the straightforward questions first; I quickly checked “no” to a long series of questions about professional liability, malpractice insurance, and professional sanctions: During the previous application period, had I been involved in any litigation involving malpractice or professional liability? Were there any restrictions or limitations in my malpractice coverage? Had my license to practice ever been limited, suspended, subject to any conditions, terms of probation, formal or informal reprimand, not renewed, or revoked? Had I ever been subject to disciplinary action in any medical organization? Were there any disciplinary actions pending against me?

These questions, thank God, were easy to answer, having managed thus far, in a ridiculously litigious age, to avoid being sued for malpractice. It was the next section, “Personal Information,” that made my heart race; and, sure enough, before too long I found the question that was going to require something more than just a checkmark in the “no” column:

Are you currently suffering from, or receiving treatment for any disability or illness, including drug or alcohol abuse, that would impair the proper performance of your duties and responsibilities at this hospital?

Five lines down was the hangman’s clause:

I fully understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of appointment to or summary dismissal from the medical staff.
I read back over the “Are you currently suffering from” question, thought about it for a long time, and finally wrote next to it “Per discussion with the chairman of the Department of Psychiatry.” Then with a sinking feeling in my stomach, I telephoned my chairman at Hopkins and asked him if we could get together for lunch.

A week or so later, we met at the hospital restaurant. He was as talkative and funny as ever, so we spent several pleasant minutes catching up on departmental activities, teaching, research grants, and psychiatric politics. With my hands clenched in my lap and my heart in my throat, I told him about the clinical privileges form, my manic-depressive illness, and the treatment I was receiving for it. My closest colleague at Hopkins already knew about my illness, as I had always told those physicians with whom I most closely practiced. At UCLA, for example, I had discussed my illness in detail with the physicians who, with me, had set up the UCLA Affective Disorders Clinic and then, subsequently, with the doctor who had been the medical director of the clinic during virtually all of the years I was its director. My chairman at UCLA also knew that I was being treated for manic-depressive illness. I felt then, as I do now, that there should be safeguards in place in the event that my clinical judgment became impaired due to mania or severe depression. If I did not tell them, not only would the care of patients be jeopardized, but I would be placing my colleagues in an untenable position of professional and legal risk as well.

I made it clear to each of the doctors I worked closely with that I was under the care of an excellent psychiatrist, taking medication, and had no alcohol or drug abuse problem. I also asked them to feel free to ask my psychiatrist whatever questions they felt they needed to about my illness and my competence to practice (my psychiatrist, in turn, was asked to communicate both to me, and to whomever else he thought necessary, if he had any concerns about my clinical judgment). My colleagues agreed that if they had any doubts whatsoever about my clinical judgment they would tell me directly, immediately remove me from any patient care responsibilities, and alert my psychiatrist. I think that all of them have, at one time or another, spoken with my psychiatrist in order to obtain information about my illness and treatment; fortunately, none have ever had to contact him because of concerns about my clinical performance. Nor have I ever had to give up my clinical privileges, although I have, on my own, canceled or rescheduled appointments when I felt it would be in the best interests of patients.

I have been both fortunate and careful. The possibility always exists that my illness, or the illness of any clinician, for that matter, might interfere with clinical judgment. Questions about hospital privileges are neither unfair nor irrelevant. I don’t like having to answer them, but they are completely reasonable. The privilege to practice is exactly that, a privilege; it is not a right. The real dangers, of course, come about from those clinicians (or, indeed, from those politicians, pilots, businessmen, or other individuals responsible for the welfare and lives of others) who—because of the stigma or the fear of suspension of their privileges or expulsion from medical school, graduate school, or residency—are hesitant to seek out psychiatric treatment. Left untreated, or unsupervised, many become ill, endanger-
ing not only their own lives but the lives of others; often, in an attempt to medicate their own moods, many doctors will also become alcoholics or drug abusers. It is not uncommon for depressed physicians to prescribe antidepressant medications for themselves; the results can be disastrous.

Hospitals and professional organizations need to acknowledge the extent to which untreated doctors, nurses, and psychologists present risks to the patients they treat. But they also need to encourage effective and compassionate treatment and work out guidelines for safeguards and intelligent, nonpaternalistic supervision. Untreated mood disorders result in risks not only to patients, but to the doctors themselves. Far too many doctors—many of them excellent physicians—commit suicide each year; one recent study concluded that, until quite recently, the United States lost annually the equivalent of a medium-sized medical school class from suicide alone. Most physician suicides are due to depression or manic-depressive illness, both of which are eminently treatable. Physicians, unfortunately, not only suffer from a higher rate of mood disorders than the general population, they also have a greater access to very effective means of suicide.

Doctors, of course, need first to heal themselves; but they also need accessible, competent treatment that allows them to heal. The medical and administrative system that harbors them must be one that encourages treatment, provides reasonable guidelines for supervised practice, but also one that does not tolerate incompetence or jeopardize patient care. Doctors, as my chairman is fond of pointing out, are there to treat patients; patients never should have to pay—either literally or medically—for the problems and sufferings of their doctors. I strongly agree with him about this; so it was not without a sense of dread that I waited for his response to my telling him that I was being treated for manic-depressive illness, and that I needed to discuss the issue of my hospital privileges with him. I watched his face for some indication of how he felt. Suddenly, he reached across the table, put his hand on mine, and smiled. "Kay, dear," he said, "I know you have manic-depressive illness." He paused, and then laughed. "If we got rid of all of the manic-depressives on the medical school faculty, not only would we have a much smaller faculty, it would also be a far more boring one."
A Life in Moods

We are all, as Byron put it, differently organized. We each move within the restraints of our temperament and live up only partially to its possibilities. Thirty years of living with manic-depressive illness has made me increasingly aware of both the restraints and possibilities that come with it. The ominous, dark, and deathful quality that I felt as a young child watching the high clear skies fill with smoke and flames is always there, somehow laced into the beauty and vitality of life. That darkness is an integral part of who I am, and it takes no effort of imagination on my part to remember the months of relentless blackness and exhaustion, or the terrible efforts it took in order to teach, read, write, see patients, and keep relationships alive. More deeply layered over but all too readily summoned up with the first trace of depression are the unforgettable images of violence, utter madness, mortifying behavior, and moods savage to experience, and even more disturbingly brutal in their effects upon others.

Yet however genuinely dreadful these moods and memories have been, they have always been offset by the elation and vitality of others; and whenever a mild and gentlish wave of brilliant and bubbling manic enthusiasm comes over me, I am transported by its exuberance—as surely as one is transported by a pungent scent into a world of profound recollection—to earlier, more intense and passionate times. The vividness that mania infuses into one’s experiences of life creates strong, keenly recollected states, much as war must, and love and early memories surely do. Because of this, there is now, for me, a rather bittersweet exchange of a comfortable and settled present existence for a troubled but intensely lived past.

There are still occasional sirens to this past, and there remains a seductive, if increasingly rare, desire to recreate the furor and fever of earlier times. I look back over my shoulder and feel the presence of an intense young girl and then a volatile and disturbed young woman, both with high dreams and restless, romantic aspirations: How could one, should one, recapture that intensity or reexperience the glorious moods of dancing all night and into the morning, the gliding through starfields and dancing along the rings of Saturn, the zany manic enthusiasms? How can one ever bring back the long summer days of passion, the remembrance of lilacs, ecstasy, and gin fizzes that spilled down over a garden wall, and the peals of riotous laughter that lasted until the sun came up or the police arrived?

There is, for me, a mixture of longings for an earlier age; this is inevitable, perhaps, in any life, but there is an extra twist of almost painful nostalgia brought about by having lived a life particularly intense in moods. This
makes it even harder to leave the past behind, and life, on occasion, becomes a kind of elegy for lost moods. I miss the lost intensities, and I find myself unconsciously reaching out for them, as I still now and again reach back with my hand for the fall and heaviness of my now-gone, long, thick hair; like the trace of moods, only a phantom weight remains. These current longings are, for the most part, only longings, and I do not feel compelled to re-create the intensities: the consequences are too awful, too final, and too damaging.

Still, the seductiveness of these unbridled and intense moods is powerful; and the ancient dialogue between reason and the senses is almost always more interestingly and passionately resolved in favor of the senses. The milder manias have a way of promising—and, for a very brief while, delivering—springs in the winter and epochal vitalities. In the cold light of day, however, the reality and destructiveness of rekindled illness tend to dampen the evocativeness of such selectively remembered, wistful, intense, and gentle moments. Any temptation that I now may have to recapture such moods by altering my medication is quickly hosed down by the cold knowledge that a gentle intensity soon becomes first a frenetic one and then, finally, an uncontrolled insanity. I am too frightened that I will again become morbidly depressed or virulently manic—either of which would, in turn, rip apart every aspect of my life, relationships, and work that I find most meaningful—to seriously consider any change in my medical treatment.

Although I am basically optimistic about remaining well, I know my illness from enough different vantage points to remain rather fatalistic about the future. As a result, I know that I listen to lectures about new treat-

ments for manic-depressive illness with far more than just a professional interest. I also know that when I am doing Grand Rounds at other hospitals, I often visit their psychiatric wards, look at their seclusion rooms and ECT suites, wander their hospital grounds, and do my own internal ratings of where I would choose to go if I had to be hospitalized. There is always a part of my mind that is preparing for the worst, and another part of my mind that believes if I prepare enough for it, the worst won’t happen.

Many years of living with the cyclic upheaval of manic-depressive illness has made me more philosophical, better armed, and more able to handle the inevitable swings of mood and energy that I have opted for by taking a lower level of lithium. I agree absolutely with Eliot’s Ecclesiastic belief that there is a season for everything, a time for building, and “a time for the wind to break the loosened pane.” Therefore, I now move more easily with the fluctuating tides of energy, ideas, and enthusiasms that I remain so subject to. My mind, now and again, becomes a carnival of lights, laughter, and sounds and possibilities. The laughter and exuberance and ease will, filling me, spill out and over and into others. These glinting, glorious moments will last for a while, a short season, and then move on. My high moods and hopes, having ridden briefly in the top car of the Ferris wheel will, as suddenly as they came, plummet into a black and gray and tired heap. Time will pass; these moods will pass; and I will, eventually, be myself again. But then, at some unknown time, the electrifying carnival will come back into my mind.

These comings and goings, this grace and godlessness, have become such a part of my life that the wild
colors and sounds now have become less strange and less strong; and the blacks and grays that inevitably follow are, likewise, less dark and frightening. “Beneath those stars,” Melville once said, “is a universe of gliding monsters.” But, with time, one has encountered many of the monsters, and one is increasingly less terrified of those still to be met. Although I continue to have emergences of my old summer manias, they have been gutted not only of most of their terror, but of most of their earlier indescribable beauty and glorious rush as well: sludged by time, tempered by a long string of jading experiences, and brought to their knees by medication, they now coalesce, each July, into brief, occasionally dangerous cracklings together of black moods and high passions. And then they, too, pass. One comes out of such experiences with a more surrounding sense of death, and of life. Having heard so often, and so believably, John Donne’s bell tolling softly that “Thou must die,” one turns more sharply to life, with an immediacy and appreciation that would not otherwise exist.

We all build internal sea walls to keep at bay the sadnesses of life and the often overwhelming forces within our minds. In whatever way we do this—through love, work, family, faith, friends, denial, alcohol, drugs, or medicine—we build these walls, stone by stone, over a lifetime. One of the most difficult problems is to construct these barriers of such a height and strength that one has a true harbor, a sanctuary away from crippling turmoil and pain, but yet low enough, and permeable enough, to let in fresh seawater that will fend off the inevitable inclination toward brackishness. For someone with my cast of mind and mood, medication is an integral element of this wall: without it, I would be constantly beholden to the crushing movements of a mental sea; I would, unquestionably, be dead or insane.

But love is, to me, the ultimately more extraordinary part of the breakwater wall: it helps to shut out the terror and awfulness, while, at the same time, allowing in life and beauty and vitality. When I first thought about writing this book, I conceived of it as a book about moods, and an illness of moods, in the context of an individual life. As I have written it, however, it has somehow turned out to be very much a book about love as well: love as sustainer, as renewer, and as protector. After each seeming death within my mind or heart, love has returned to re-create hope and to restore life. It has, at its best, made the inherent sadness of life bearable, and its beauty manifest. It has, inexplicably and savingly, provided not only cloak but lantern for the darker seasons and grimmer weather.

I long ago abandoned the notion of a life without storms, or a world without dry and killing seasons. Life is too complicated, too constantly changing, to be anything but what it is. And I am, by nature, too mercurial to be anything but deeply wary of the grave unnaturalness involved in any attempt to exert too much control over essentially uncontrollable forces. There will always be propelling, disturbing
An Unquiet Mind

elements, and they will be there until, as Lowell put it, the watch is taken from the wrist. It is, at the end of the day, the individual moments of restlessness, of bleakness, of strong persuasions and maddened enthusiasms, that inform one’s life, change the nature and direction of one’s work, and give final meaning and color to one’s loves and friendships.

Epilogue

I have often asked myself whether, given the choice, I would choose to have manic-depressive illness. If lithium were not available to me, or didn’t work for me, the answer would be a simple no—and it would be an answer laced with terror. But lithium does work for me, and therefore I suppose I can afford to pose the question. Strangely enough I think I would choose to have it. It’s complicated. Depression is awful beyond words or sounds or images; I would not go through an extended one again. It bleeds relationships through suspicion, lack of confidence and self-respect, the inability to enjoy life, to walk or talk or think normally, the exhaustion, the night terrors, the day terrors. There is nothing good to be said for it except that it gives you the experience of how it must be to be old, to be old and sick, to be dying; to be slow of mind; to be lacking in grace, polish, and coordination; to be ugly; to have no belief in the possibilities of life, the pleasures of sex, the exquisiteness of music, or the ability to make yourself and others laugh.

Others imply that they know what it is like to be
depressed because they have gone through a divorce, lost a job, or broken up with someone. But these experiences carry with them feelings. Depression, instead, is flat, hollow, and unendurable. It is also tiresome. People cannot abide being around you when you are depressed. They might think that they ought to, and they might even try, but you know and they know that you are tedious beyond belief: you’re irritable and paranoid and humorless and lifeless and critical and demanding and no reassurance is ever enough. You’re frightened, and you’re frightening, and you’re “not at all like yourself but will be soon,” but you know you won’t.

So why would I want anything to do with this illness? Because I honestly believe that as a result of it I have felt more things, more deeply; had more experiences, more intensely; loved more, and been more loved; laughed more often for having cried more often; appreciated more the springs, for all the winters; worn death “as close as dungarees,” appreciated it—and life—more; seen the finest and the most terrible in people, and slowly learned the values of caring, loyalty, and seeing things through. I have seen the breadth and depth and width of my mind and heart and seen how frail they both are, and how ultimately unknowable they both are. Depressed, I have crawled on my hands and knees in order to get across a room and have done it for month after month. But, normal or manic, I have run faster, thought faster, and loved faster than most I know. And I think much of this is related to my illness—the intensity it gives to things and the perspective it forces on me. I think it has made me test the limits of my mind (which, while wanting, is holding) and the limits of my upbringing, family, education, and friends.

The countless hypomanias, and mania itself, all have brought into my life a different level of sensing and feeling and thinking. Even when I have been most psychotic—delusional, hallucinating, frenzied—I have been aware of finding new corners in my mind and heart. Some of those corners were incredible and beautiful and took my breath away and made me feel as though I could die right then and the images would sustain me. Some of them were grotesque and ugly and I never wanted to know they were there or to see them again. But, always, there were those new corners and—when feeling my normal self, beholden for that self to medicine and love—I cannot imagine becoming jaded to life, because I know of those limitless corners, with their limitless views.