sive injection of an antipsychotic medication, but the drug had not yet taken hold. He was delusional, paranoid, largely incoherent, and experiencing both visual and auditory hallucinations. He reminded me of films I had seen of horses trapped in fires with their eyes wild with fear and their bodies paralyzed in terror. I tightened my hand on his shoulder, shook him gently, and said, "It's Dr. Jamison. You've been given some Haldol; we're going to take you up to the ward. You're going to be all right." I caught his eye for a moment. Then he screamed again. "You'll be fine. I know you don't believe it now, but you will be well again." I looked over at the three thick volumes of his medical records lying on the table nearby, thought about his countless hospitalizations, and wondered about the truthfulness of my remarks.

That he would get well again, I had no doubt. How long it would last was another question. Lithium worked remarkably well for him, but once his hallucinations and abject terror stopped, he would quit taking it. Neither the resident nor I needed to see the results of the lithium blood level that had been drawn on his admission to the emergency room. There would be no lithium in his blood. The result had been mania. Suicidal depression would inevitably follow, as would the indescribable pain and disruptiveness to his life and to the lives of the members of his family. The severity of his depressions was a black mirror image of the dangerousness of his manias. In short, he had a particularly bad, although not uncommon, form of the illness; lithium worked well, but he wouldn't take it. In many ways, it seemed to me, as I stood there next to him in the emergency room, that all of the time, effort, and emotional energy that I and the others put into treating him were to little or no avail.

Gradually the Haldol began to take effect. The screaming stopped, and the frantic straining against his restraints died down. He was both less frightened and less frightening; after a while he said to me, in a slowed and slurred voice, "Don't leave me, Dr. Jamison. Please, please don't leave me." I assured him I would stay with him until he got to the ward. I knew that I was the one constant throughout all of his hospitalizations, court appearances, family meetings, and black depressions. As his psychotherapist for years, I had been privy to his dreams and fears, hopeful and then ruined relationships, grandiose and then shattered plans for the future. I had seen his remarkable resilience, personal courage, and wit; I liked and respected him enormously. But I also had been increasingly frustrated by his repeated refusals to take medication. I could, from my own experience, understand his concerns about taking lithium, but only up to a point; past that point, I was finding it very difficult to watch him go through such predictable, painful, and unnecessary recurrences of his illness.

No amount of psychotherapy, education, persuasion, or coercion worked; no contracts worked out by the medical and nursing staff worked; family therapy didn't help; no tallying up of the hospitalizations, broken relationships, financial disasters, lost jobs, imprisonments, squanderings of a good, creative, and educated mind worked. Nothing I or anyone else could think of worked. Over the years, I asked several of my colleagues to see him in consultation, but they, like me, could find no way to reach him, no chink in the tightly riveted armor of his resistance. I spent hours talking to my own psychiatrist about him, in part to seek his clinical advice, and in part to make sure that my own history of stopping and starting lithium was not playing some sort of unconscious, unacknowledged role. His attacks of mania and depression became more frequent and severe. No breakthrough ever came; no happy ending ever materialized. There was simply nothing that medicine or psychology could bring to bear that would make him take his medication long enough to stay well. Lithium worked, but he would not take it; our relationship worked, but not well enough. He had a terrible disease and it eventually cost him his life—as it does tens of thousands of people every year. There were limits on what any of us could do for him, and it tore me apart inside.

We all move uneasily within our restraints.

The Charnel House

I reaped a bitter harvest from my own refusal to take lithium on a consistent basis. A floridly psychotic mania was followed, inevitably, by a long and lacerating, black, suicidal depression; it lasted more than a year and a half. From the time I woke up in the morning until the time I went to bed at night, I was unbearably miserable and seemingly incapable of any kind of joy or enthusiasm. Everything—every thought, word, movement—was an effort. Everything that once was sparkling now was flat. I seemed to myself to be dull, boring, inadequate, thick brained, unlit, unresponsive, chill skinned, bloodless, and sparrow drab. I doubted, completely, my ability to do anything well. It seemed as though my mind had slowed down and burned out to the point of being virtually useless. The wretched, convoluted, and pathetically confused mass of gray worked only well enough to torment me with a dreary litany of my inadequacies and shortcomings in character, and to taunt me with the total, the desperate, hopelessness of it all. What is the point in going on like this? I would ask myself. Others would say to me, "It is only temporary, it will pass, you will get over it," but of course they had no idea how I felt, although they were certain that they did. Over and over and over I would say to myself, If I can't feel, if I can't move, if I can't think, and I can't care, then what conceivable point is there in living?

The morbidity of my mind was astonishing: Death and its kin were constant companions. I saw Death everywhere, and I saw winding sheets and toe tags and body bags in my mind's eye. Everything was a reminder that everything ended at the charnel house. My memory always took the black line of the mind's underground system; thoughts would go from one tormented moment of my past to the next. Each stop along the way was worse than the preceding one. And, always, everything was an effort. Washing my hair took hours to do, and it drained me for hours afterward; filling the ice-cube tray was beyond my capacity, and I occasionally slept in the same clothes I had worn during the day because I was too exhausted to undress.

During this time I was seeing my psychiatrist two or three times a week and, finally, again taking lithium on a regular basis. His notes, in addition to keeping track of the medications I was taking—I had briefly taken antidepressants, for example, but they had only made me more dangerously agitated—also recorded the unrelenting, day-in and day-out, week-in and week-out, despair, hopelessness, and shame that the depression was causing: *"Patient intermittently suicidal. Wishes to jump from the top of hospital stairwell"; "Patient continues to be a significant suicide risk. Hospitalization is totally unacceptable to her and in my view she cannot be held under LPS [the California commitment law]"; "Despairs for the* *future; fears recurrence and fears having to deal with the fact that she has felt what she has felt"; "Patient feels very embarrassed about feelings she has and takes attitude that regardless of the course of her depression she 'won't put up with it' "; "Patient reluctant to be with people when depressed because she feels her depression is such an intolerable burden on others"; "Afraid to leave my office. Hasn't slept in days. Desperate."* At this point there was a brief lull in my depression, only to be followed by its seemingly inevitable, dreadful return: *"Patient feels as if she has cracked. Hopeless that depressed feelings have returned."*

My psychiatrist repeatedly tried to persuade me to go into a psychiatric hospital, but I refused. I was horrified at the thought of being locked up; being away from familiar surroundings; having to attend group therapy meetings; and having to put up with all of the indignities and invasions of privacy that go into being on a psychiatric ward. I was working on a locked ward at the time, and I didn't relish the idea of not having the key. Mostly, however, I was concerned that if it became public knowledge that I had been hospitalized, my clinical work and privileges at best would be suspended; at worst, they would be revoked on a permanent basis. I continued to resist voluntary hospitalization; and, because the California commitment code is designed more for the well-being of lawyers than of patients, it would have been relatively easy for me to talk my way out of an involuntary commitment. Even had I been committed, there was no guarantee at all that I would not have attempted or committed suicide while on the ward; psychiatric hospitals are not uncommon places for suicide. (After this experience, I drew up a clear arrangement with my psychiatrist and family that if I again become severely depressed they have the authority to approve, against my will if necessary, both electroconvulsive therapy, or ECT, an excellent treatment for certain types of severe depression, and hospitalization.)

At the time, nothing seemed to be working, despite excellent medical care, and I simply wanted to die and be done with it. I resolved to kill myself. I was cold-bloodedly determined not to give any indication of my plans or the state of my mind; I was successful. The only note made by my psychiatrist on the day before I attempted suicide was: *Severely depressed. Very quiet.*

In a rage I pulled the bathroom lamp off the wall and felt the violence go through me but not yet out of me. "For Christ's sake," he said, rushing in—and then stopping very quietly. Jesus, I must be crazy, I can see it in his eyes: a dreadful mix of concern, terror, irritation, resignation, and why me, Lord? "Are you hurt?" he asks. Turning my head with its fast-scanning eyes I see in the mirror blood running down my arms, collecting into the tight ribbing of my beautiful, erotic negligee, only an hour ago used in passion of an altogether different and wonderful kind. "I can't help it. I can't help it," I chant to myself, but I can't say it; the words won't come out, and the thoughts are going by far too fast. I bang my head over and over against the door. God make it stop, I can't stand it, I know I'm insane again. He really cares, I think, but within ten minutes he too is screaming, and his eyes have a wild look from contagious madness, from the lightning adrenaline between the two of us. "I can't leave you like this," but I say a few truly awful things and *then go for his throat in a more literal way, and he does leave me, provoked beyond endurance and unable to see the devastation and despair inside. I can't convey it and he can't see it; there's nothing to be done. I can't think, I can't calm this murderous cauldron, my grand ideas of an hour ago seem absurd and pathetic, my life is in ruins and—worse still—ruinous; my body is uninhabitable. It is raging and weeping and full of destruction and wild energy gone amok. In the mirror I see a creature I don't know but must live and share my mind with.*

I understand why Jekyll killed himself before Hyde had taken over completely. I took a massive overdose of lithium with no regrets.

Within psychiatric circles, if you kill yourself, you earn the right to be considered a "successful" suicide. This is a success one can live without. Suicidal depression, I decided in the midst of my indescribably awful, eighteen-month bout of it, is God's way of keeping manics in their place. It works. Profound melancholia is a day-in, day-out, night-in, night-out, almost arterial level of agony. It is a pitiless, unrelenting pain that affords no window of hope, no alternative to a grim and brackish existence, and no respite from the cold undercurrents of thought and feeling that dominate the horribly restless nights of despair. There is an assumption, in attaching Puritan concepts such as "successful" and "unsuccessful" to the awful, final act of suicide, that those who "fail" at killing themselves not only are weak, but incompetent, incapable even of getting their dying quite right. Suicide, however, is almost always an irrational act and seldom is it accompanied by the kind of rigorous intellect that goes with one's better days. It is also often impulsive and not necessarily undertaken in the way one originally planned.

I, for example, thought I had covered every contingency. I could not stand the pain any longer, could not abide the bone-weary and tiresome person I had become, and felt that I could not continue to be responsible for the turmoil I was inflicting upon my friends and family. In a perverse linking within my mind I thought that, like the pilot whom I had seen kill himself to save the lives of others, I was doing the only fair thing for the people I cared about; it was also the only sensible thing to do for myself. One would put an animal to death for far less suffering.

At one point I bought a gun, but, in a transient wave of rational thought, I told my psychiatrist; reluctantly, I got rid of it. Then for many months I went to the eighth floor of the stairwell of the UCLA hospital and, repeatedly, only just resisted throwing myself off the ledge. Suicidal depression does not tend to be a considerate, outward, or other-considering sort of state, but somehow the thought that my family would have to identify the fallen and fractured me made that ultimately not an acceptable method. So I decided upon a solution that seemed to me to be poetic in its full-circledness. Lithium, although it ultimately saved my life, at that particular time was causing me no end of grief and sorrow. So I decided to take a massive overdose.

In order to keep the lithium from being vomited back up, I had gone to an emergency room and obtained a prescription for an anti-emetic medication. I then waited for a break in the informal "suicide watch" that my friends and family, in conjunction with my psychiatrist, had put into place. This done, I removed the telephone from my bedroom so I would not inadvertently pick it up—I could not take the phone off its hook entirely as I knew this would alert my keepers—and, after a terrible row, and in a very agitated and violent state, I took handful after handful of pills. I then curled up in my bed and waited to die. I hadn't planned on the fact that one's drugged brain acts differently from one's alert brain. When the telephone rang I must have instinctively thought to answer it; thus I crawled, semi-comatose, to the telephone in the living room. My slurred voice alerted my brother, who was calling from Paris to see how I was doing. He immediately called my psychiatrist.

It was not a pleasant way not to commit suicide. Lithium is used to teach coyotes to stop killing sheep: often a single experience with a lithium-treated sheep carcass will make a coyote sick enough to keep his teeth to himself. Although I had taken medication to keep me from vomiting up the lithium, I still ended up sicker than a coyote, sicker than a dog, sicker than I could ever wish anyone to be. I also was in and out of a coma for several days, which, given the circumstances, was probably just as well.

For a long time both before and after I tried to kill myself, I was in the close care of a friend of mine, one who redefined for me the notion of friendship. He was a psychiatrist, as well as a warm, whimsical, and witty man who had a mind like a cluttered attic. He was intrigued by a variety of bizarre things, including me, and wrote fascinating articles about such topics as nutmeg psychoses and the personal habits of Sherlock Holmes. He was intensely loyal and spent evening after evening with me, somehow enduring my choleric moods. He was generous with both his time and money, and he stubbornly believed that I would make it through my depression and, ultimately, thrive.

Sometimes, after I had told him that I simply had to be alone, he would call me later, at one or two o'clock in the morning, to see how I was doing. He could tell from my voice what state I was in, and, despite my pleas to be left alone, he would insist on coming over. Often this was in the guise of "I can't sleep. You wouldn't refuse to keep a friend company, would you?" Knowing full well that he was only checking up on me, I would say, "Yes. Trust me. I can refuse. Leave me alone. I'm in a foul mood." He would call back again in a few minutes and say, "Please, please, pretty please. I really need the company. We can go somewhere and get some ice cream." So we would get together at some ungodly hour, I would be secretly and inexpressibly grateful, and he somehow would have finessed it so that I didn't feel like I was too huge a burden to him. It was a rare gift of friendship.

Fortuitously, he also worked as an emergency room physician on weekends. After my suicide attempt, he and my psychiatrist worked out a plan for my medical care and supervision. My friend kept a constant watch on me, drew my blood for lithium and electrolyte levels, and walked me repeatedly to pull me out of my drugged state, as one would move a sick shark around its tank in order to keep the water circulating through its gills. He was the only person I knew who could make me laugh during my truly morbid moments. Like my husband, from whom I was legally separated but still frequently in contact, he had a gentling and calming effect on me when I was vastly irritable, perturbed, or perturbing. He nursed me through the most awful days of my life, and it is to him, only next to my psychiatrist and family, that I most owe my life.

The debt I owe my psychiatrist is beyond description. I remember sitting in his office a hundred times during those grim months and each time thinking, What on earth can he say that will make me feel better or keep me alive? Well, there never was anything he could say, that's the funny thing. It was all the stupid, desperately optimistic, condescending things he *didn't* say that kept me alive; all the compassion and warmth I felt from him that could not have been said; all the intelligence, competence, and time he put into it; and his granite belief that mine was a life worth living. He was terribly direct, which was terribly important, and he was willing to admit the limits of his understanding and treatments and when he was wrong. Most difficult to put into words, but in many ways the essence of everything: He taught me that the road from suicide to life is cold and colder and colder still, but—with steely effort, the grace of God, and an inevitable break in the weather—that I could make it.

My mother also was wonderful. She cooked meal after meal for me during my long bouts of depression, helped me with my laundry, and helped pay my medical bills. She endured my irritability and boringly bleak moods, drove me to the doctor, took me to pharmacies, and took me shopping. Like a gentle mother cat who picks up a straying kitten by the nape of its neck, she kept her marvelously maternal eyes wide-open, and, if I floundered too far away, she brought me back into a geographic and emotional range of security, food, and protection. Her formidable strength slowly eked its way into my depleted marrowbone. It, coupled with medicine for my brain and superb psychotherapy for my mind, pulled me through day after impossibly hard day. Without her I never could have survived. There were times when I would struggle to put together a lecture, and, having no idea whether it made sense or not, I would deliver it through the din and dreadful confusion that masqueraded as my mind. Often the only thing that would keep me going was the belief, instilled by my mother years before, that will and grit and responsibility are what ultimately make us supremely human in our existence. For each terrible storm that came my way, my mother—her love and her strong sense of values—provided me with powerful, and sustaining, countervailing winds.

The complexities of what we are given in life are vast and beyond comprehension. It was as if my father had given me, by way of temperament, an impossibly wild, dark, and unbroken horse. It was a horse without a name, and a horse with no experience of a bit between its teeth. My mother taught me to gentle it; gave me the discipline and love to break it; and—as Alexander had known so intuitively with Bucephalus—she understood, and taught me, that the beast was best handled by turning it toward the sun.

Both my manias and depressions had violent sides to them. Violence, especially if you are a woman, is not something spoken about with ease. Being wildly out of control—physically assaultive, screaming insanely at the top of one's lungs, running frenetically with no purpose or limit, or impulsively trying to leap from cars—is frightening to others and unspeakably terrifying to oneself. In blind manic rages I have done all of these things, at one time or another, and some of them repeatedly; I remain acutely and painfully aware of how difficult it is to control or understand such behaviors, much less explain them to others. I have, in my psychotic, seizurelike attacks—my black, agitated manias—destroyed things I cherish, pushed to the utter edge people I love, and survived to think I could never recover from the shame. I have been physically restrained by terrible, brute force; kicked and pushed to the floor; thrown on my stomach with my hands pinned behind my back; and heavily medicated against my will.

I do not know how I have recovered from having done the things that necessitated such actions, any more than I know how and why my relationships with friends and lovers have survived the grinding wear and tear of such dark, fierce, and damaging energy. The aftermath of such violence, like the aftermath of a suicide attempt, is deeply bruising to all concerned. And, as with a suicide attempt, living with the knowledge that one has been violent forces a difficult reconciliation of totally divergent notions of oneself. After my suicide attempt, I had to reconcile my image of myself as a young girl who had been filled with enthusiasm, high hopes, great expectations, enormous energy, and dreams and love of life, with that of a dreary, crabbed, pained woman who desperately wished only for death and took a lethal dose of lithium in order to accomplish it. After each of my violent psychotic episodes, I had to try and reconcile my notion of myself as a reasonably quiet-spoken and highly disciplined person, one at least generally sensitive to the moods and feelings of others, with an enraged, utterly insane, and abusive woman who lost access to all control or reason.

These discrepancies between what one is, what one is brought up to believe is the right way of behaving toward others, and what actually happens during these awful black manias, or mixed states, are absolute and disturbing beyond description—particularly, I think, for a woman brought up in a highly conservative and traditional world. They seem a very long way from my mother's grace and gentleness, and farther still from the quiet seasons of cotillions, taffetas and silks, and elegant gloves that slid up over the elbows and had pearl buttons at the wrist, when one had no worries other than making sure that the seams in one's stockings were straight before going to Sunday-night dinners at the Officers' Club.

For the most important and shaping years of my life I had been brought up in a straitlaced world, taught to be thoughtful of others, circumspect, and restrained in my actions. We went as a family to church every Sunday, and all of my answers to adults ended with a "ma'am" or a "sir." The independence encouraged by my parents had been of an intellectual, not socially disruptive, nature. Then, suddenly, I was unpredictably and uncontrollably irrational and destructive. This was not something that could be overcome by protocol or etiquette. God, conspicuously, was nowhere to be found. Navy Cotillion, candy-striping, and *Tiffany's Table Manners for Teenagers* could not, nor were they ever intended to be, any preparation or match for madness. Uncontrollable anger and violence are dreadfully, irreconcilably, far from a civilized and predictable world.

I had, ever since I could remember, inclined in the direction of strong and exuberant feelings, loving and living with what Delmore Schwartz called "the throat of exaltation." Inflammability, however, always lay just the other side of exaltation. These fiery moods were, at least initially, not all bad: in addition to giving a certain romantic tumultuousness to my personal life, they had, over the years, added a great deal that was positive to my professional life. Certainly, they had ignited and propelled much of my writing, research, and advocacy work. They had driven me to try and make a difference. They had made me impatient with life as it was and made me restless for more. But, always, there was a lingering discomfort when the impatience or ardor or restlessness tipped over into too much anger. It did not seem consistent with being the kind of gentle, well-bred woman I had been brought up to admire and, indeed, continue to admire.

Depression, somehow, is much more in line with society's notions of what women are all about: passive, sensitive, hopeless, helpless, stricken, dependent, confused, rather tiresome, and with limited aspirations. Manic states, on the other hand, seem to be more the provenance of men: restless, fiery, aggressive, volatile, energetic, risk taking, grandiose and visionary, and impatient with the status quo. Anger or irritability in men, under such circumstances, is more tolerated and understandable; leaders or takers of voyages are permitted a wider latitude for being temperamental. Journalists and other writers, quite understandably, have tended to focus on women and depression, rather than women and mania. This is not surprising: depression is twice as common in women as men. But manic-depressive illness occurs equally often in women and men, and, being a relatively common condition, mania ends up affecting a large number of women. They, in turn, often are misdiagnosed, receive poor, if any, psychiatric treatment, and are at high risk for suicide, alcoholism, drug abuse, and violence. But they, like men who have manic-depressive illness, also often contribute a great deal of energy, fire, enthusiasm, and imagination to the people and world around them.

Manic-depression is a disease that both kills and gives life. Fire, by its nature, both creates and destroys. "The force that through the green fuse drives the flower," wrote Dylan Thomas, "Drives my green age; that blasts the roots of trees / Is my destroyer." Mania is a strange and driving force, a destroyer, a fire in the blood. Fortunately, having fire in one's blood is not without its benefits in the world of academic medicine, especially in the pursuit of tenure.

Tenure

Tenure is the closest thing to a blood sport that first-class universities can offer: it is intensely competitive, all-consuming, exciting, fast, rather brutal, and very male. Pursuing tenure in a university medical school—where clinical responsibilities are layered upon the usual ones of research and teaching—ratchets up everything by several orders of magnitude. All things considered, being a woman, a nonphysician, and a manic-depressive was not the ideal way to start down the notoriously difficult road to tenure.

Obtaining tenure was not only a matter of academic and financial security for me. I had had, within months of starting as an assistant professor, my first episode of psychotic mania. The years leading up to tenure, which extended from 1974 to 1981, consisted of more than just the usual difficulties of competing in the very energetic and aggressive world of academic medicine. They were, more important, marked by struggles to stay sane, stay alive, and to come to terms with my illness. As the years went by I became more and more determined to pull out some good from all of the pain, to try and put my illness to some use. Tenure became a time of both possibility and transformation; it also became a symbol of the stability I craved and the ultimate recognition I sought for having competed and survived in the normal world.

After I was assigned to the adult inpatient service for my first teaching and clinical responsibilities, I soon grew restless, to say nothing of finding it increasingly difficult to keep a straight face while interpreting the psychological test results of patients from the ward. Trying to make sense out of Rorschach tests, which seemed a speculative venture on a good day, often made me feel as though I might as well be reading tarot cards or discussing the alignment of the planets. This was not why I had gotten a Ph.D., and I was beginning to understand Bob Dylan's lines "Twenty years of schoolin' and they put you on the day shift." Only it was twenty-three years, and I was still pulling a lot of night shift as well. My intellectual interests were widely and absurdly scattered during my early years on the faculty. I was, among other things, starting up a research project on hyraxes, elephants, and violence (a lingering remnant of the chancellor's garden party); writing up findings from the LSD, marijuana, and opiate studies I had done in graduate school; contemplating a study, to be done with my brother, that would examine the economics of dam-building behavior in beavers; conducting pain research and studies of phantom breast syndrome with my colleagues in the anesthesiology department; coauthoring an undergraduate textbook on abnormal psychology; acting as co-investigator on a study of the effects of marijuana on nausea and vomiting in cancer chemotherapy patients; and trying to figure out a legitimate way to do animal behavior studies at the Los Angeles Zoo. It was too much and too diffuse. My personal interests eventually forced me to focus on what I was doing and why. I gradually narrowed down my work to the study and treatment of mood disorders.

More specifically, and not surprisingly, I became particularly interested in manic-depressive illness. I was absolutely and single-mindedly determined to make a difference in how the illness was seen and treated. Two of my colleagues, both of whom had a great deal of clinical and research experience with mood disorders, and I decided to set up an outpatient clinic at UCLA that would specialize in the diagnosis and treatment of depression and manic-depressive illness. We received enough initial funding from the hospital to allow us to hire a nurse and buy some file cabinets. The medical director and I spent weeks developing diagnostic and research forms and then put together a teaching program that would qualify as a clinical rotation, or training experience, for third-year psychiatric residents and predoctoral psychology interns. Although there was some opposition to the fact that I, as a nonphysician, was the director of a medical clinic, most of the medical staff—especially the medical director of the clinic, the chairman of the psychiatry department, and the chief of staff of the Neuropsychiatric Institute—backed me up.

Within a few years, the UCLA Affective Disorders Clinic had become a large teaching and research facility. We evaluated and treated thousands of patients with mood disorders, carried out a large number of both medical and psychological research studies, and taught psychiatric residents and clinical psychology interns how to diagnose and take care of patients with mood disorders. The clinic became a popular choice for training. It was a scurrying, busy, emergency- and crisis-filled rotation due to the nature and severity of the illnesses being treated, but it also was generally a warm and laughter-filled place. The medical director and I encouraged not only hard work and long hours, but after-hour partying as well. The stress of treating suicidal, psychotic, and potentially violent patients was considerable for all of us, but we tried to back up the clinical responsibility carried by the interns and residents with as much supervision as possible. When the relatively rare catastrophe did occur—an extremely bright young lawyer, for example, refused all efforts to be hospitalized and then committed suicide by shooting himself through the head—the faculty, residents, and interns would meet, in small and larger groups, in order to figure out what had happened and to support not only the devastated family members, but the individuals who had borne the primary clinical responsibility. In the particular instance of the lawyer, the resident had done everything that anyone could possibly have been expected to do; not surprisingly, she was terribly shaken by his death. Ironically, it is usually those doctors who are the most competent and conscientious who feel the most sense of failure and pain.

We placed a strong emphasis upon the combined use of medications and psychotherapy, rather than medications alone, and stressed the importance of education about the illnesses and their treatments to patients and their families. My own experience as a patient had made me particularly aware of how critical psychotherapy could be in making some sense out of all the pain; how it could keep one alive long enough to have a chance at getting well; and how it could help one to learn to reconcile the resentments at taking medication with the terrible consequences of not taking it. In addition to the basics of teaching differential diagnosis, psychopharmacology, and other aspects of the clinical management of mood disorders, much of the teaching, clinical practice, and research revolved around a few central themes: why patients resist or refuse to take lithium and other medications; clinical states most likely to result in suicide, and how to mitigate them; the role of psychotherapy in the long-term outcome of depressive and manic-depressive illness; and the positive aspects of the illness that can arise during the milder manic states: heightened energy and perceptual awareness, increased fluidity and originality of thinking, intense exhilaration of moods and experience, increased sexual desire, expansiveness of vision, and a lengthened grasp of aspiration. I tried to encourage our clinic doctors to see that this was an illness that could confer advantage as well as disadvantage, and that for many individuals these intoxicating experiences were highly addictive in nature and difficult to give up.

In order to give the residents and interns some notion of the experiences that patients went through when manic and depressed, we encouraged them to read firsthand accounts from patients and writers who had suffered from mood disorders. I also started giving Christmas lectures to the house staff and clinic staff that focused on music written by composers who had experienced severe depression or manic-depressive illness.

These informal lectures became the basis for a concert that a friend of mine, a professor of music at UCLA, and I subsequently produced in 1985 with the Los Angeles Philharmonic. In an attempt to raise public awareness about mental illness, especially manic-depressive illness, we proposed to the executive director of the Philharmonic a program based on the lives and music of several composers who had suffered from the illness, including Robert Schumann, Hector Berlioz, and Hugo Wolf. The Philharmonic was enthusiastic, cooperative, and generous in the fees they negotiated. Unfortunately, a few days after I signed the contract, the University of California announced that it was beginning a major financial development campaign and that individual members of the faculty no longer would be able to solicit funds from private donors. I was left with a personal bill for twenty-five thousand dollars, which, as one of my friends pointed out, was a lot of money for concert tickets. Still, the concert filled UCLA's huge Royce Hall and was a great success; it also turned out to be the beginning of a series of concerts performed across the country, including one that we did a few years later with the National Symphony Orchestra at the John F. Kennedy Center for the Performing Arts in Washington, D.C. It was also the basis for the first of a series of public television specials that we produced around the theme of manic-depressive illness and the arts.

Throughout the setting up and running of the clinic I was fortunate to have the support of the chairman of my department. He backed my being director of a medical clinic despite the fact that I was not a physician, and despite the fact that he knew I had manic-depressive illness. Rather than using my illness as a reason to curtail my clinical and teaching responsibilities, he—after being assured that I was receiving good psychiatric care and that the medical director of the clinic knew about my condition—encouraged me to use it to try and develop better treatments and to help change public attitudes. Although he never said, I assume my chairman found out about my illness after my first episode of severe psychotic mania; my ward chief certainly knew, and I imagine that the information quickly drifted upward. In any event, my chairman treated the issue strictly as a medical one. He first broached the subject by coming up to me at a meeting, putting his arm around me, and saying, "I understand you have some problems with your moods. I'm sorry. For God's sake, just be sure to keep taking your lithium." Now and again, after that, he would ask me how I was doing and make sure that I was still taking my medication. He was straightforward, supportive, and never suggested for a moment that I stop or curtail my clinical work.

My concerns about openly discussing my illness with others, however, were enormous. My first psychotic episode occurred long before I received my license from the California Board of Medical Examiners. During the period of time between starting lithium and passing my written and oral board examinations, I observed many medical students, clinical psychology interns, and residents denied permission to continue their studies because of psychiatric illness. This happens far less often now—indeed, most graduate and medical schools encourage students who become ill to get treatment and, if at all possible, to return to their clinical work—but my early years on the faculty at UCLA were plagued by fears that my illness would be discovered, that I would be reported to one kind of hospital or licensing board or another, and that I would be required to give up my clinical practice and teaching.

It was a high-pressure existence in many ways, but mostly I loved it. Academic medicine provides an interesting and varied lifestyle, lots of travel, and most of one's colleagues are bright-eyed, bushy tailed, and generally thrive on the stresses of having to combine clinical practice with publishing papers and teaching. These stresses were compounded by the fluctuations in mood, however attenuated, that I continued to experience while on lithium. It took several years for them to truly even out. For me, when I was well, it was a wide-open opportunity to write, think, see patients, and teach. When I was ill, it was simply overwhelming: for days and weeks at a time, I would put up the DO NOT DISTURB sign on my door, stare mindlessly out the window, sleep, contemplate suicide, or watch my guinea pig—a memento of one of my manic buying sprees—furiously scurrying around in his cage. During those times I could not imagine writing another paper, and I was incapable of comprehending any of the journal articles that I would try to read. Supervising and teaching were ordeals.

But it was a tidal existence: When I was depressed, nothing came to me, and nothing came out of me. When manic, or mildly so, I would write a paper in a day, ideas would flow, I would design new studies, catch up on my patient charts and correspondence, and chip away at the mindless mounds of bureaucratic paper-work that defined the job of a clinic director. Like everything else in my life, the grim was usually set off by the grand; the grand, in turn, would yet again be canceled out by the grim. It was a loopy but intense life: marvelous, ghastly, dreadful, indescribably difficult, gloriously and unexpectedly easy, complicated, great fun, and a no-exit nightmare.

My friends, fortunately, were either a bit loopy themselves, or remarkably tolerant of the chaos that formed the basic core of my emotional existence. I spent a great deal of time with them during those assistant-professorship years. I also traveled frequently, for business and pleasure, and played squash with interns, friends, and colleagues. Sports were fun only up to a point, however, as lithium threw off my coordination. This was true not only for squash, but particularly for riding horses; I finally had to stop riding for several years, after falling off one too many times while jumping. I can look back now and think that perhaps all of that wasn't so bad, but, in fact, each time I had to give up a sport I had to give up not only the fun of that sport, but also that part of myself that I had known as an athlete. Manic-depressive illness forces one to deal with many aspects of growing old—with its physical and mental infirmities—many decades in advance of age itself.

Life in the fast track, the dashing about and scrambling for tenure and for recognition from one's peers, continued at a frenetic pace. When I was manic, the tempo seemed slow; when I was normal, frenetic seemed fine; when I was depressed, the pace was impossible. Other than my psychiatrist, there was no one I could talk to about the real extent of the difficulties I was having. Or perhaps there was, but it never really occurred to me to try. There were next to no other women in the adult psychiatry division; the women that did exist in the department all clumped together in child psychiatry. They were no protection against the weasels in the woodwork, and, besides, they had weasels enough in their own quarters. Although most of my male colleagues were fair, and many were exceptionally supportive, there were several men whose views of women had to be experienced to be believed.

The Oyster was one such man, one such experience. Named for his smooth and slithery essence, the Oyster was a senior professor: he was patronizing, smug, and had all of the intellectual and emotional complexity of, as one might expect, a small mollusk. He thought of women in terms of breasts, not minds, and it always seemed to irritate him that most women had both. He also thought women who strayed into academic medicine were fundamentally flawed, and, as I was particularly disinclined to be deferential, I seemed especially to annoy him. We served together on the Appointments and Promotions Committee for the department, where I was the only woman among the eighteen members. On the occasions when he would actually show up for meetings—the Oyster was notorious for earning a maximum amount of money for spending a minimum amount of time in the hospital—I would try to sit directly across the table from him and watch his failed attempts to be unfailingly polite.

I always had the sense that he thought I was a bit of a mutant but, because I was not absolutely hideous, that I might yet be saved by a good marriage. I, for my part, would randomly congratulate him on his efforts to recruit more women into the department. His lack of gray matter was ably matched by his lack of wit, and, as he of course had never made any attempts whatsoever in that direction, he would look suspiciously in my direction and then dart me a baffled and irritated smile. He would have been likably goofy except that he had real power in the department, and he made clear his views about women every step of the way: his sexual innuendos were deeply offensive, and his level of condescension whenever he spoke with me, or women interns and residents, was infuriating. He was a caricature of himself, in many ways, but it was clear that being a woman on his service meant starting ten seconds late for a hundred-yard dash. Fortunately, the tenure process has many checks and balances built into it, and, at least in the two universities that I know best—the University of California and Johns Hopkins—the system seems to me to be a remarkably fair one. Entities like the Oyster didn't make it any easier, however.

Finally, after much rodenting along and through the tenure maze, I received my letter from the regents notifying me that I had been promoted to the next set of academic mazes: the holding pattern, the Inferno-land of Associate Professordom. I celebrated for weeks. One of my best friends had a lovely dinner party for about thirty people, on a perfect California night; the terraces in her gardens were filled with flowers and candles; it could not have been more beautiful. My family provided the champagne, along with their gift to me of Baccarat glasses for the champagne, and I had a wonderful time. More than anyone, my family and friends knew how much the tenure party was a celebration over years of struggling against severe mental illness, as well as a celebration of the major rite of academic passage.

Tenure really sank in, however, when one of my colleagues, a member of the all-male Bohemian Club, came over to my house with some wine from his club. "Congratulations, Professor," he said, handing me the bottle. "Welcome to an all-men's club."

Part Three

THIS MEDICINE, LOVE

An Officer and a Gentleman

There was a time when I honestly believed that there was only a certain amount of pain one had to go through in life. Because manic-depressive illness had brought such misery and uncertainty in its wake, I presumed life should therefore be kinder to me in other, more balancing ways. But then I also had believed that I could fly through starfields and slide along the rings of Saturn. Perhaps my judgment left something to be desired. Robert Lowell, often crazy but rarely stupid, knew better than to assume a straight shot at happiness: If we see a light at the end of the tunnel, he said, it's the light of an oncoming train.

For a while—courtesy of lithium, time's passing, and the love of a tall, handsome Englishman—I caught a glimpse of what I imagined to be the light at the end of the tunnel, and I could feel, however elusively, what seemed to be the return of a warm and secure existence. I learned how marvelously the mind can heal, given half a chance, and how patience and gentleness can put back together the pieces of a horribly shattered world. What God had put asunder, an elemental salt, a first-rank psychiatrist, and a man's kindness and love could put almost right again.

I met David my first year on the faculty at UCLA. It was early in 1975, six months after I had gone barkingly manic, and my brain had gradually knit itself into a rather brittle, but vaguely coherent, version of its former self. My mind was skating on thin ice, my emotions were completely frayed, and most of my true existence was lived within the narrow range of very long-cast inner shadows. But my overt actions were within the conservative range of my so-called normal colleagues, so—at least professionally speaking—all was ostensibly well.

On this particular day I had unlocked the door to the inpatient ward with my usual sense of annoyance—not because of the patients, but because there was a staff meeting scheduled, which meant that the nurses would be venting their collective spleen on the psychiatric residents, who would, in turn, be irritatingly secure in their knowledge that they had the final authority and higher degrees; the ward chief, who was hopelessly ineffectual, would allow the resentments, envies, and personal animosities to completely dominate the meetings. Patient care, on that particular ward, often took a backseat to staff neuroses, internecine wars, and self-indulgence. Having procrastinated as long as I could, I walked into the conference room, looked for a chair out of the line of fire, and sat down to see how the inevitable unpleasantries would unfold.

To my amazement, the ward psychiatrist came in accompanied by a very tall, good-looking man who looked at me and smiled wonderfully. He turned out to be a visiting professor, a psychiatrist on leave from the Royal Army Medical Corps, and we liked one another immediately. That afternoon we had a cup of coffee together in the hospital cafeteria, and I found myself opening up to him in a way that I hadn't done in a very long time. He was soft-spoken, quiet and thoughtful, and didn't push too hard against the edges of my still very raw soul. We both loved music and poetry; had military backgrounds in common; and, because I had studied in Scotland and England, had common experiences of cities, hospitals, and countrysides as well. He was interested in learning about the differences between British and American psychiatric practices, so I asked him to consult on one of my most difficult patients, a schizophrenic girl who believed she was a witch. He quickly saw through to the medical and psychotherapeutic issues that had been so slow to come out of her guarded and frightened mind. He was unbelievably kind to her, while remaining very much a doctor, and she sensed—as I did later—that she could trust him implicitly. His manner was matter-of-fact, but warm, and I enjoyed watching him gently phrase and then rephrase questions so as to win her trust and reach beyond her paranoia.

David and I frequently had lunch together during his months at UCLA, often in the university's botanical gardens. He repeatedly asked me to dinner, and I, as repeatedly, said I could not because I was still married and again living with my husband, after our initial separation. He returned to London, and, although we wrote to one another occasionally, I was preoccupied with teaching, running a clinic, getting tenure, problems in my marriage, and another bad attack of mania, which, as day the night, was followed by a long, absolutely paralyzing depression.

My husband and I, although we had remained close friends and saw one another often, finally decided that our marriage was beyond the point of repair. I don't think it ever really had a chance after I had impulsively left during my first manic episode. But we both tried. We talked a lot, and we discussed our mistakes and possibilities over many a meal and glass of wine. There was a great deal of goodwill and caring, but nothing could put our marriage back together after all that had happened in the wake of my illness. Somewhere in the midst of all of this, I wrote to David that I had again and finally separated from my husband. Life went on, a blur of clinic meetings, writing papers, seeing patients, and teaching residents, interns, and graduate students. I lived in terror that someone would find out how ill I had been, how fragile I still was, but—oddly and fortunately—sensitivity and keen observation are not always the long suits of academic psychiatrists.

Then one day, more than eighteen months after he had left UCLA, I returned to my office to find David sitting in my chair, playing with a pencil, and smiling broadly. He said, half laughing, "Surely you'll have dinner with me now. I've waited a long time and come a long way." I did, of course, and we had several marvelous days in Los Angeles before he returned to England. He asked me to come stay with him for a few weeks in London. Although I was still recovering from a long suicidal depression, and my thoughts were so halting and my feelings so gray I could scarcely bear it, I somehow knew that things would be made better by being with him. They were. Immeasurably. We had long, late-spring evening walks in St. James's Park, dinner at his club overlooking the Thames, and picnics in Hyde Park, which was just across the street from his flat. Gradually the exhaustion, wariness, and black faithlessness lifted. I began to enjoy music and paintings again, to laugh again, to write poetry again. Long nights and early mornings of incredible passion made me again believe in, or remember, how important a sense of life is to love, and love to life.

David worked at the hospital during the days so I reinvolved myself in the London I had once cared so much about. I went for long walks in the parks, visited and revisited the Tate, wandered aimlessly around the Victoria and Albert, as well as the Natural History and Science Museums. One day, on David's suggestion, I took the boat from Westminster Pier to Greenwich and back; another day I took the train to Canterbury. I hadn't been to Canterbury in years and had seen it only, but unforgettably, through rather manic eyes. I had long-lasting, mystical memories of the dark gorgeous stained glass, the chilled sounds, the simple, grim place of Becket's murder, and the intense, transient light patterns on the cathedral floor. This time, however, I kneeled without ecstasy, prayed without belief, and felt as a stranger. It was, all the same, a quieter and gentler sense of Canterbury that I got.

In the midst of this godless kneeling, I suddenly remembered that I had forgotten to take my lithium the night before. I reached into my purse for my medication, opened the bottle, and immediately dropped all of the pills onto the cathedral floor. The floor was filthy, there were people all around, and I was too embarrassed to bend over and pick up the pills. It was a moment not only of embarrassment, but of reckoning as well; it meant I would have to ask David to write a prescription for me, and that meant, of course, that I would have to tell him about my illness. I couldn't help thinking, with more than a trace of bitterness, that God seldom opens one door that he doesn't close another. However, I couldn't afford not to obtain new medication: the last time I had stopped my lithium I had gotten manic almost immediately. I could not survive another year like the one I had just been through.

That night, before we went to bed, I told David about my manic-depressive illness. I dreaded what his reaction would be and was furious with myself for not having told him earlier. He was silent for a very long time, and I could see that he was sorting through all of the implications, medical and personal, of what I had just said. I had no doubt he loved me, but he knew as well as I did how uncertain the course of the illness could be. He was an army officer, his family was extremely conservative, he desperately wanted children, and manic-depressive illness was hereditary. It also was not talked about. It was unpredictable, and not uncommonly fatal. I wished I had never told him; I wished I was normal, wished I was anywhere but where I was. I felt like an idiot for hoping that anyone could accept what I had just said and resigned myself to a subtle round of polite farewells. We were not married, after all, nor had we been seriously involved for any extended time.

Finally, after eternity had ticked to a close, David turned to me, put his arms around me, and said softly, "I say. *Rotten* luck." I was overcome with relief; I also was struck by the absolute truth of what he just had said. It *was* rotten luck, and somebody finally understood. All the while, in the midst of my relief, the small, shredded island of humor that remained in my mind, recorded, on a totally different brain track, that David's phrasing sounded like something straight out of a P. G. Wodehouse novel. I told him this and reminded him of the Wodehouse character who complained that while it was true that he wasn't disgruntled, he wasn't altogether gruntled either. We both laughed for a long time, somewhat nervously to be sure, but some of the awful ice was broken.

David could not have been kinder or more accepting; he asked me question after question about what I had been through, what had been most terrible, what had frightened me the most, and what he could do to help me when I was ill. Somehow, after that conversation, everything became easier for me: I felt, for the first time, that I was not alone in dealing with all of the pain and uncertainty, and it was clear to me that he genuinely wanted to understand my illness and to take care of me. He started that night. I explained to him that, due to the relatively rare side effects of lithium that affected both my vision and concentration, I essentially could not read more than a paragraph or two at a time. So he read to me: he read poetry, Wilkie Collins, and Thomas Hardy, with one arm around me in bed, smoothing my hair now and again, as though I were a child. Moment by moment, with infinite patience and tact, his gentleness—and his belief in me, in who I was, and in my basic health—pushed back the nightmare fears of unpredictable moods and violence.

It must have been clear to David that I despaired of ever returning to my normal self, because he set about, in his rather systematic way, to reassure me. The next evening, when he came home, he announced that he had arranged dinner invitations from two senior British army officers, both of whom had manic-depressive illness. The evenings that we spent with these two men and their wives were unforgettable. One of the men, a general, was elegant, charming, and very smart; his lucidity was beyond question. He was—other than an occasional restlessness in his eyes and a slightly melancholic, albeit savingly sardonic, tinge to his conversation—indistinguishable from the animated, self-assured, and entertaining types one encounters at London and Oxford dinner parties. The other officer was also wonderful—warm, witty, and, like the general, had a "frightfully, frightfully" upper-crust accent. He, too, had an occasional sad aspect to his eyes, but he was terrific company and has remained, over many years, a close friend.

At no time during either of the dinner parties was manic-depressive illness discussed; it was, in fact, the very normality of the evenings that was so reassuring and so important to me. Being introduced to such "normal" men, both from a world much like the one I had known as a child, was one of David's many intuitive acts of kindness. "It is the history of our kindnesses that alone makes this world tolerable," wrote Robert Louis Stevenson. "If it were not for that, for the effect of kind words, kind looks, kind letters . . . I should be inclined to think our life a practical jest in the worst possible spirit." After knowing David, I never again saw life in its worst possible spirit.

I left London with a terrible sense of apprehension, but David wrote and called often. In the late fall we spent time together in Washington, and, as I finally was feeling myself again, I enjoyed life in ways that I hadn't for years. Those November days remain in my memory as a gentle yet intensely romantic swirl of long walks in the cold, visits to old houses and yet older churches, light snows covering the eighteenth-century gardens of Annapolis, and icy rivers threading their way out of and beyond the Chesapeake Bay. The evenings were filled with dry sherry and meandering dinner conversations about almost everything; the nights were filled with wonderful lovemaking and much-sought, long-absent, untroubled sleep.

David returned to London; I returned to Los Angeles; we wrote and spoke often, missed one another, and threw ourselves into our respective lives of work. I went back to England in May, and we had two weeks of long, warm pre-summer days in London, Dorset, and Devon. One Sunday morning, after church, we walked up into the hills to listen to the ringing of the church bells, and I noticed that David had stopped, was standing still, and breathing heavily. He joked about getting too much strenuous exercise at night, we both laughed, and left it at that.

David was posted to the British Army Hospital in Hong Kong, and he made plans for me to visit him there. He wrote in detail about the evening events he had arranged for us, the people he wanted me to meet, and the picnics we would take to the islands nearby. I could not wait to be with him again. But then one night, not too long before I was to join him, I was at home writing a chapter for a textbook when there was a knock at my door. It was an odd hour, I was expecting no one, and for some even odder reason I suddenly remembered what my mother had said about how pilots' wives dreaded the chaplain's knock on the door. I opened the door, and it was a diplomatic courier with a letter from David's commanding officer saying that David, who had been on general medical duty in Kathmandu, had died very suddenly of a massive heart attack. He was forty-four, and I was thirty-two.

Very little sank in. I remember sitting down, picking up my work again, writing for a while, and then telephoning my mother. I spoke also with David's parents and his commanding officer. Even when we were discussing plans for the funeral, which was significantly delayed because the army required an autopsy before David's body could be returned to England, his death in no way seemed real to me. I went through all of the motions in a state of complete shock—I booked a flight, taught my seminar the next morning, ran a clinic staff meeting, renewed my passport, packed my clothes, and carefully gathered up all of David's letters to me. Once I was on the airplane, I methodically put the letters into order according to when they had been written; I decided to wait until I got to London, however, before reading them. The next day, in Hyde Park, when I sat down to read, I found I could get through only the first half of the first letter. I started sobbing uncontrollably. To this day I have neither reopened nor reread any of his letters.

I found my way to Harrods to pick out a black hat for the funeral and then had lunch with David's commanding officer at his club. He was, by virtue of his job, chief psychiatrist for the British army; by temperament, he was kind, direct, and tremendously understanding. He was used to dealing with women whose husbands had died unexpectedly, knew desperate denial when he saw it, and clearly grasped that I had not even begun to comprehend the reality of David's death. He talked to me for a long time about David, about the many years he had known and worked with him, and what a wonderful doctor and person he had been. He also said he thought it might be "terribly difficult, but a good idea" if he read me portions of the autopsy report. Ostensibly, this was to reassure me that the massiveness of David's heart attack was such that no treatment or medical intervention would have helped. In actuality, it was clear he knew that the cold-blooded medical language would shock me into beginning to deal with the finality of it all. It certainly helped, although it was not so much the gruesome medical details that lurched me toward reality; it was, instead, the brigadier's statement that "a young officer had accompanied the body of Colonel Laurie on the Royal Air Force plane from Hong Kong to Brize Norton airfield." David no longer was Colonel Laurie; he no longer was Dr. Laurie; he was a body.

The British army was unbelievably kind to me. By definition the army is used to death, especially sudden death, and much that is healing comes from their traditions. The rituals of military funerals are in themselves predictable, reassuring, dignified, religious, and dreadfully final. David's friends and fellow officers were blunt, witty, matter-of-fact, and deeply compassionate. They made clear the expectation that I would handle things well, but they also did every conceivable thing possible to make a terrible situation more bearable. They never left me alone, but they never hovered; they kept me plied with sherry and scotch; they offered me legal counsel. They frequently, openly, and humorously discussed David; they left little room for denial.

During the funeral itself, the brigadier insisted I sing along with the hymns, kept his arm around me during particularly difficult times, and laughed out loud when I whispered to him, during a somewhat overdone eulogy about officers and gentlemen, that I wished I could just get up and say that David had been great in bed. Despite my revulsion at the grotesque reduction of a man who had been six feet three inches tall into a small box of ashes, and an overwhelming desire to stay back from the grave site, he again pushed me forward to watch, to take it in, to believe it to be so.

I spent the rest of my time in England with friends and, bit by bit, began to understand that the future I had assumed, and the love and support I had come to depend upon, were gone. There were a thousand things I remembered once David had died. And there were many, many regrets: for lost opportunities, unnecessary and damaging arguments, and a deepening realization that there was absolutely nothing that could be done to change that which was true. There were so many dreams lost: all of our plans for a house full of children were lost; all of seemingly everything was lost. But grief, fortunately, is very different from depression: it is sad, it is awful, but it is not without hope. David's death did not plunge me into unendurable darkness; suicide never crossed my mind. And there was very real solace in the offsetting and enormous kindness of friends, family, and even strangers. The day I left England to return to America, for instance, an agent at the British Airways ticket counter asked me if my trip had been for business or holiday. My composure, which had been airtight for almost two weeks, suddenly snapped. I explained, through a flood of tears, the circumstances of my visit; the agent immediately upgraded my seat and put me where I could have as much privacy as possible. He must have sent the word ahead to the stewardesses, because they too were unusually kind, solicitous, and left me to my thoughts. Since that day, whenever possible, I fly British Airways. And, each time, I am reminded of the importance of small kindnesses.

I returned home to a tremendous amount of work, which was genuinely helpful, and, unnervingly, to several letters from David, which had arrived in my absence. In the days to follow I received two other letters, long delayed in the mail, and then, inevitably and terribly, they stopped. The shock of David's death gradually disappeared over time. Missing him never has. Several years after his death I was asked to speak about it. I ended with a poem written by Edna St. Vincent Millay:

Time does not bring relief; you all have lied
Who told me time would ease me of my pain!
I miss him in the weeping of the rain;
I want him at the shrinking of the tide;
The old snows melt from every mountain-side,
And last year's leaves are smoke in every lane;

But last year's bitter loving must remain
Heaped on my heart, and my old thoughts abide.
There are a hundred places where I fear
To go,—so with his memory they brim.
And entering with relief some quiet place
Where never fell his foot or shone his face
I say, "There is no memory of him here!"
And so stand stricken, so remembering him.

Time finally did bring relief. But it took its own, and not terribly sweet, time in doing so.

They Tell Me It Rained

The accumulated pain and uncertainty from David's death, as well as from my own illness, for several years very much lowered and narrowed my expectations of life. I drew into myself and, for all intents and purposes, shuttered my heart from any unnecessary exposure to the world. I worked hard. Running a clinic, teaching, doing research, and writing books were no substitute for love, but they were interesting and gave some meaning to my badly interrupted life. Having finally cottoned onto the disastrous consequences of starting and stopping lithium, I took it faithfully and found that life was a much stabler and more predictable place than I had ever reckoned. My moods were still intense and my temperament rather quick to the boil, but I could make plans with far more certainty and the periods of absolute blackness were fewer and less extreme.

Still, I was unquestionably raw and unhealed inside. At no point in the eight years since I had joined the faculty—despite the repeated, long months of manias and depressions, my suicide attempt, and David's death—had I taken off any extended time from work, or away from Los Angeles, in order to heal and bind up the massive and long-standing wounds. So dipping into that most fabulous of all professorial perks, I decided to take a year's sabbatical leave in England. Like St. Andrews many years before, it turned out to be a gentle and wonderful interlude. Love, long periods of time to myself, and a marvelous life in London and Oxford gave both my mind and heart the chance to slowly put back together most of that which had been ripped apart.

My academic reasons for going to England were to conduct a study of mood disorders in eminent British artists and writers and to work on a medical text about manic-depressive illness that I was writing with a colleague. My time was split between work at St. George's Hospital Medical School in London and the University of Oxford. They could not have been more different experiences, each wonderful in very different ways. St. George's, a large teaching hospital now in the middle of one of London's poorest neighborhoods, was active and lively in the way that good teaching hospitals tend to be. It was 250 years old and had been home to Edward Jenner, the great surgeon John Hunter, and many other clinicians and scientists famous in the history of medicine; the hospital was also the final resting place for Blossom, the cow that Jenner had used in carrying out his smallpox vaccine research. Her somewhat mangy but magnificent hide hung under glass in the medical school library. When I first saw it, at a distance and without my glasses, I thought it was a strange and oddly beautiful abstract painting. I was delighted when I found out it was actually the hide of a cow, and not that of just any cow, but such a medically famous one. There was something very nice about working near Blossom, and I spent many happy hours in her company, working, or thinking about working, and looking up now and again at her motley but charming remains.

Oxford was totally different. I was a senior research fellow of Merton College, one of the three original Oxford colleges founded in the thirteenth century. Merton's chapel had been built during the same period, and some of its incredibly beautiful, deeply stained glass windows date from then as well. The library, built a century later and one of the finest medieval libraries in England, was also the first to house books upright on shelves instead of keeping them flat in chests. Its collection of early printed books is said to have been hampered by the fact that the college was convinced that the printing press was only a passing fad, one that would never be able to replace handwritten manuscripts. Some of that extraordinary confidence—so unburdened by either the realities of the present or the approaching of the future—still seeps through the Oxford colleges, creating, variously, annoyance or amusement, depending upon one's mood and circumstance.

I had a lovely suite of rooms at Merton overlooking the playing fields, and I read (albeit with difficulty) and wrote in total peace, interrupted only by a college servant who brought coffee in the mornings and tea in the afternoons. Lunch was almost always with the senior fellows, a remarkably interesting, if occasionally odd, group of senior lecturers and professors representing all fields of study within the university. There were historians, mathematicians, philosophers, and literary scholars, but whenever possible I would sit next to Sir Alister Hardy, the marine biologist, who was a fascinating man and an extraordinary storyteller; I listened for hours to his accounts of his early scientific explorations to Antarctica, as well as his discussions of his ongoing research into the nature of religious experiences. We shared strong common interests in William James and the nature of ecstatic experiences, and he leapfrogged fields, from literature to biology to theology, without effort or pause.

Merton was not only among the oldest and wealthiest of the Oxford colleges, it was also widely acclaimed for having the best food and the finest wine cellar. For that reason, I not infrequently found myself in Oxford for college dinners. Those evenings were evenings far far back in time: sipping sherry and talking with the dons before dinner began; walking together, in procession, into the old and beautiful dining hall; watching with amusement as the black-gowned, scraggly undergraduates rose to their feet as the dons came in (the deference had a certain appeal; curtsying, perhaps, was not such a bad thing after all). Heads bowed, quick prayers in Latin, students and dons alike, we all would wait for the college warden to sit; this then, would be followed by an immediate and overpowering din of undergraduates scuffling with chairs, laughing, and shouting loudly up and down the long dining tables.

At the high table, the conversations and enthusiasm were more restrained, and, always, there was vintage Oxfordtalk, usually clever, often hilarious, occasionally stifling; excellent dinners with superb wines were all noted on elegantly calligraphied and crested menus; then we filed out into a smaller, private dining room for brandies and ports and fruit and candied ginger with the warden and fellows. I cannot imagine how anyone got any work done after these dinners, but, as everyone I met who taught at Oxford seemed to have written at least four definitive books on one obscure topic or another, they must have inherited, or cultivated, very different kinds of livers and brains. For my part, the wine and port would inevitably catch up with me, and, after pouring myself onto the last train to London, I would stare out of the window into the night, caught up, for an hour or so, in other centuries, and happily lost between worlds and eras.

Although I went to Oxford several times a week, most of my life was centered in London. I spent great and vastly enjoyable amounts of time wandering through parks and museums and took long weekends with friends who lived in East Sussex, walking along the downs overlooking the English Channel. I also started riding again. I felt the return of an amazing sense of life and vitality when taking a horse out through the misty mornings of Hyde Park during the cold, late autumn, and even more so galloping pell-mell over the Somerset countryside, through beech woods and across farmlands. I had forgotten what it felt like to be that open to wind and rain and beauty, and I could feel life seeping back into crevices of my body and mind that I had completely written off as dead or dormant.

It took my year in England to make me realize how much I had been simply treading water, settling on surviving and avoiding pain rather than being actively involved in and seeking out life. The chance to escape from the reminders of illness and death, from a hectic life, and from clinical and teaching responsibilities was not unlike my earlier year as an undergraduate in St. Andrews: it gave me a semblance of peace that had eluded me, and a place of my own to heal and mull, but most important to heal. England did not have the Celtic, magical quality of St. Andrews—nothing, I suppose, ever could for me—but it gave me back myself again, gave me back my high hopes of life. And it gave me back my belief in love.

I had come at last to some sort of terms with David's death. Visiting his grave in Dorset one cold, sunny day, I was taken aback by the loveliness of the churchyard in which he was buried. I had not remembered very much of it from the funeral, and certainly not its tranquillity and beauty. The deathly quietness was a certain kind of consolation, I suppose, but not necessarily the kind one would seek. I put a bouquet of long-stemmed violets on his grave and sat, tracing the letters of his name in the granite, remembering our times together in England and Washington and Los Angeles. It seemed a very long time ago, but I could see him still, tall and handsome, standing, arms crossed and laughing, at the top of a hill, during one of our walks in the English countryside; I still could feel his presence next to mine, kneeling together in a strange intimacy, at the communion rail in St. Paul's; and I still could feel, with absolute clarity, his arms tight around me, holding the world at bay, giving me comfort and safety in the midst of total desolation. I wished more than anything that he could see that I was well, and that I somehow could repay him for his kindness and his belief in me. But mostly, as I was sitting there in the graveyard, I thought of all of the things that David had missed by dying young. And then, after an hour or more of being lost in my thoughts, I was caught up short by the realization that I had been thinking, for the first time, about how much David had missed, rather than what we together would miss.

David had loved and accepted me in an extraordinary way; his steadiness and kindness had sustained and saved me, but he was gone. Life—because of him, and despite his death—went on. And now, four years after his death, I found a very different kind of love and a renewed belief in life. These came by way of an elegant, moody, and totally charming Englishman whom I had met early in the year. We both knew that, due to personal and professional circumstances, our affair would have to end once the year did, but it was—despite or because of this—a relationship that succeeded, finally, in restoring love and laughter and desire to a walled-in life and a thoroughly iced heart.

We had first met at a London dinner party during one of my earlier visits to England; it was, wonderfully, and without question, love at first sight. Neither of us had any awareness of anyone else at the dinner table that night, and neither of us—we agreed much later—had ever been so completely and irrationally swept away by the power of our feelings. Several months later, when I returned to London for my year's sabbatical leave, he called and asked me to go out to dinner. I was renting a mews house in South Kensington, so we went to a restaurant nearby. It was, for both of us, a continuation of what we had felt when we first met. I was spellbound by the ease with which he understood me, and physically overwhelmed by his intensity. We both knew, long before the wine was through, that we were beyond any way of turning back.

It was raining when we left the restaurant, and he put his arm around me as we ran madcap to my place. Once there, he held me very close to him for a long, long time. I felt and smelled the rain against his coat, felt his arms around me, and remembered, with relief, how extraordinary scents and rain and love and life can be. I had not been with a man in a very long time, and, understanding this, he was kind and gentle and utterly loving. We saw each other as often as we could. Because we both were inclined to intense feelings and moods, we could console one another easily and, likewise, give one another a wide berth whenever necessary. We talked about everything. He was almost frighteningly intuitive, smart, passionate, and, occasionally, deeply melancholic; and he came to know me better than anyone had ever known me. He had no difficulty seeing the complexity in emotional situations or moods—his own made him well able to understand and respect irrationality, wild enthusiasms, paradox, change, and contradiction. We shared a love for poetry, music, tradition, and irreverence, as well as an unflagging awareness of the darker side of almost everything that was light, and the lighter side of almost everything that was bleak or morbid.

We created our own world of discussion, desire, and love, living on champagne, roses, snow, rain, and borrowed time, an intense and private island of restored life for both of us. I had no hesitancy in telling him everything about myself, and he, like David, was extremely understanding about my manic-depressive illness. His immediate response, after I told him, was to take my face in his hands, kiss me gently on either cheek, and say, "I thought it was impossible for me to love you any more than I do." He was silent for a while and then added, "It doesn't really surprise me, but it does explain a certain vulnerability that goes along with your boldness. I am very glad you told me." He meant it. They were not just easy words to cover awkward feelings. Everything he did and said after our discussion only underscored the meaning of his words. He understood, took into account, and put into perspective my vulnerabilities; but he also knew and loved my strengths as he saw them. He kept both in mind, protecting me from the hurt and pain of my illness and loving those aspects of me that he felt carried over with passion into life and love and work and people.

I told him about my problems with the idea of taking lithium, but also that my life was dependent upon it. I told him that I had discussed with my psychiatrist the possibility of taking a lower dose in hopes of alleviating some of the more problematic side effects; I was eager to do this, but very frightened that I would have a recurrence of my mania. He argued that there would never be a safer or more protected period of time in my life in which to do it and that he would see me through. After discussing it with my psychiatrist in Los Angeles and my doctor in London, I did, very slowly, cut back on the amount of lithium I was taking. The effect was dramatic. It was as though I had taken bandages off my eyes after many years of partial blindness. A few days after lowering my dose, I was walking in Hyde Park, along the side of the Serpentine, when I realized that my steps were literally bouncier than they had been and that I was taking in sights and sounds that previously had been filtered through thick layers of gauze. The quacking of the ducks was more insistent, clearer, and more intense; the bumps on the sidewalk were far more noticeable; I felt more energetic and alive. Most significant, I could once again read without effort. It was, in short, remarkable.

That night, waiting for my moody, intense Englishman to appear—needlepointing, watching the snow fall, listening to Chopin and Elgar—I suddenly was aware of how clear and poignant the music seemed, how intensely, beautifully melancholic it was to watch the snow and wait for him. I was feeling more beauty, but more real sadness as well. When he arrived—elegant, just in from a formal dinner party, black tie, white silk evening scarf draped, askew, around his neck, a bottle of champagne in his hand—I put on Schubert's posthumous Piano Sonata in B-flat, D. 960. Its haunting, beautiful eroticism absolutely filled me with emotion and made me weep. I wept for the poignancy of all the intensity I had lost without knowing it, and I wept for the pleasure of experiencing it again. To this day, I cannot hear that piece of music without feeling surrounded by the beautiful sadness of that evening, the love I was privileged to know, and the recollection of the precarious balance that exists between sanity and a subtle, dreadful muffling of the senses.

Once, after several days completely to ourselves and with no contact at all with the outside world, he brought me an anthology of writings about love. He had tagged one short entry that captured the essence not only of those intense, glorious days but of the entire year as well:

Thank you for a lovely weekend.
They tell me it rained.

Love Watching Madness

I dreaded leaving England. My moods had held at a more even keel for longer than I could remember; my heart was newly alive; and my mind was in a glorious state, having loped, grazed, and mulled its less medicated self through Oxford and St. George's. It was increasingly hard to imagine giving up the gentle pace of days I had set for myself in London, and harder still to think of losing the passion and close understanding that had filled my nights. England had laid to rest most of my incessant wondering about the what-ifs and whys and what-might-have-beens; it also had laid to rest, in a very different way, my relentless warrings with lithium, most of which had been nothing but a futile battle against the givens of my own mind. These warrings had cost me dearly in time lost, and, feeling myself again, I was unwilling to risk losing any more time than I already had. Life had become worth not losing.

Inevitably, the year passed: the snows and warming brandies of the English winter gave way to the soft rains and white wines of early summer. Roses and horses appeared in Hyde Park; gorgeous, diaphanous apple blossoms spread out over the black branches of the trees in St. James's Park; and the long, still hours of summer light cast an Edwardian hue over the days just up to my parting. It had become difficult to remember my life in Los Angeles, much less to think about returning to the chaotic days of running a large university clinic filled with very sick patients, teaching, and seeing a full caseload of patients again. I was beginning to have doubts that I could remember the details of conducting a psychiatric history and examination, much less teaching others how to do it. I was reluctant to leave England, and even more reluctant to return to a city I had come to associate not only with a grueling academic career, but also with breakdowns, the worn, cold, bloodlessness following in their wake, and the draining charade of pretending to be well when I wasn't and going through the motions of being pleasant when I felt dreadful.

I was, however, very wrong in my forebodings. The year had served as far more than just a restful interlude; it had been, in fact, truly restorative. Teaching was once again fun; supervising the clinical work of the residents and interns was, as it had been in earlier times, a pleasure; and seeing patients gave me the opportunity to try to put into practice some of what I had learned from my own experiences. Mental exhaustion had taken a long, terrible toll, but, strangely, it was only in feeling well, energetic, and high-spirited again that I had any true sense of the toll taken.

So work went well and relatively smoothly. Much of my time was spent working on a textbook that I was coauthoring about manic-depressive illness, delighted with how much easier it was to read, analyze, and retain the medical literature, which, until only recently, had been a terrible struggle to comprehend. I found writing my sections of the textbook a satisfying mix of science, clinical medicine, and personal experience. I was concerned that these experiences might unduly influence—by content or emphasis—portions of what I wrote, but my coauthor was fully aware of my illness, and many other clinicians and scientists also reviewed what we wrote. Often, though, I found myself drawing upon certain aspects of what I had been through in order to emphasize a particular point of phenomenology or clinical practice. Many of the chapters I wrote—those about suicide, medication compliance, childhood and adolescence, psychotherapy, clinical description, creativity, personality and interpersonal behavior, thought disorder, perception, and cognition—were influenced by my strong belief that these were areas that had been relatively overlooked in the field. Others—such as epidemiology, alcohol and drug abuse, and assessment of manic and depressive states—were more straightforwardly a review of the existing psychiatric literature.

For the clinical description chapter—the basic characterization of hypomanic and manic states, depressive and mixed states, as well as the cyclothymic features underlying these clinical conditions—I relied not only upon the work of classic clinicians such as Professor Emil Kraepelin, and the many clinical researchers who had conducted extensive data-based studies, but upon the writings of manic-depressive patients themselves. Many of the descriptions were from writers and artists who had given highly articulate and vivid descriptions of their manias, depressions, and mixed states. Most of the rest of the accounts were from my patients or passages taken from the psychiatric literature. In a few instances, however, I used my own descriptions of my experiences that I had written for teaching purposes over the years. So interspersed throughout clinical studies, symptom frequencies, and classic clinical descriptions from the European and British medical literature were excerpts from poems, novels, and autobiographical accounts written by individuals who had suffered from manic-depressive illness.

Time and again, because of both personal and clinical experiences, I found myself emphasizing the terrible lethality of manic-depressive illness, the dreadful agitation involved in mixed manic states, and the importance of dealing with patients' reluctance to take lithium or other medications to control their moods. Having to stand back from my own feelings and past in order to write in a more cerebral, scholarly way was refreshing, and it forced me to structure and put into a more objective perspective the turmoil I had been through. Often, the science of the field was not only exciting, but it also held out the very realistic hope of new treatments. Although it was, on occasion, disturbing to see powerful and complicated emotions and behaviors distilled into deadeningly dull diagnostic phrases, it was hard not to be caught up in the new methods and findings of a very rapidly progressing field of clinical medicine.

I ended up strangely loving the discipline and obsessiveness that went into developing the countless tables of data. There was something lullingly reassuring about entering number after number, percentage after percentage, into the summary charts; critiquing the methods used in the various studies; and then trying to make some overall sense out of the large number of articles and books that had been reviewed. Much as I had done when frightened or upset as a child, I found that asking questions, tracking down answers as best I could, and then asking yet more questions was the best way to provide a distance from anxiety and a framework for understanding.

Lowering my lithium level had allowed not only a clarity of thinking, but also a vividness and intensity of experience, back into my life; these elements had once formed the core of my normal temperament, and their absence had left gaping hollows in the way in which I could respond to the world. The too rigid structuring of my moods and temperament, which had resulted from a higher dose of lithium, made me less resilient to stress than a lower dose, which, like the building codes in California that are designed to prevent damage from earthquakes, allowed my mind and emotions to sway a bit. Therefore, and rather oddly, there was a new solidness to both my thinking and emotions. Gradually, as I began to look around me, I realized that this was the kind of evenness and predictability most people had, and probably took for granted, throughout their lives.

When I was an undergraduate I tutored a blind student in statistics; once a week he would make his way, with his guide dog, to my small office in the basement of the psychology building. I was very affected by working with him, seeing how difficult it was for him to do the things I so much took for granted and by watching the extraordinarily close relationship he had with his collie, who, having accompanied him to the office, would immediately curl up and fall asleep at his feet. As the term went on I felt increasingly comfortable in asking him about what it was like to be blind; what it was like to be blind, young, and an undergraduate at the University of California; and what it was like to have to be so dependent upon others to learn and survive. After several months I had deluded myself that I had at least some notion, however small, of what life was like for him. Then one day he asked me if I would mind meeting him for his tutorial session in the blind reading room of the undergraduate library, rather than in my office.

I tracked down the reading room with some difficulty and started to go in. I stopped suddenly when I realized with horror that the room was almost totally dark. It was dead silent, no lights were on, and yet there were half a dozen students bending over their books or listening intently to the audiotapes of the professors' lectures that they had recorded. A total chill went down my spine at the eeriness of the scene. My student heard me come in, got up, walked over to the light switch, and turned on the lights for me. It was one of those still, clear moments when you realize that you haven't understood anything at all, that you have had no real comprehension of the other person's world. As I gradually entered into the world of more stable moods and more predictable life, I began to realize that I knew very little about it and had no real idea of what it would be like to live in such a place. In many ways, I was a stranger to the normal world.

It was a sobering thought, and one that cut both ways. My moods still shifted often and precipitously enough to afford me occasional intoxicating, mind-on-the-edge experiences; these white manias were infused with the intense, high-flying exuberance, absolute assuredness of purpose, and easy cascading of ideas that had made taking lithium so difficult for so long. But then when the black tiredness inevitably followed, I would be subdued back into the recognition that I had a bad disease, one that could destroy all pleasure and hope and competence. I began to covet the day-to-day steadiness that most of my colleagues seemed to enjoy. I also began to appreciate how draining and preoccupying it had become just to keep my mind bobbing above water. It was true that much got done during the days and weeks of flying high, but it was also true that one generated new projects and made new commitments, which then had to be completed during the grayer times. I was constantly chasing the tail of my own brain, recovering from, or delving into, new moods and new experiences. The new was beginning to lack both newness and luster, and the mere accumulation of experiences was beginning to seem far less meaningful than I imagined exploring the depths of such experiences ought to be.

The extremes in my moods were not nearly as pronounced as they had been, but it was clear that a low-grade, fitful instability had become an integral part of my life. I had now, after many years, finally convinced myself that a certain intellectual steadiness was not only desirable, but essential; somewhere in my heart, however, I continued to believe that intense and lasting love was possible only in a climate of somewhat tumultuous passions. This, I felt, consigned me to being with a man whose temperament was largely similar to my own. I was late to understand that chaos and intensity are no substitute for lasting love, nor are they necessarily an improvement on real life. Normal people are not always boring. On the contrary. Volatility and passion, although often more romantic and enticing, are not intrinsically preferable to a steadiness of experience and feeling about another person (nor are they incompatible). These are beliefs, of course, that one has intuitively about friendships and family; they become less obvious when caught up in a romantic life that mirrors, magnifies, and perpetuates one's own mercurial emotional life and temperament. It has been with pleasure, and not-inconsiderable pain, that I have learned about the possibilities of love—its steadiness and its growth—from my husband, the man with whom I have lived for almost a decade.

I first met Richard Wyatt at a Christmas party in Washington, and he certainly was not at all what I expected. I had heard of him—he is a well-known schizophrenia researcher, Chief of Neuropsychiatry at the National Institute of Mental Health, and the author of more than seven hundred scientific papers and books—but I was completely unprepared for the handsome, unassuming, quietly charming man I found myself talking with near a gigantic Christmas tree. He was not only attractive, he was very easy to talk to, and we got together often in the months that followed. Less than a year after we met, I returned to London for another marvelous six months, again on sabbatical leave from UCLA, and then went back to Los Angeles long enough to fulfill my post-sabbatical obligations and make plans to move to Washington. The whole thing had been a short but very convincing courtship. I loved being with him and found him not just unbelievably smart, but imaginative, fiendishly curious, refreshingly open-minded, and wonderfully easygoing. Even then, very early in our relationship, I could not imagine my life without him. I resigned my tenured position at the medical school with genuine regret at leaving the University of California, which I loved, and considerable anxiety about the financial implications of giving up a secure income, and then went to a long round of farewell parties given by colleagues, friends, and students. Overall, however, I left Los Angeles with few regrets. It had never been the City of Angels to me, and I was more than happy to leave it, first, thousands of feet below me—and then, finally, thousands of miles behind—filled with near death, a completely shattered innocence, and a recurrently lost and broken mind. Life in California had been often good, even very wonderful, but it was hard for me to see any of that at the time I returned to Washington to live. The ever promising, always elusive, and infinitely complex Promised Land seemed to me to be exactly that: promised.

Richard and I moved into a house in Georgetown and quickly confirmed what our common sense should have told us: we could not have been more different. He was low-key, I was intense; things that cut me to the quick he was able to sail by with scarcely a notice; he was slow to anger, I quick; the world registered gently upon him, sometimes not at all, whereas I was fast to feel both pleasure and pain. He was, indeed, in most ways and at most times, a man of moderation; I was quicker to slight, quicker to sense, and perhaps quicker to reach out and attempt to heal hurts we inevitably caused one another. Concerts and opera, mainstays of my existence, were torture to him, as were long, extended talks or vacations lasting more than three days. We were a complete mismatch. I was filled with a thousand enthusiasms or black despair; Richard, who for the most part maintained an even emotional course, found it difficult to handle—or, worse yet, take seriously—my intensely mercurial moods. He had no idea what to do with me. If I asked him what he was thinking, it was never about death, the human condition, relationships, or us; it was, instead, almost always about a scientific problem or, occasionally, about a patient. He pursued his science and the practice of medicine with the same romantic intensity that was integral to the way I pursued the rest of life.

He was not, it was clear, going to gaze meaningfully into my eyes over long dinners and fine wines, nor discuss literature and music over late-night coffee and port. He, in fact, *couldn't* sit still very long, had a scarcely measurable attention span, didn't drink much, never touched coffee, and wasn't particularly interested in the complexities of relationships or the affirmations of art. He couldn't abide poetry and was genuinely amazed that I seemed to spend so much of my day just wandering around, rather aimlessly, going to the zoo, visiting art galleries, walking my dog—a sweet, wholly independent, morbidly shy basset hound named Pumpkin—or meeting friends for lunch and breakfast. Yet not once in the years we have been together have I doubted

Richard's love for me, nor mine for him. Love, like life, is much stranger and far more complicated than one is brought up to believe. Our common intellectual interests—medicine, science, and psychiatry—are very strong ones, and our differences in both substance and style have allowed each of us a great deal of independence, which has been essential and which, ultimately, has bound us very close to one another over the years. My life with Richard has become a safe harbor: an extremely interesting place, filled with love and warmth and always a bit open to the outer sea. But like all safe harbors that manage to retain fascination as well as safety, it was less than smooth sailing to reach.

When I first told Richard about my manic-depressive illness, soon after we met, he looked genuinely stunned. We were sitting in the main dining room of the Del Coronado Hotel in San Diego at the time; he slowly put down the hamburger he was eating, stared straight into my eyes, and, without missing a beat, said rather dryly, "That explains a lot." He was remarkably kind. Much as David Laurie had done, he asked me a great deal about what form my illness took and how it had affected my life. Perhaps because both were physicians, he, too, asked question after question of a more medical nature: what were my symptoms when I was manic, how depressed had I gotten, had I ever been suicidal, what medications had I taken in the past, what medications was I now taking, did I have any side effects. He was, as ever, low-key and reassuring; whatever deeper concerns he had, he was kind and smart enough to keep to himself.

But, as I well knew, an understanding at an abstract level does not necessarily translate into an understanding at a day-to-day level. I have become fundamentally and deeply skeptical that anyone who does not have this illness can truly understand it. And, ultimately, it is probably unreasonable to expect the kind of acceptance of it that one so desperately desires. It is not an illness that lends itself to easy empathy. Once a restless or frayed mood has turned to anger, or violence, or psychosis, Richard, like most, finds it very difficult to see it as illness, rather than as being willful, angry, irrational, or simply tiresome. What I experience as beyond my control can instead seem to him deliberate and frightening. It is, at these times, impossible for me to convey my desperation and pain; it is harder still, afterward, to recover from the damaging acts and dreadful words. These terrible black manias, with their agitated, ferocious, and savage sides, are understandably difficult for Richard to understand and almost as difficult for me to explain.

No amount of love can cure madness or unblacken one's dark moods. Love can help, it can make the pain more tolerable, but, always, one is beholden to medication that may or may not always work and may or may not be bearable. Madness, on the other hand, most certainly can, and often does, kill love through its mistrustfulness, unrelenting pessimism, discontents, erratic behavior, and, especially, through its savage moods. The sadder, sleepier, slower, and less volatile depressions are more intuitively understood and more easily taken in stride. A quiet melancholy is neither threatening nor beyond ordinary comprehension; an angry, violent, vexatious despair is both. Experience and love have, over much time, taught both of us a great deal about dealing with manic-depressive illness; I occasionally laugh and tell him that his imperturbability is worth three hundred milligrams of lithium a day to me, and it is probably true.

Sometimes, in the midst of one of my dreadful, destructive upheavals of mood, I feel Richard's quietness nearby and am reminded of Byron's wonderful description of the rainbow that sits "Like Hope upon a death-bed" on the verge of a wild, rushing cataract; yet, "while all around is torn / By the distracted waters," the rainbow stays serene:

> *Resembling, 'mid the torture of the scene,*
> *Love watching Madness with unalterable mien.*

But if love is not the cure, it certainly can act as a very strong medicine. As John Donne has written, it is not so pure and abstract as one might once have thought and wished, but it does endure, and it does grow.

Part Four

AN UNQUIET MIND

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.

The Troubled Helix

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 imaginative 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, 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 temperamental, 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 embarrassed, 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 discomforting 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, suicide, 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, endangering 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 treatments 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 upheavals 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 Ecclesiastian 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 still, 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 medication—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 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.*

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