There is a particular kind of pain, elation, loneliness, and terror involved in this kind of madness. When you're high it's tremendous. The ideas and feelings are fast and frequent like shooting stars, and you follow them until you find better and brighter ones. Shyness goes, the right words and gestures are suddenly there, the power to captivate others a felt certainty. There are interests found in uninteresting people. Sensuality is pervasive and the desire to seduce and be seduced irresistible. Feelings of ease, intensity, power, well-being, financial omnipotence, and euphoria pervade one's marrow. But, somewhere, this changes. The fast ideas are far too fast, and there are far too many; overwhelming confusion replaces clarity. Memory goes. Humor and absorption on friends' faces are replaced by fear and concern. Everything previously moving with the grain is now against—you are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of the mind. You never knew those caves were there. It will never end, for madness carves its own reality.
It goes on and on, and finally there are only others' recollections of your behavior—your bizarre, frenetic, aimless behaviors—for mania has at least some grace in partially obliterating memories. What then, after the medications, psychiatrist, despair, depression, and overdose? All those incredible feelings to sort through. Who is being too polite to say what? Who knows what? What did I do? Why? And most hauntingly, when will it happen again? Then, too, are the bitter reminders—medicine to take, resent, forget, take, resent, and forget, but always to take. Credit cards revoked, bounced checks to cover, explanations due at work, apologies to make, intermittent memories (what did I do?), friendships gone or drained, a ruined marriage. And always, when will it happen again? Which of my feelings are real? Which of the me's is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully much that is neither. Virginia Woolf, in her dives and climbs, said it all: "How far do our feelings take their colour from the dive underground? I mean, what is the reality of any feeling?"

I did not wake up one day to find myself mad. Life should be so simple. Rather, I gradually became aware that my life and mind were going at an ever faster and faster clip until finally, over the course of my first summer on the faculty, they both had spun wildly and absolutely out of control. But the acceleration from quick thought to chaos was a slow and beautifully seductive one. In the beginning, everything seemed perfectly normal. I joined the psychiatry faculty in July of 1974 and was assigned to one of the
adult inpatient wards for my clinical and teaching responsibilities. I was expected to supervise psychiatric residents and clinical psychology interns in diagnostic techniques, psychological testing, psychotherapy, and, because of my background in psychopharmacology, some issues related to drug trials and medications. I was also the faculty liaison between the Departments of Psychiatry and Anesthesiology, where I did consultations, seminars, and put into place some research protocols that were designed to investigate psychological and medical aspects of pain. My own research consisted primarily of writing up some of the drug studies I had carried out in graduate school. I had no particular interest in either clinical work or research related to mood disorders, and as I had been almost entirely free of serious mood swings for more than a year, I assumed that those problems were behind me. Feeling normal for any extended period of time raises hopes that turn out, almost invariably, to be writ on water.

I settled into my new job with great optimism and energy. I enjoyed teaching, and, although it initially seemed strange to be supervising the clinical work of others, I liked it. I found the transition from intern to faculty status far less difficult than I had imagined; it was, needless to say, one that was greatly helped along by an invigorating difference in salary. The relative freedom I had to pursue my own academic interests was intoxicating. I worked very hard and, looking back on it, slept very little. Decreased sleep is both a symptom of mania and a cause, but I didn’t know that at the time, and it probably would not have made any difference to me if I had. Summer had often brought me longer nights and higher moods, but this time it pushed me
into far higher, more dangerous and psychotic places than I had ever been. Summer, a lack of sleep, a deluge of work, and exquisitely vulnerable genes eventually took me to the back of beyond, past my familiar levels of exuberance and into florid madness.

The chancellor's garden party was given annually to welcome new faculty members to UCLA. By coincidence the man who was to become my psychiatrist also happened to be attending the garden party, having himself just joined the adjunct medical school faculty. It proved to be an interesting example of the divide between one's self-perception and the cooler, more measured observations of an experienced clinician who suddenly found himself in a social situation watching a somewhat wild-eyed and frenzied former intern that he, as the recent chief resident, had supervised the preceding year. My recollection of the situation was that I was perhaps a bit high, but primarily I remember talking to scads of people, feeling that I was irresistibly charming, and zipping around from hors d'oeuvre to hors d'oeuvre, and drink to drink. I talked with the chancellor for a long time; he, of course, had absolutely no idea who I was, but he was either being exceedingly polite by talking to me for so long or simply holding true to his reputation as having a penchant for young women. Whatever he actually felt, I was sure he was finding me captivating.

I also had an extended and rather odd conversation with the chairman of my department—odd, but a conversation I found delightful. My chairman was himself a not unexpansive person, and he harbored a very imag-
inative mind that did not always keep within the common grazing lands of academic medicine. He was somewhat notorious within psychopharmacology circles for having accidentally killed a rented circus elephant with LSD—a complicated, rather improbable story involving large land mammals in must, temporal lobe glands, the effects of hallucinogenic drugs on violent behavior, and miscalculated volumes and surface areas—and we started a long, dendritic discussion about doing research on elephants and hyraxes. Hyraxes are small African animals that bear no resemblance whatsoever to elephants but, based on the patterning of their teeth, are thought to be their closest living relatives. I cannot begin to remember the detailed arguments and common interests underlying this strange and extremely animated conversation—except that I immediately, and with great gusto, took upon myself the task of tracking down every article, and there were hundreds, ever written about hyraxes. I also volunteered to work on animal behavior studies at the Los Angeles Zoo, as well as to co-teach a course in ethology and yet another one in pharmacology and ethology.

My memories of the garden party were that I had had a fabulous, bubbly, seductive, assured time. My psychiatrist, however, in talking with me about it much later, recollected it very differently. I was, he said, dressed in a remarkably provocative way, totally unlike the conservative manner in which he had seen me dressed over the preceding year. I had on much more makeup than usual and seemed, to him, to be frenetic and far too talkative. He says he remembers having thought to himself, Kay looks manic. I, on the other hand, had thought I was splendid.
My mind was beginning to have to scramble a bit to keep up with itself, as ideas were coming so fast that they intersected one another at every conceivable angle. There was a neuronal pileup on the highways of my brain, and the more I tried to slow down my thinking the more I became aware that I couldn’t. My enthusiasms were going into overdrive as well, although there often was some underlying thread of logic in what I was doing. One day, for example, I got into a frenzy of photocopying: I made thirty to forty copies of a poem by Edna St. Vincent Millay, an article about religion and psychosis from the American Journal of Psychiatry, and another article, “Why I Do Not Attend Case Conferences,” written by a prominent psychologist who had elucidated all of the reasons why teaching rounds, when poorly conducted, are such a horrendous waste of time. All three of these articles seemed to me, quite suddenly, to have profound meaning and relevance for the clinical staff on the ward. So I passed them out to everyone I could.

What is interesting to me now is not that I did such a typically manic thing; rather, it’s that there was some prescience and sense in those early days of incipient madness. The ward rounds were a complete waste of time, although the ward chief was less than appreciative of my pointing it out to everyone (and even less appreciative of my circulating the article to the entire staff). The Millay poem, “Renascence,” was one I had read as a young girl, and, as my mood became more and more ecstatic, and my mind started racing ever and ever faster, I somehow remembered it with utter clarity and straightaway looked it up. Although I was just begin-
ning my journey into madness, the poem described the entire cycle I was about to go through: it started with normal perceptions of the world ("All I could see from where I stood / Was three long mountains and a wood") and then continued through ecstatic and visionary states to unremitting despair and, finally, reemergence into the normal world, but with height-ened awareness. Millay was nineteen years old when she wrote the poem, and, although I did not know it at the time, she later survived several breakdowns and hospitalizations. Somehow, in the strange state I was in, I knew that the poem had meaning for me; I understood it totally. I gave it to the residents and interns as a metaphorical description of the psychotic process and the important possibilities in a subsequent renewal. The residents, unaware of the internal flurry that propelled the readings, seemed to respond well to the articles and, almost to the person, expressed pleasure in the break from their regular medical reading.

During this same period of increasingly feverish behavior at work, my marriage was falling apart. I separated from my husband, ostensibly because I wanted children and he didn’t—which was true and important—but it was far more complicated than that. I was increasingly restless, irritable, and I craved excitement; all of a sudden, I found myself rebelling against the very things I most loved about my husband: his kindness, stability, warmth, and love. I impulsively reached out for a new life. I found an exceedingly modern apartment in Santa Monica, although I hated modern architecture; I bought modern Finnish furniture, although I loved warm and old-fashioned things. Everything I acquired was cool, modern, angular, and, I suppose, strangely
soothing and relatively uninvasive of my increasingly chaotic mind and jangled senses. There was, at least, a spectacular—and spectacularly expensive—view of the ocean. Spending a lot of money that you don’t have—or, as the formal diagnostic criteria so quaintly put it, “engaging in unrestrained buying sprees”—is a classic part of mania.

When I am high I couldn’t worry about money if I tried. So I don’t. The money will come from somewhere; I am entitled; God will provide. Credit cards are disastrous, personal checks worse. Unfortunately, for manics anyway, mania is a natural extension of the economy. What with credit cards and bank accounts there is little beyond reach. So I bought twelve snakebite kits, with a sense of urgency and importance. I bought precious stones, elegant and unnecessary furniture, three watches within an hour of one another (in the Rolex rather than Timex class; champagne tastes bubble to the surface, are the surface, in mania), and totally inappropriate sirentlike clothes. During one spree in London I spent several hundred pounds on books having titles or covers that somehow caught my fancy: books on the natural history of the mole, twenty sundry Penguin books because I thought it could be nice if the penguins could form a colony. Once I think I shoplifted a blouse because I could not wait a minute longer for the woman—with-molasses feet in front of me in line. Or maybe I just thought about shoplifting. I don’t remember, I was totally confused. I imagine I must have spent far more than thirty thousand dollars during my two major manic episodes, and God only knows how much more during my frequent milder manias.
But then back on lithium and rotating on the planet at the same pace as everyone else, you find your credit is decimated, your mortification complete: mania is not a luxury one can easily afford. It is devastating to have the illness and aggravating to have to pay for medications, blood tests, and psychotherapy. They, at least, are partially deductable. But money spent while manic doesn’t fit into the Internal Revenue Service concept of medical expense or business loss. So after mania, when most depressed, you’re given excellent reason to be even more so.

Having a Ph.D. in economics from Harvard in no way prepared my brother for the sprawling financial mess he saw on the floor in front of him. There were piles of credit card receipts, stacks of pink overdraft notices from my bank, and duplicate and triplicate billings from all of the stores through which I had so recently swirled and charged. In a separate, more ominous pile were threatening letters from collection agencies. The chaotic visual impact upon entering the room reflected the higgledy-piggledy, pixilated collection of electric lobes that only a few weeks earlier had constituted my manic brain. Now, medicated and dreary, I was obsessively sifting through the remnants of my fiscal irresponsibility. It was like going on an archaeological dig through earlier ages of one’s mind. There was a bill from a taxidermist in The Plains, Virginia, for example, for a stuffed fox that I for some reason had felt I desperately needed. I had loved animals all of my life, had at one point wanted to be a veterinarian. How on earth could I have bought a dead animal? I had adored foxes and admired them for
as long as I could remember; I thought them fast and smart and beautiful. How could I have so directly contributed to killing one? I was appalled by the grisly nature of my purchase, disgusted with myself, and incapable of imagining what I would do with the fox once it actually arrived.

In an attempt to divert myself, I began pawing my way through the credit card slips. Near the top of the pile was a bill from the pharmacy where I had gotten my snakebile kits. The pharmacist, having just filled my first prescription for lithium, had smiled knowingly as he rang up the sale for my snakebile kits and the other absurd, useless, and bizarre purchases. I knew what he was thinking and, in the benevolence of my expansive mood, could appreciate the humor. He, unlike me, however, appeared to be completely unaware of the life-threatening problem created by rattlesnakes in the San Fernando Valley. God had chosen me, and apparently only me, to alert the world to the wild proliferation of killer snakes in the Promised Land. Or so I thought in my scattered delusional meanderings. In my own small way, by buying up the drugstore's entire supply of snakebile kits, I was doing all I could do to protect myself and those I cared about. In the midst of my crazed scurries up and down the aisles of the drugstore, I had also come up with a plan to alert the Los Angeles Times to the danger. I was, however, far too manic to tie my thoughts together into a coherent plan.

My brother, seemingly having read my mind, walked into the room with a bottle of champagne and glasses on a tray. He imagined, he said, that we would need the champagne because the whole business might be a "bit
unpleasant." My brother is not one for overstatement. Neither is he one for great wringings of hands and gnashings of teeth. He is, instead, a fair and practical man, generous, and one who, because of his own confidence, tends to inspire confidence in others. In all of these things, he is very much like our mother. During the time of my parents' separation, and subsequent divorce, he had put his wing out and around me, protecting me to the extent that he could from life’s hurts and my own turbulent moods. His wing has been reliably available ever since. From the time I started college and then throughout my graduate and faculty days—indeed, until now, and still—whenever I have needed a respite from pain or uncertainty, or just to get away, I have found an airplane ticket in the mail, with a note suggesting I join him someplace like Boston or New York, or Colorado, or San Francisco. Often, he will be in one of these places to give a talk, consult, or take a few days off from work himself; I catch up with him in some hotel lobby or another, or in a posh restaurant, delighted to see him—tall, handsome, well dressed—walking quickly across the room. No matter my mood or problem, he always manages to make me feel that he is glad to see me. And each of the times I went abroad to live—first to Scotland as an undergraduate, then to England as a graduate student, and twice again to London on sabbatical leaves from the University of California—I always knew that it would be only a matter of weeks until he would arrive to check out where I was living, what I was up to, take me out to dinner, and suggest we rummage together through Hatchards or Dil-lons or some other bookstore. After my first severe
manic attack, he drew his wing around me even tighter. He made it unequivocally clear that if I needed him, no matter where he was, he would be on the next plane home.

Now he made no judgments about my completely irrational purchases; or, if he did, at least he didn't make them to me. Courtesy of a personal loan he had taken out from the credit union at the World Bank, where he worked as an economist, we were able to write checks to cover all of the outstanding bills. Slowly, over a period of many years, I was able to pay him back what I owed him. More accurate, I was able to pay back the money I owed him. I can never pay back the love, kindness, and understanding.

I kept on with my life at a frightening pace. I worked ridiculously long hours and slept next to not at all. When I went home at night it was to a place of increasing chaos: Books, many of them newly purchased, were strewn everywhere. Clothes were piled up in mounds in every room, and there were unwrapped packages and unemptied shopping bags as far as the eye could see. My apartment looked like it had been inhabited and then abandoned by a colony of moles. There were hundreds of scraps of paper as well; they cluttered the top of my desk and kitchen counters, forming their own little mounds on the floor. One scrap contained an incoherent and rambling poem; I found it weeks later in my refrigerator, apparently triggered by my spice collection, which, needless to say, had grown by leaps and bounds during my mania. I had titled it, for reasons that I am sure made sense at the
time, "God Is a Herbivore." There were many such poems and fragments, and they were everywhere. Weeks after I finally cleaned up my apartment, I still was coming across bits and pieces of paper—filled to the edges with writing—in unimaginably unlikely places.

My awareness and experience of sounds in general and music in particular were intense. Individual notes from a horn, an oboe, or a cello became exquisitely poignant. I heard each note alone, all notes together, and then each and all with piercing beauty and clarity. I felt as though I were standing in the orchestra pit; soon, the intensity and sadness of classical music became unbearable to me. I became impatient with the pace, as well as overwhelmed by the emotion. I switched abruptly to rock music, pulled out my Rolling Stones albums, and played them as loud as possible. I went from cut to cut, album to album, matching mood to music, music to mood. Soon my rooms were further strewn with records, tapes, and album jackets as I went on my way in search of the perfect sound. The chaos in my mind began to mirror the chaos of my rooms; I could no longer process what I was hearing; I became confused, scared, and disoriented. I could not listen for more than a few minutes to any particular piece of music; my behavior was frenetic, and my mind more so.

Slowly the darkness began to weave its way into my mind, and before long I was hopelessly out of control. I could not follow the path of my own thoughts. Sentences flew around in my head and fragmented first into phrases and then words; finally, only sounds remained. One evening I stood in the middle of my living room and looked out at a blood-red sunset spreading out over
the horizon of the Pacific. Suddenly I felt a strange sense of light at the back of my eyes and almost immediately saw a huge black centrifuge inside my head. I saw a tall figure in a floor-length evening gown approach the centrifuge with a vase-sized glass tube of blood in her hand. As the figure turned around I saw to my horror that it was me and that there was blood all over my dress, cape, and long white gloves. I watched as the figure carefully put the tube of blood into one of the holes in the rack of the centrifuge, closed the lid, and pushed a button on the front of the machine. The centrifuge began to whirl.

Then, horrifyingly, the image that previously had been inside my head now was completely outside of it. I was paralyzed by fright. The spinning of the centrifuge and the clanking of the glass tube against the metal became louder and louder, and then the machine splintered into a thousand pieces. Blood was everywhere. It spattered against the windowpanes, against the walls and paintings, and soaked down into the carpets. I looked out toward the ocean and saw that the blood on the window had merged into the sunset; I couldn’t tell where one ended and the other began. I screamed at the top of my lungs. I couldn’t get away from the sight of the blood and the echoes of the machine’s clanking as it whirled faster and faster. Not only had my thoughts spun wild, they had turned into an awful phantasmagoria, an apt but terrifying vision of an entire life and mind out of control. I screamed again and again. Slowly the hallucination receded. I telephoned a colleague for help, poured myself a large scotch, and waited for his arrival.
Fortunately, before my mania could become very public, this colleague—a man whom I had been dating during my separation from my husband, and someone who knew and understood me very well—was willing to take on my manic wrath and delusions. He confronted me with the need to take lithium, which was not a pleasant task for him—I was wildly agitated, paranoid, and physically violent—but it was one he carried out with skill, grace, and understanding. He was very gentle but insistent when he told me that he thought I had manic-depressive illness, and he persuaded me to make an appointment to see a psychiatrist. Together we tracked down everything we could find that had been written about the illness; we read as much as we could absorb and then moved on to what was known about treatment. Lithium had been approved for use in mania only four years earlier, in 1970, by the Food and Drug Administration, and was not yet in widespread use in California. It was clear from reading the medical literature, however, that lithium was the only drug that had any serious chance of working for me. He prescribed lithium and other antipsychotic medications for me, on a very short-term, emergency basis, only long enough to tide me over until I saw my psychiatrist for the first time. He put the correct number of pills out for me to take each morning and evening, and he spent hours talking with my family about my illness and how they might best handle it. He drew blood for several lithium levels and provided encouragement about the prognosis for my recovery. He also insisted that I take a short time off from work, which ultimately
saved me from losing my job and my clinical privileges, and arranged for me to be looked after at home during those periods when he was unable to.

I felt infinitely worse, more dangerously depressed, during this first manic episode than when in the midst of my worst depressions. In fact, the most dreadful I had ever felt in my entire life—one characterized by chaotic ups and downs—was the first time I was psychologically manic. I had been mildly manic many times before, but these had never been frightening experiences—ecstatic at best, confusing at worst. I had learned to accommodate quite well to them. I had developed mechanisms of self-control, to keep down the peals of singularly inappropriate laughter, and set rigid limits on my irritability. I avoided situations that might otherwise trip or jangle my hypersensitive wiring, and I learned to pretend I was paying attention or following a logical point when my mind was off chasing rabbits in a thousand directions. My work and professional life flowed. But nowhere did this, or my upbringing, or my intellect, or my character, prepare me for insanity.

Although I had been building up to it for weeks, and certainly knew something was seriously wrong, there was a definite point when I knew I was insane. My thoughts were so fast that I couldn't remember the beginning of a sentence halfway through. Fragments of ideas, images, sentences, raced around and around in my mind like the tigers in a children's story. Finally, like those tigers, they became meaningless melted pools. Nothing once familiar to me was familiar. I wanted desperately to slow down but could not. Nothing helped—not running around a parking lot for hours on end or swimming for miles. My energy level was
untouched by anything I did. Sex became too intense for pleasure, and during it I would feel my mind encased by black lines of light that were terrifying to me. My delusions centered on the slow painful deaths of all the green plants in the world—vine by vine, stem by stem, leaf by leaf they died, and I could do nothing to save them. Their screams were cacophonous. Increasingly, all of my images were black and decaying.

At one point I was determined that if my mind—by which I made my living and whose stability I had assumed for so many years—did not stop racing and begin working normally again, I would kill myself by jumping from a nearby twelve-story building. I gave it twenty-four hours. But, of course, I had no notion of time, and a million other thoughts—magnificent and morbid—wove in and raced by. Endless and terrifying days of endlessly terrifying drugs—Thorazine, lithium, valium, and barbiturates—finally took effect. I could feel my mind being reined in, slowed down, and put on hold. But it was a very long time until I recognized my mind again, and much longer until I trusted it.

I first met the man who was to become my psychiatrist when he was chief resident at the UCLA Neuropsychiatric Institute. Tall, good-looking, and a man of strong opinions, he had a steel-trap mind, a quick wit, and an easy laugh that softened an otherwise formidable presence. He was tough, disciplined, knew what he was doing, and cared very much about how he did it. He genuinely loved being a doctor, and he was a superb teacher. During my year as a predoctoral clinical psychology intern he had been
assigned to supervise my clinical work on the adult inpatient service. He turned out to be an island of rational thought, rigorous diagnosis, and compassion in a ward situation where fragile egos and rapid speculation about intrapsychic and sexual conflicts prevailed. Although he was adamant about the importance of early and aggressive medical treatments for psychotic patients, he also had a genuine and deep belief in the importance of psychotherapy in bringing about healing and lasting change. His kindness to patients, combined with an extremely keen knowledge of medicine, psychiatry, and human nature, made a critical impression upon me. When I became violently manic just after joining the UCLA faculty, he was the only one I trusted with my mind and life. I knew intuitively that there wasn’t a snowball’s chance in hell that I could outtalk, outthink, or outmaneuver him. In the midst of utter confusion, it was a remarkably clear and sane decision.

I was not only very ill when I first called for an appointment, I was also terrified and deeply embarrassed. I had never been to a psychiatrist or a psychologist before. I had no choice. I had completely, but completely, lost my mind; if I didn’t get professional help, I was quite likely to lose my job, my already precarious marriage, and my life as well. I drove from my office at UCLA to his office in the San Fernando Valley; it was an early southern California evening, usually a lovely time of day, but I was—for the first time in my life—shaking with fear. I shook for what he might tell me, and I shook for what he might not be able to tell me. For once, I could not begin to think or laugh my way out of the situation I was in, and I had no idea whether anything existed that would make me better.
I pushed the elevator button and walked down a long corridor to a waiting room. Two other patients were waiting for their doctors, which only added to my sense of indignity and embarrassment at finding myself with the roles reversed—character building, no doubt, but I was beginning to tire of all the opportunities to build character at the expense of peace, predictability, and a normal life. Perhaps, had I not been so vulnerable at the time, all of this would not have mattered so much. But I was confused and frightened and terribly shattered in all of my notions of myself; my self-confidence, which had permeated every aspect of my life for as long as I could remember, had taken a very long and disquieting holiday.

On the far wall of the waiting room I saw an array of lit and unlit buttons. It was clear I was supposed to push one of them; this, in turn, would let my psychiatrist-to-be know that I had arrived. I felt like a large white rat pressing paw to lever for a pellet. It was a strangely degrading, albeit practical, system. I had the sinking feeling that being on the wrong side of the desk was not going to sit very well with me.

My psychiatrist opened the door and, taking one long look at me, sat me down and said something reassuring. I have completely forgotten what it was—and I am sure it was as much the manner in which it was said as the actual words—but slowly a tiny, very tiny, bit of light drifted into my dark and frightened mind. I have next to no memory of what I said during that first session, but I know it was rambling, unstrung, and confused. He sat there, listening forever, it seemed, his long six-foot-four-inch frame spread out from chair to floor, legs tangling and untangling, long hands touching,
fingertip to fingertip—and then he started asking questions.

How many hours of sleep had I been getting? Did I have any problems in concentrating? Had I been more talkative than usual? Did I talk faster than usual? Had anyone told me to slow down or that they couldn’t make sense out of what I was saying? Had I felt a pressure to talk constantly? Had I been more energetic than usual? Were other people saying that they were having difficulty keeping up with me? Had I become more involved in activities than usual, or undertaken more projects? Had my thoughts been going so quickly that I had difficulty keeping track of them? Had I been more physically restless or agitated than usual? More sexually active? Had I been spending more money? Acting impulsively? Had I been more irritable or angry than usual? Had I felt as though I had special talents or powers? Had I had any visions or heard sounds or voices that other people probably hadn’t seen or heard? Had I experienced any strange sensations in my body? Had I ever had any of these symptoms earlier in my life? Did anyone else in my family have similar sorts of problems?

I realized that I was on the receiving end of a very thorough psychiatric history and examination; the questions were familiar, I had asked them of others a hundred times, but I found it unnerving to have to answer them, unnerving not to know where it all was going, and unnerving to realize how confusing it was to be a patient. I answered yes to virtually all of his questions, including a long series of additional ones about depression, and found myself gaining a new respect for psychiatry and professionalism.
Gradually, his experience as a physician, and self-confidence as a person, began to take effect, much in the same way that medications gradually begin to take hold and calm the turmoil of mania. He made it unambiguously clear that he thought I had manic-depressive illness and that I was going to need to be on lithium, probably indefinitely. The thought was very frightening to me—much less was known then than is known now about the illness and its prognosis—but all the same I was relieved: relieved to hear a diagnosis that I knew in my mind of minds to be true. Still, I flailed against the sentence I felt he had handed me. He listened patiently. He listened to all of my convoluted, alternative explanations for my breakdown—the stress of a stressed marriage, the stress of joining the psychiatry faculty, the stress of overwork—and he remained firm in his diagnosis and recommendations for treatment. I was bitterly resentful, but somehow greatly relieved. And I respected him enormously for his clarity of thought, his obvious caring, and his unwillingness to equivocate in delivering bad news.

Over the next many years, except when I was living in England, I saw him at least once a week; when I was extremely depressed and suicidal I saw him more often. He kept me alive a thousand times over. He saw me through madness, despair, wonderful and terrible love affairs, disillusionments and triumphs, recurrences of illness, an almost fatal suicide attempt, the death of a man I greatly loved, and the enormous pleasures and aggravations of my professional life—in short, he saw me through the beginnings and endings of virtually every aspect of my psychological and emotional life. He was
very tough, as well as very kind, and even though he understood more than anyone how much I felt I was losing—in energy, vivacity, and originality—by taking medication, he never was seduced into losing sight of the overall perspective of how costly, damaging, and life threatening my illness was. He was at ease with ambiguity, had a comfort with complexity, and was able to be decisive in the midst of chaos and uncertainty. He treated me with respect, a decisive professionalism, wit, and an unshakable belief in my ability to get well, compete, and make a difference.

Although I went to him to be treated for an illness, he taught me, by example, for my own patients, the total beholddeness of brain to mind and mind to brain. My temperament, moods, and illness clearly, and deeply, affected the relationships I had with others and the fabric of my work. But my moods were themselves powerfully shaped by the same relationships and work. The challenge was in learning to understand the complexity of this mutual beholddeness and in learning to distinguish the roles of lithium, will, and insight in getting well and leading a meaningful life. It was the task and gift of psychotherapy.

At this point in my existence,

I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy. Lithium prevents my seductive but disastrous highs, diminishes my depressions, clears out the wool and webbing from my disordered thinking, slows me down, gentles me out, keeps me from ruining my career and relationships, keeps me out of a hospital, alive, and makes psychotherapy possible.
But, ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all. Pills cannot, do not, ease one back into reality; they only bring one back headlong, careening, and faster than can be endured at times. Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But, always, it is where I have believed—or have learned to believe—that I might someday be able to contend with all of this.

No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my manias and depressions. I need both. It is an odd thing, owing life to pills, one’s own quirks and tenacities, and this unique, strange, and ultimately profound relationship called psychotherapy.

That I owed my life to pills was not, however, obvious to me for a long time; my lack of judgment about the necessity to take lithium proved to be an exceedingly costly one.
People go mad in idiosyncratic ways. Perhaps it was not surprising that, as a meteorologist’s daughter, I found myself, in that glorious illusion of high summer days, gliding, flying, now and again lurching through cloud banks and ethers, past stars, and across fields of ice crystals. Even now, I can see in my mind’s rather peculiar eye an extraordinary shattering and shifting of light; inconstant but ravishing colors laid out across miles of circling rings; and the almost imperceptible, somehow surprisingly pallid, moons of this Catherine wheel of a planet. I remember singing “Fly Me to the Moons” as I swept past those of Saturn, and thinking myself terribly funny. I saw and experienced that which had been only dreams, or fitful fragments of aspiration.

Was it real? Well, of course not, not in any meaningful sense of the word “real.” But did it stay with me? Absolutely. Long after my psychosis cleared, and the medications took hold, it became part of what one remembers forever, surrounded by an almost Proustian
melancholy. Long since that extended voyage of my mind and soul, Saturn and its icy rings took on an elegiac beauty, and I don’t see Saturn’s image now without feeling an acute sadness at its being so far away from me, so unobtainable in so many ways. The intensity, glory, and absolute assuredness of my mind’s flight made it very difficult for me to believe, once I was better, that the illness was one I should willingly give up. Even though I was a clinician and a scientist, and even though I could read the research literature and see the inevitable, bleak consequences of not taking lithium, I for many years after my initial diagnosis was reluctant to take my medications as prescribed. Why was I so unwilling? Why did it take having to go through more episodes of mania, followed by long suicidal depressions, before I would take lithium in a medically sensible way?

Some of my reluctance, no doubt, stemmed from a fundamental denial that what I had was a real disease. This is a common reaction that follows, rather counter-intuitively, in the wake of early episodes of manic-depressive illness. Moods are such an essential part of the substance of life, of one’s notion of oneself, that even psychotic extremes in mood and behavior somehow can be seen as temporary, even understandable, reactions to what life has dealt. In my case, I had a horrible sense of loss for who I had been and where I had been. It was difficult to give up the high flights of mind and mood, even though the depressions that inevitably followed nearly cost me my life.

My family and friends expected that I would welcome being “normal,” be appreciative of lithium, and take in stride having normal energy and sleep. But if you have had stars at your feet and the rings of planets
through your hands, are used to sleeping only four or five hours a night and now sleep eight, are used to staying up all night for days and weeks in a row and now cannot, it is a very real adjustment to blend into a three-piece-suit schedule, which, while comfortable to many, is new, restrictive, seemingly less productive, and maddeningly less intoxicating. People say, when I complain of being less lively, less energetic, less high-spirited, “Well, now you’re just like the rest of us,” meaning, among other things, to be reassuring. But I compare myself with my former self, not with others. Not only that, I tend to compare my current self with the best I have been, which is when I have been mildly manic. When I am my present “normal” self, I am far removed from when I have been my liveliest, most productive, most intense, most outgoing and effervescent. In short, for myself, I am a hard act to follow.

And I miss Saturn very much.

My war with lithium began not long after I started taking it. I was first prescribed lithium in the fall of 1974; by the early spring of 1975, against medical advice, I had stopped taking it. Once my initial mania had cleared and I had recovered from the terrible depression that followed in its wake, an army of reasons had gathered in my mind to form a strong line of resistance to taking medication. Some of the reasons were psychological in nature. Others were related to the side effects that I experienced from the high blood levels of lithium that were required, at least initially, to keep my illness in check. (In 1974 the standard medical practice was to maintain patients at con-
siderably higher blood levels of lithium than is now the case. I have been taking a lower dose of lithium for many years, and virtually all of the problems I experienced earlier in the course of my treatment have disappeared.) The side effects I had for the first ten years were very difficult to handle. In a small minority of patients, including myself, the therapeutic level of lithium, the level at which it works, is perilously close to the toxic level.

There was never any question that lithium worked very well for me—my form of manic-depressive illness is a textbook case of the clinical features related to good lithium response: I have grandiose and expansive manias, a strong family history of manic-depressive illness, and my manias precede my depressions, rather than the other way around—but the drug strongly affected my mental life. I found myself beholden to medication that also caused severe nausea and vomiting many times a month—I often slept on my bathroom floor with a pillow under my head and my warm, woolen St. Andrews gown tucked over me—when, because of changes in salt levels, diet, exercise, or hormones, my lithium level would get too high. I have been violently ill more places than I choose to remember, and quite embarrassingly so in public places ranging from lecture halls and restaurants to the National Gallery in London. (All of this changed very much for the better when I switched to a time-released preparation of lithium.) When I got particularly toxic I would start trembling, become ataxic and walk into walls, and my speech would become slurred; this resulted not only in several trips to the emergency room, where I would get intravenous drips to deal with the toxicity, but,
much more mortifying, make me appear as though I were on illicit drugs or had had far too much to drink.

One evening, after a riding lesson in Malibu during which I twice fell off my horse into the poles of a jump, I was pulled over to the side of the road by the police. They put me through an impressively thorough road-side neurological exam—I walked a not very straight line; was not able to make my fingertip reach my nose; and was hopelessly bad at getting my fingertips to tap against my thumb; God only knows what the pupils of my eyes were doing when a police officer blared a light into them—and until I got out my bottles of medication, gave the officers the name and telephone number of my psychiatrist, and agreed to whatever blood tests they wanted to order, the police refused to believe that I was not on drugs or hadn’t been drinking.

Not long after that incident, shortly after I learned to ski, I was on a very tall mountain somewhere in Utah and unaware that high altitude coupled with rigorous exercise can raise lithium levels. I became completely disoriented and totally incapable of navigating my way down the mountain. Fortunately, a colleague of mine who knew I was taking lithium, and who was himself an expert on its medical uses, became concerned when I didn’t catch up with him at the time we had arranged to meet. He concluded that I might have become toxic from it, sent the ski patrol after me, and I came down the mountain safely, although rather more horizontally than I would have liked.

Nausea and vomiting and occasional toxicity, while upsetting and embarrassing at times, were far less important to me than lithium’s effect on my ability to read, comprehend, and remember what I read. In rare
instances, lithium causes problems of visual accommodation, which can, in turn, lead to a form of blurred vision. It also can impair concentration and attention span and affect memory. Reading, which had been at the heart of my intellectual and emotional existence, was suddenly beyond my grasp. I was used to reading three or four books a week; now it was impossible. I did not read a serious work of literature or nonfiction, cover to cover, for more than ten years. The frustration and pain of this were immeasurable. I threw books against the wall in a blind fury and sailed medical journals across my office in a rage. I could read journal articles better than books, because they were short; but it was with great difficulty, and I had to read the same lines repeatedly and take copious notes before I could comprehend the meaning. Even so, what I read often disappeared from my mind like snow on a hot pavement. I took up needlepoint as a diversion and made countless cushions and firescreens in a futile attempt to fill the hours I had previously filled with reading.

Poetry, thank God, remained within my grasp, and, having always loved it, I now fell upon it with a passion that is hard to describe. I found that children’s books, which, in addition to being shorter than books written for adults, also had larger print, were relatively accessible to me, and I read over and over again the classics of childhood—Peter Pan, Mary Poppins, Charlotte’s Web, Huckleberry Finn, the Oz books, Doctor Dolittle—that had once, so many years earlier, opened up such unforgettable worlds to me. Now they gave me a second chance, a second wind of pleasure and beauty. But of all the children’s books, I returned most often to The Wind in the Willows. I found myself occasionally totally over-
whelmed by it. Once, I remember, I broke down entirely at a particular passage describing Mole and his house. I cried and cried and could not stop.

Recently, I pulled down my copy of *The Wind in the Willows*, which had remained on the bookshelf unopened once I had regained my ability to read, and tried to track down what it was that had created such a shattering reaction. After a brief search I found the passage I had been looking for. Mole, who had been away from his underground home for a very long time, exploring the world of light and adventure with his friend Ratty, one winter evening is walking along and suddenly and powerfully, with "recollection in fullest flood," smells his old home. Desperate to revisit it, he struggles to persuade the Rat to accompany him:

"Please stop, Ratty!" pleaded the poor Mole, in anguish of heart. "You don't understand! It's my home, my old home! I've just come across the smell of it, and it's close by here, really quite close. And I must go to it, I must, I must! O, come back, Ratty! Please, please come back!"

The Rat, initially preoccupied and reluctant to take the time to do so, finally does visit Mole in his home. Later, after Christmas carols and a nightcap of mulled ale in front of the fire, Mole reflects on how much he has missed the warmth and security of what he once had known, all of those "friendly things which had long been unconsciously a part of him." At this point in my rereading, I remembered exactly, and with visceral force, what I had felt reading it not long after I had started taking lithium: I missed my home, my mind, my
life of books and “friendly things,” my world where most things were in their place, and where nothing awful could come in to wreck havoc. Now I had no choice but to live in the broken world that my mind had forced upon me. I longed for the days that I had known before madness and medication had insinuated their way into every aspect of my existence.

Rules for the Gracious Acceptance of Lithium into Your Life

1. Clear out the medicine cabinet before guests arrive for dinner or new lovers stay the night.
2. Remember to put the lithium back into the cabinet the next day.
3. Don’t be too embarrassed by your lack of coordination or your inability to do well the sports you once did with ease.
4. Learn to laugh about spilling coffee, having the palsied signature of an eighty-year-old, and being unable to put on cufflinks in less than ten minutes.
5. Smile when people joke about how they think they “need to be on lithium.”
6. Nod intelligently, and with conviction, when your physician explains to you the many advantages of lithium in leveling out the chaos in your life.
7. Be patient when waiting for this leveling off. Very patient. Reread the Book of Job. Continue being patient. Contemplate the similarity between the phrases “being patient” and “being a patient.”
8. Try not to let the fact that you can’t read without effort annoy you. Be philosophical. Even if you could read, you probably wouldn’t remember most of it anyway.

9. Accommodate to a certain lack of enthusiasm and bounce that you once had. Try not to think about all the wild nights you once had. Probably best not to have had those nights anyway.

10. Always keep in perspective how much better you are. Everyone else certainly points it out often enough, and, annoyingly enough, it’s probably true.

11. Be appreciative. Don’t even consider stopping your lithium.

12. When you do stop, get manic, get depressed, expect to hear two basic themes from your family, friends, and healers:
   • But you were doing so much better, I just don’t understand it.
   • I told you this would happen.

13. Restock your medicine cabinet.

Psychological issues ultimately proved far more important than side effects in my prolonged resistance to lithium. I simply did not want to believe that I needed to take medication. I had become addicted to my high moods; I had become dependent upon their intensity, euphoria, assuredness, and their infectious ability to induce high moods and enthusiasms in other people. Like gamblers who sacrifice everything for the fleeting but ecstatic moments of winning, or cocaine addicts who risk their families,
careers, and lives for brief interludes of high energy and mood, I found my milder manic states powerfully inebriating and very conducive to productivity. I couldn't give them up. More fundamentally, I genuinely believed—courtesy of strong-willed parents, my own stubbornness, and a WASP military upbringing—that I ought to be able to handle whatever difficulties came my way without having to rely upon crutches such as medication.

I was not the only one who felt this way. When I became ill, my sister was adamant that I should not take lithium and was disgusted that I did. In an odd reversion to the Puritan upbringing she had raged against, she made it clear that she thought I should “weather it through” my depressions and manias, and that my soul would wither if I chose to dampen the intensity and pain of my experiences by using medication. The combination of her worsening moods with mine, along with the dangerous seductiveness of her views about medication, made it very difficult for me to maintain a relationship with her. One evening, now many years ago, she tore into me for “capitulating to Organized Medicine” by “lithiumizing away my feelings.” My personality, she said, had dried up, the fire was going out, and I was but a shell of my former self. This hit an utterly raw nerve in me, as I imagine she knew it would, but it simply enraged the man I was going out with at the time. He had seen me very ill indeed and saw nothing of value to preserve in such insanity. He tried to deflect the situation with wit—“Your sister may be just a shell of her former self,” he said, “but her shell is as much or more than I can handle”—but my sister then took off after him, leaving me sick inside, and
doubtful, yet again, about my decision to take lithium.

I could not afford to be too near someone representing, as she did, the temptations residing in my unmedicated mind; the voice of upbringing that said one should be able to handle everything by oneself; the catnip allure of recapturing lost moods and ecstasies. I was beginning, but just beginning, to understand that not only my mind but also my life was at stake. I had not been brought up to submit without a fight, however. I really believed all of the things I had been taught about weathering it through, self-reliance, and not imposing your problems on other people. But looking back over the wreckage brought about by this kind of blind stupidity and pride, I now wonder, What on earth could I have been thinking? I also had been taught to think for myself: Why, then, didn’t I question these rigid, irrelevant notions of self-reliance? Why didn’t I see how absurd my defiance really was?

A few months ago I asked my psychiatrist for a copy of my medical records. When I read over them, it was a very disconcerting experience. By March of 1975, six months after starting lithium, I had stopped taking it. Within weeks I became manic and then severely depressed. Later that year I resumed my lithium. As I read through my doctor’s notes for the time, I was appalled to find a continuation of the pattern:

7-17-75 Patient has elected to resume lithium because of the severity of her depressive episodes. Will begin with lithium 300mg. BID [twice a day].

7-25-75 Vomiting.
8–5–75  Tolerating lithium. Feeling depressed at realization she was more hypomanic than she believed.

9–30–75  Patient has stopped lithium again. Very important, she says, to prove she can handle stress without it.

10–2–75  Persists in not taking lithium. Already hypomanic. Patient well aware of it.

10–7–75  Patient has resumed lithium because of increased irritability, insomnia, and inability to concentrate.

Part of my stubbornness can be put down to human nature. It is hard for anyone with an illness, chronic or acute, to take medications absolutely as prescribed. Once the symptoms of an illness improve or go away, it becomes even more difficult. In my case, once I felt well again I had neither the desire nor incentive to continue taking my medication. I didn't want to take it to begin with; the side effects were hard for me to adjust to; I missed my highs; and, once I felt normal again, it was very easy for me to deny that I had an illness that would come back. Somehow I was convinced that I was an exception to the extensive research literature, which clearly showed not only that manic-depressive illness comes back, but that it often comes back in a more severe and frequent form.

It was not that I ever thought lithium was an ineffective drug. Far from it. The evidence for its efficacy and safety was compelling. Not only that, I knew it worked for me. It certainly was not that I had any moral argu-
ments against psychiatric medications. On the contrary, I had, and have, no tolerance for those individuals—especially psychiatrists and psychologists—who oppose using medications for psychiatric illnesses; those clinicians who somehow draw a distinction between the suffering and treatability of “medical illnesses” such as Hodgkin’s disease or breast cancer, and psychiatric illnesses such as depression, manic-depression, or schizophrenia. I believe, without doubt, that manic-depressive illness is a medical illness; I also believe that, with rare exception, it is malpractice to treat it without medication. All of these beliefs aside, however, I still somehow thought that I ought to be able to carry on without drugs, that I ought to be able to continue to do things my own way.

My psychiatrist, who took all of these complaints very seriously—existential qualms, side effects, matters of value from my upbringing—never wavered in his conviction that I needed to take lithium. He refused, thank God, to get drawn into my convoluted and impassioned web of reasoning about why I should try, just one more time, to survive without taking medication. He always kept the basic choice in perspective: The issue was not whether lithium was a problematic drug; it was not whether I missed my highs; it was not whether taking medication was consistent with some idealized notion of my family background. The underlying issue was whether or not I would choose to use lithium only intermittently, and thereby ensure a return of my manias and depressions. The choice, as he saw it—and as is now painfully clear to me—was between madness and sanity, and between life and death. My manias were occurring more frequently and, increas-
ingly, were becoming more "mixed" in nature (that is, my predominantly euphoric episodes, those I thought of as my "white manias," were becoming more and more overlaid with agitated depressions); my depressions were getting worse and far more suicidal. Few medical treatments, as he pointed out, are free of side effects, and, all things considered, lithium causes fewer adverse reactions than most. Certainly, it was a vast improvement on the brutal and ineffectual treatments that preceded it—chains, bloodletting, wet packs, asylums, and ice picks through the lobes—and although the anticonvulsant medications now work very effectively, and often with fewer side effects, for many people who have manic-depressive illness, lithium remains an extremely effective drug. I knew all of this, although it was with less conviction than I have now.

In fact, underneath it all, I was actually secretly terrified that lithium might not work: What if I took it, and I still got sick? If, on the other hand, I didn't take it, I wouldn't have to see my worst fears realized. My psychiatrist very early on saw this terror in my soul, and there is one brief observation in his medical notes that captured this paralyzing fear completely: Patient sees medication as a promise of a cure, and a means of suicide if it doesn't work. She fears that by taking it she will risk her last resort.

Years later, I was in a hotel ballroom packed with more than a thousand psychiatrists, many of them in a feeding frenzy; free food and drinks, however abysmal, have a way of bringing doctors out of the woodwork and up to the troughs. Jour-
nalists and other writers often discuss the August migration of psychiatrists, but there is a different kind of herding behavior in May—the peak month for suicide, one might note—when fifteen thousand shrinks of all stripes attend the annual meeting of the American Psychiatric Association. Several of my colleagues and I were to give talks about recent advances in the diagnosis, pathophysiology, and treatment of manic-depressive illness. I was, of course, pleased that the disease I suffered from drew such a large crowd; it was in one of its vogue years, but I also knew that it was inevitable, in other years, that this role would be captured, in turn, by obsessive-compulsive disorder or multiple-personality disorder or panic disorder, or whatever other illness caught the fancy of the field, promised a new breakthrough treatment, had the most colorful PET (positron emission tomography) scan images, had been central to a particularly nasty and expensive lawsuit, or was becoming more readily reimbursable by insurance companies.

I was scheduled to speak about psychological and medical aspects of lithium treatment, so, as was often the case, I started off with a quote from “a patient with manic-depressive illness.” I read it as if it had been written by someone else, although it was my own experience being recounted.

The endless questioning finally ended. My psychiatrist looked at me, there was no uncertainty in his voice. “Manic-depressive illness.” I admired his bluntness. I wished him locusts on his lands and a pox upon his house. Silent, unbelievable rage. I smiled pleasantly, He smiled back. The war had just begun.
The truth of the clinical situation hit a responsive chord, for it is an unusual psychiatrist who has not had to deal with the subtle, and not so subtle, resistance to treatment shown by many patients with manic-depressive illness. The final sentence, “The war had just begun,” brought a roar of laughter. The humor, however, was a bit more in the recounting than in the actual living through it. Unfortunately, this resistance to taking lithium is played out in the lives of tens of thousands of patients every year. Almost always it leads to a recurrence of the illness; not uncommonly it results in tragedy. I was to see this, a few years after my own struggles with lithium, in a patient of mine. He became a particularly painful reminder to me of the high costs of defiance.

The UCLA emergency room was alive with residents, interns, and medical students; it was also, rather strangely, very much alive with illness and death. People were moving quickly, with the kind of brisk self-assurance that high intelligence, good training, and demanding circumstances tend to breed; and, despite the unfortunate reason for my having been called down to the ER—one of my patients had been admitted acutely psychotic—I found myself unavoidably caught up in the exhilarating pace and chaotic rhythm. Then came an absolutely blood-curdling scream from one of the examining rooms—a scream of terror and undeniable madness—and I ran down the corridor: past the nurses, past a medical resident dictating notes for a patient’s chart, and past a surgical resident poring over the PDR with a cup of coffee in one
hand, a hemostat clamped and dangling from the short sleeve of his green scrub suit, and a stethoscope draped around his neck.

I opened the door to the room where the screams had begun, and my heart sank. The first person I saw was the psychiatry resident on call, whom I knew; he smiled sympathetically. Then I saw my patient, strapped down on a gurney, in four-point leather restraints. He was lying spread-eagle on his back, each wrist and ankle bound in a leather cuff, with an additional leather restraining strap across his chest. I felt sick to my stomach. Despite the restraints, I also felt scared. A year before this same patient had held a knife to my throat during a psychotherapy session in my office. I had called the police at that time, and he had been involuntarily committed to one of the locked wards at UCLA’s Neuropsychiatric Institute. Seventy-two hours later, in the impressively blind wisdom of the American justice system, he had been released back into the community. And to my care. I noted with some irony that the three police officers who were standing by the gurney, two of whom had their hands resting on their guns, evidently thought he represented a “threat to himself or others” even if the judge hadn’t.

He screamed again. It was a truly primitive and frightening sound, in part because he himself was so frightened, and in part because he was very tall, very big, and completely psychotic. I put my hand on his shoulder and could feel his whole body shaking out of control. I had never seen such fear in anyone’s eyes, nor such visceral agitation and psychological pain. Delirious mania is many things, and all of them are awful beyond description. The resident had given him a mas-
sive injection of an antipsychotic medication, but the
drug had not yet taken hold. He was delusional, para-
noid, 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 Hal-
dol; 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 halluci-
nations 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. Suici-
dal 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 danger-
ousness 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.
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 morbidty 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 nut-
meg 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 doc-
tor, 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
inward 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 tra-
ditional 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 but-
tons 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 Sun-
day, 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 dis-
ruptive, 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-stripping, 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, irrevocably, 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 temperament. 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 vomit-
ing 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 mani-
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, glo-
rously and unexpectedly easy, complicated, great fun,
and a no-exit nightmare.

My friends, fortunately, were either a bit loopy them-
selves, 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 scram-
bling 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 impos-
sible. 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."