An Unquiet Mind

A Memoir of Moods and Madness

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INTRODUCTION

This paper will stress how difficult it is to determine just who is driven or hypo-manic, on the one hand, and who, on the other hand is euthymic, that is, of normal, healthily balanced mood and disposition. I will argue that while it is not easy to define healthy mood in a "normal" person - that is, a person who is not psychiatrically ill, such a definition may not at all be possible in a person who suffers from bipolar illness. While no two bipolar patients are the same, and while a person can scarcely be known from reading her book, I will explore a number of issues raised by Kay Redfield's story as she has written it. In doing so, I will specifically question whether Kay Redfield, in addition to her bipolar illness, is suffering, quite out of her awareness, from significant narcissistic personality issues which bear directly on both the clinical course of her illness and the quality of her life. Kay Redfield, like any bipolar patient, has a unique illness, expressed through her unique person and life experience. In the model that informs my exploration of her story, psyche and soma interact bi-directionally. Such a model allows questions and issues to be understood in the depth and complexity due them. For instance, was Kay Redfield given optimal medication for her condition? Can one even answer the question if one cannot distinguish an inadequately treated bipolar illness from some of the same temperament/personality traits which underlie the patient's value system and which, in turn, determine her attitude toward her illness and the medications which treat it? So this paper is about my fascination with and attempt to illuminate the interplay of (A) biological temperament out of which her bipolar illness emerged, and both (B) the pathology of self and self-esteem (C) the valor and grace - all of which resulted from and influenced in their own right Kay Redfield's bipolar matrix.

Kay Redfield Jamison is Professor of Psychiatry at the Johns Hopkins University School of Medicine. She is an international authority on manic-depressive illness and in addition to today's volume *An Unquiet Mind* (1995), she is the author of *Touched with Fire* (1993) and the coauthor of *Manic-Depressive Illness* (1990), the standard medical text on manic-depressive illness. As I report on this book today I am more than a little troubled by the following words of Kay-Redfield (1995):

> "I have become fundamentally and deeply skeptical that anyone who does not have this illness can truly understand it." (p.171)

I hope that my report is not an exercise in proving her point. In my work as a therapist I often sense within me enough of the disorder, pathology, aberration in a patient to understand and empathize. My reaction to Kay Redfield's story has been more complex; I both learned a great deal and was left with quite a few questions. My experience was a peculiar mix of "she is really telling me her story," and, "there is something she really is not telling me about her story".

I will not try to cover in this paper, or even to mention all of the worthwhile issues in this deceptively small volume. I have stressed what I found most intriguing; the interaction of the

unique person with his or her unique form of the illness is what makes our work so interesting. Let us see what reacting to and wondering about Kay Redfield's story can do for our understanding of bipolarity.

THE STORY

This is a fascinating, beautifully written book. Patients have told me they felt more understood by it than anything they have ever read. I believe Dr. Jamison has been courageous in sharing her struggle with what she prefers to call Manic -Depressive illness. I have been both touched and informed by the rich, sensate language of her story telling: she brings us very close to the anguish and ecstasy of her moods and madness...we can see their colors, almost palpate their blackness, eeriness and airiness. Her description of her first psychotic mania, for instance, is electrifying. Let me give you the spine of the story, after first sharing with you a taste of Kay Redfield's poetic rendering of it:

> The Chinese believe that before you can conquer a beast you first must make it beautiful. In some strange way, I have tried to do that with manic-depressive illness It has been my fascinating, albeit deadly, enemy and companion. (p. 5)

The plot, then, is about Kay Redfield and her illness, as she slowly and torturously comes to recognize that the illness is a deadly enemy at the same time that is a marvelous, intoxicating companion...indeed, for a long time, it is neither enemy nor companion, but experienced by her as an extension of her own being. I will return later, however, to Kay Redfield's tendency to make beasts beautiful, which, while she seems to own it so beautifully, has, I believe, a significantly obscuring effect on an otherwise compelling and illuminating story. Most of the action takes place in Washington D.C., then California and then back again to Washington and Johns Hopkins. There are significant interludes in the British Isles. Her father, a career Air Force officer, was a meteorologist. By the fifth grade, she and her siblings had attended four different elementary schools and had lived in Florida, Puerto Rico, California, Tokyo, and twice Washington, D.C. Kay Redfield describes herself as an "intensely emotional, mercurial" (p.5) young person. For as long as she can remember, she has been, "frighteningly, although often wonderfully beholden to moods". (p.4) She has a three year older brother of superb character who remained devoted to her throughout the awful times in the years that followed. Her sister, thirteen months older, seems to have been touched by the fire of manic-depressive illness even more than Kay herself was. Her father carried the fiery genes, and was vastly witty, enormously creative, magically expansive....until Kay Redfield's later teen years, when his moods became increasingly black, full of rage and despair. We are told in some detail of the atmosphere, values and personalities of her family of origin. She stresses the temperament and values she inherited, and is quite unpsychologically-minded (if that is the correct term) as to having internalized or otherwise been meaningfully affected by any of the distorted interpersonal patterns which became undeniably

prominent as her father's bipolar illness worsened. Her own words as a graduate student convey this turn to her mind:

> "I decided early in graduate school that I needed to do something about my moods. It quickly came down to a choice between seeing a psychiatrist or buying a horse. Since almost everyone I knew was seeing a psychiatrist (this was Los Angeles), and since I had an absolute belief that I should be able to handle my own problems, I naturally bought a horse." (p. 55)

Returning to the plot, Kay Redfield had her own first attack of Manic-Depressive illness at seventeen years of age, as a high school senior. The way she experienced loss of control of her thinking is noteworthy:

> "I was used to my mind being my best friend; of carrying on endless conversations within my head; of having a built-in source of laughter or analytic thought to rescue me from boring or painful surroundings." (p. 37)

In l971, when she was twenty-five years old, Kay Redfield began doctoral studies in psychology at UCLA, and soon after married a French artist Although, she says, UCLA had one of the best graduate psychology programs in the country, one of her minor areas of study , animal behavior, was most exciting to her; she studied whales, dolphins and sea otters. As her own illness becomes apparent, we are taken for the better part of the book on an intense, roller coaster ride of black depressions, psychotic manias, and the frantic attempt both to keep her illness secret, and to pursue an academic/clinical career in something in between psychology and psychiatry. She set up and, although a non-physician, directed an important medical clinic, the UCLA Affective Disorders Clinic. She was clearly a dynamic researcher and teacher, determined to have a positive impact on the illness from which she suffered. In l981, at the age of thirty-five, she became a tenured Professor of Psychiatry at UCLA Medical School. She says she competed fiercely for tenure, as a symbol of the "stability" she craved and the "ultimate recognition" (p. 125) she sought. Going back nine years, In l974, she had her first manic psychosis and was begun on lithium (and briefly on a variety of other medications). For the next ten years she resisted mightily taking her lithium regularly; during this first ten years (l974 to l984) she was prescribed the high lithium dose that was the standard of care. Kay Redfield describes in rich personal and clinical detail the terrible cost to her of this heavy lithium dose. From '84 on, on a lighter dose, she felt much more the person she wanted to be, but still resisted lithium, although less mightily.

All this is artfully interwoven with a robust romantic, passionate love life with a succession of extremely attractive, interesting men. In fact, one could say that, although she clearly suffers from a tragic illness, she is blessed with a series of men in her life that nobody would believe, even in a movie. Her teachers, mentors, friends (a few of whom are psychiatrists who help her at critical moments), her colleagues, and even her psychiatrist, seem clearly called to be there for this

attractive, fiery, creative, brilliant woman. When I refer to the movies, I do so because, unlike Kay Redfield, I don't often run into colleagues that remind me of Michael Redgrave or Michael Rennie - RAF type shrinks (actually, Royal Army Medical Corp). Do I sound less than gracious here? I admit being initially charmed, and then increasingly irritated by what I found to be an elitist tone to the story. I don't get invited to nearly as many dinner parties as Kay Redfield, and if I were on Lithium and had gone skiing as she did one time, and due to the extreme altitude and physical exertion, my elevated serum lithium level caused me to become disoriented, I cannot help believing that my afternoon would have ended with me tragically skiing into a tree. What happened to Kay Redfield was that because her skiing companion happened to be an expert on just such lithium misadventures, he figured out why she wasn't keeping up, and had the ski control fetch her.

The elitist issue I raise bears on the interesting question as to the impact that this book has had. It was on the N.Y Times Best Seller's List for seven or eight weeks, reaching as high as #7 for some of that time. Published in Sept. 95, the first printing was 75, 000, it was reprinted five times, and the seventh printing was last November, just fourteen months later. The publisher would not tell me the size of the later printings. Perhaps some of you also have bipolar patients who are not as gifted and charismatic as those that populate the pages of this book Ivan Goldberg (personal communication) assures me, by the way, that bipolar illness falls along a spectrum of personality traits, such that just as many sufferers are dull-witted, sit around doing nothing most of the day, and are married to spouses with lackluster lives. Some of these people may have been inspired by all that Kay Redfield has accomplished as a sufferer of the illness, but some may have found her a bit remote as a figure with whom to identify. Some of you may have heard her on a radio interview late last year, or had patients who told you of their impressions of the book/interview.

Although I obviously have had some problems with this book, let me repeat, it is courageous, beautifully written and fascinating. Her fierce resistance to taking lithium is a central issue, even after a serious suicide attempt. There is a lot of excellent clinical detail about lithium and its interaction with Kay Redfield's symptoms and personality. Getting back for a moment to the book not being psychologically minded: this is no small item in a book written, Kay Redfield says, to change public attitudes about psychiatric illness in general and manic -depressive illness in particular ; the good guys are no-nonsense scientists, pilots and psychiatrists with a medical (in the best sense of the word) cast to them. They are really good doctors, and they convey to Kay Redfield that she is a valuable human being who will survive and triumph in the battle with her illness. Kay Redfield repeatedly says that her psychotherapy was crucial, life-saving to her: she seems to be talking about the therapy having imparted an understanding, life-affirming attitude in the face of serious illness, which lent her strength and courage.

The doctors further believe that her illness has a definite, neurobiological basis in her brain. Kay Redfield tells us frankly that although she first desperately fought the fact of her having a serious, neuro-chemically based illness which she could not think her way out of; once she understood this, she much preferred an illness the physical reality of which she could see in the high-resolution MRI pictures and multicolored PET scans...to the shame and weakness of ordinary neurosis. Much of her reading public may feel the same way. Finally, Psychoanalysts definitely tend to be bad guys, are presented as nerds, and when Kay Redfield isn't ridiculing them, she is being shamed by them (usually both occur at the same time).

The book jacket notes that Kay Redfield is "one of the few women who are full professors of medicine at American universities," so it is perhaps to be expected that no women appear to live in Kay Redfield's world, other than her mother and sister. She is very direct about how difficult it was to write this story and still be respectful of her family's privacy. One senses that she is being fairly discreet about the details of her sister's dark-sounding mood disorder. Her mother looms very large as a decidedly loved woman of loving and admirable character. Among the gender issues which Kay Redfield raises, are A) her own desire to parent a child as distinct from her desire to pass on her genetic material, and B) what genetic counseling a bipolar female patient should be offered.

There are many other fascinating issues raised by Kay Redfield, which are beyond the focus of this paper, that I will simply note:

There is her concern that perhaps she does not have the right to treat patients because of her illness. A related concern is that her professional work, her clinical research will be viewed as suspect because it lacks objectivity. I agree with Redfield's counterargument that many valuable contributions have come from people in our field who are looking for answers to personal problems. She suggests with tact and humor that there are wounded healers to be found among us in the most unexpected places.

Also fascinating is her treatment of ethical issues regarding bipolar genes on the level of population genetics...issues that are closing in on us as the Human Genome Project and molecular biology proceed. I was myself confused by her personal statement "not having children of my own was the single most intolerable regret of my life" (p. 190). I am not sure if the phrase, "children of my own", means "children with my own genetic material". It would seem that seeing her own genes validated by being perpetuated ties so deeply into her own sense of worth that she might have tried to have one child with her husband Richard (Chief of Neuropsychiatry, National Institute of Mental Health and author of more than 700 scientific articles and books), although he already had three by another marriage. Many couples do just that. In addition to all the concerns Kay Redfield does mention in regard to parenting a child, I would add the obvious fact that with

both her and her husband having such high-powered careers, the nanny would be doing the parenting. Chances are I am missing some key gender issues here.

Finally, given that this book was published in 1995, and given Kay Redfield's tremendous resistance to taking lithium, it is puzzling that there is no mention of other mood stabilizers such as the anticonvulsants *valproic acid* and *carbamazapine*. It would seem particularly the case given her clinical course with the development of increasingly mixed manias, etc. that either of the latter medications might have been used in combination with lithium to achieve maximum mood stabilization with minimal emotional monochromicity. I will elaborate on this point with the help of Jonathan Himmelhoch(1994) in the next section of my paper. Perhaps Kay Redfield's loyalty to lithium is not that surprising; given her conclusion that, given the choice, and, given the availability of lithium, and all things considered, she would choose to have the illness.

THE LIMITS TO OUR KNOWLEDGE OF WHAT IS "NORMAL" OR "HEALTHY" MOOD

How "normal" are Kay Redfield and other bipolar patients when they are judged to be in remission? I refer to the period when they are neither clinically depressed nor clinically elated- or should I say hypomanic or manic. Hagop Akiskal (1992)) has written extensively on the dys and hyperthymic temperaments which he sees as underlying the manifest episodes of severe mood swings. This question has to do with the broader issue of what "normal" mood is and what the range is. Is it normal to be hypomanic most of the time? Do you base the answer on what is statistically normal? I quote Akiskal (May, 1992):

The question arises, because hypomania is such an important feature of our distinctions, how do we distinguish it from ordinary human happiness? I would suggest that the drivenness in clinically significant hypomania is often dysphoric, it may lead to substance abuse, it tends to impair social judgment, and, finally, it tends to recur. This last characteristic is probably the most important: hypomania is a recurrent condition-happiness is not!

Akiskal's humor is one way of coping with the limits to our knowledge. Our language reflects the fact that although we are continuously asked to be experts on abnormal (disordered) moods, it is not at all clear that we have an adequate model for what healthy mood is. When judgments are subjective, and involve subtlety, the ebullience or restraint of the mental health expert may become the standard against which the patient is calibrated. The word elation is often used clinically as synonymous with hypo manic: it is defined (Webster's New World Dictionary-Third College Edition) as: a feeling of exultant joy or pride: high spirits. Euphoria, in it's original Greek meaning, to bear well, did not denote an excessive, abnormal state. Its current usage in Websters is: a feeling of vigor, well-being or high spirits. In psychiatric texts (1988), however, it is defined

as an exaggerated feeling of physical and emotional well-being, usually of psychologic origin, also seen in organic mental disorder and in toxic and drug-induced states) How much of any day is it normal, healthy to feel vigorous and in high spirits? Mood varies diurnally, it is not a static phenomena. Among the many variables that affect high spirits are age, physical health, stress, all of the details of one's environment. Himmelhoch (1994) cites Kurt Goldstein's 1971 characterization of the neurologically normal as opposed to the neurologically abnormal organism"

> "Whenever anxiety, as the mainspring of an organism, comes into the foreground, we find that something is awry in the nature of that organism. To put it conversely, an organism is normal and healthy when its tendency toward self-actualization issues from within, and when it overcomes the disturbance arising from its clash with the world, not by virtue of anxiety but through the joy of coming to terms with the world."

Himmelhoch (1994) then continues:

> "This is the difference between hypomania and mania, between bipolar II and bipolar I disorder. It is the fundamental reason that mild hypomania is the optimal mood for many bipolar patients, especially those who fail on normal or heavy-handed doses of lithium. In the patients, lithium must be precisely and lightly applied." (p. 249)

Himmelhoch, as I understand him, seems to be saying that there is a basic difference between the chronic, stable hypomania of the bipolar II patient, and the hypomania of Kay Redfield, for instance, which was often a weigh station on her trajectory into out of control mania. But this is a controversial area. In stressing the positive aspects of hypomania, for instance, Himmelhoch makes no mention of the drivenness, dysphoria and poor judgment mentioned earlier by Akiskal. These clinical distinctions are at times not easy to make. "Akiskal (1992) offers us help with his concept of temperament as a chronic mood state; both depressive introverts and euphoric extroverts owe their personality styles to a related biological instability in modulation of affect. That there is a spectrum that runs from sub-affective dysthymia (or melancholic temperament) through hyperthermia (or sanguine temperament) all the way out to rapid cycling. Akiskal has reminded clinicians of what was understood from Greek times until the nineteenth century-namely, that dysthymia is not a matter of episodes alone. Dysthymics tend to have a gloomy and inhibited style between episodes, and there are those who have the style without the episodes but probably have the same underlying disorder. This view of the realm of the disordered or variant personality...

Consider, for instance, the personal or clinical quality we try to capture with the word "drivenness" which Akiskal used to describe a characteristic of "clinically significant" hypomania. In his excellent chaper, "the Message in the Capsule", Peter Kramer (1993) cites the case of a Mrs. B (the source of Kramer's cited vignette is Winchel (1991):

She was prescribed Prozac for trichotillomania (an illness related to obsessive-compulsive disorder). Besides hair-pulling, Mrs. B. has a second concern: she is unmarried at age thirty-six,

despite her "appropriate, if somewhat strenuous efforts to meet eligible men." On Prozac, Ms. B.'s hair-pulling diminishes, but so does her feeling of urgency about meeting men. Ms. B. does not isolate herself: on the contrary, she now enjoys time spent with people such as her parents, with whom she argued in the past. She is more content with life, more reconciled to the possibility of never marrying, and, though still interested in men, is no longer driven.(what, you ask does all this have to do with Kay-Redfield who, according to her narrative, could be internationally ranked for her ability to become involved with eligible men?).....Also, while at first glance, Ms. B.'s behavior seems to be more obsessionally and Kay Redfield's more bipolarly driven, Kay Redfield herself refers several times to the pervasive obsessional-sounding curiosity and questioning which she used as a survival technique.

I am citing Ms. B's newfound contentment in the hope that it will help me better understand what life for Kay Redfield and my bipolar patients is like when they are living in the mundane zone inbetween their severe mood swings, commonly referred to as when they are in remission. In response to the contention that Ms. B., formerly "driven", may have been opiated into a cocoon by the Prozac, Kramer counters:

> "Inner drive can lead to great accomplishments. But often, being "driven" indicates compromised autonomy(as indicated by our use of the passive participle, "driven", as if by an alien force). To be opiated into a cocoon is one thing, but to be granted peace where once you were neurotically compelled is quite another: there are instances in which contentment contains more autonomy than drive." (p. 266)

Ms. B. found out that...

> "...for the first time in her memory she felt perfectly relaxed and happy sitting at home reading books or listening to music and felt less of the free-floating anxiety that was previously quelled by going out She then mentioned, parenthetically, that for the first time in her adult life, she considered that maybe marriage wasn't in her future - but, she felt, that was not necessarily bad. She would make her life happy, she considered, in other ways." (p. 266)

I do not know if finding some inner peace has been a goal of Kay Redfield's; she says several times that she could not know what she was missing, if she had had no experience of it.....

KAY AND HER MEDICATION

In addition to Kay Redfield's other profound resistences to taking her Lithium regularly, Himmelhoch's (1994) article details how the debilitating effects of a serum level probably in excess of 0.8 mmol/l would have been a major problem for her. Her painful struggle with Lithium's side effects for the first 10 years she took the high maintenance dose that was then prescribed bears out Himmelhoch's data. His main point is that:

> "Commonly accepted maintenance lithium levels are often simply too high. Edema, thirst, excessive urinary output; carbohydrate craving and weight gain; sluggishness; impaired coordination and decreased sex drive; and, finally, stoppered creativity all seem too easily accepted by clinicians who mistakenly advise their patients to accept these impediments as 'normal mood' ... In this case, the failure to recognize lithium failure is based on a fear of and a bias against hypomania, which is the preferred mood of almost every functioning bipolar patient." (p. 243.)

THE CAVEAT HERE IS THAT IT IS NOT ALWAYS CLEAR WHEN HYPOMANIA IS OF THE BENIGN VARIETY STRESSED BY HIMMELHOCH, AND WHEN IT IS A WAY STATION TOWARDS PSYCHOTIC MANIA....BOTH THE PATIENT AND YOU MUST BE INFORMED OF THE RISK. EVEN IF YOU KNOW THE PRIOR CLINICAL PROFILE OF MOOD SWINGS OF A PARTICULAR PATIENT, A NEW AND DANGEROUS MANIC DEVELOPMENT CAN OCCUR. IF YOU BRING IN THE FAMILY AND ENLIST THEM AS ALLIES IN EARLY DETECTION FROM THE BEGINNING, THE RISK IS EASIER TO LIVE WITH.

After noting the clinical subgroups (severe dysphoric, mixed, psychotic depressives, Dunner's Bipolar II patients, etc.) that are the exceptions, Himmelhoch continues:

> "For the large majority of bipolar patients, however, productive mania is the legitimate therapeutic goal. Over control with lithium or any other anti-manic agent either cripples the patient, or more in style of most bipolar subjects, leads to gross noncompliance and dropping out of treatment." (p.244)

Himmelhoch believes that, "clinicians as a whole suffer from a general phobia of hypomanic symptoms" (245). These clinicians are presumably not the numerous faculty with bipolar illness at John Hopkins that Kay Redfield's chairman says populate their medical school. More likely they are the compulsive grinds with whom many of us went to medical school.

IF KAY REDFIELD HAD HAD A TRIAL OF PROZAC (SHE TOOK, BUT WAS MADE TOO AGITATED BY SEVERAL PRE-PROZAC ANTIEPRESSANTS), MIGHT SHE HAVE FOUND A MODICUM OF THE CAPACITY TO BE CONTENT WHICH SEEMS TO HAVE ELUDED HER? DID SHE HAVE SOME NARCISSISTIC PERSONALITY FEATURES WHICH ALLOWED HER NEITHER THIS SIMPLE CONTENTMENT NOR THE CAPACITY TO ENJOY ORDINARY(CAN TWO THERAPISTS AGREE ON WHAT IS ORDINARY) EVENTS ? OR DID SHE AND DO MANY BIPOLAR PATIENTS. SUFFER FROM CHRONIC TRAIT - LOW CAPACITY TO EXPERIENCE PLEASURE ? MIGHT PROZAC HAVE HELPED HER WITH THIS LOW HEDONIC CAPACITY EVEN THOUGH HER NARCISSISTIC ISSUES (WHICH I AM POSITING) MIGHT HAVE MADE HER BRIDLE AT LIFE'S MUNDANE PLEASURES – WITH OR WITHOUT THE HELP OF TODAY'S MORE SOPHISTICATED PSYCHOPHARMACOLOGY, THE NEED IN MOST OF US TO FEEL SPECIAL OFTEN ROBS US OF THE SIMPLEST HUMAN MOMENTS.

A LIFE UNLIVED IN THE MIDDLE

Himmelhoch explains a basic reason that confounds our understanding of mood state in the bipolar condition:

> "Euthymia (*what a non-bipolar person would perceive as a good mood, a state of well-being*) is perceived and attributed by these patients as low-grade depression and treatment failure. They are correct in their conclusion. Achieving the right maintenance mood level for the right patient is the clinician's most difficult task in designing treatment for manic-depressive illness." (p. 244)

Let me spend some time here on what is not the book: by this I mean a description of what Kay Redfield experiences when she is neither in a depressed nor an elated state. I've read the book several times, and there is something peculiar going on here. Although she believes the term Manic-Depressive more accurately captures the subjective experience and clinical accuracy of her illness, Kay Redfield gives us her official DSM-IV (1994) diagnosis as "bipolar I disorder; recurrent; severe with psychotic features; full inter-episode recovery". I repeat the last part: she experiences full inter-episode recovery. There should be quite a bit to describe, especially since Kay Redfield does not have a rapid cycling illness. Indeed, in one of the most romantic and lyrical sections of the book, Kay spends a year long sabbatical at St. Andrews University in Scotland, during which her illness is in complete remission. (Whenever, by the way, she is able to distance herself from her daunting professional schedule, her illness seems to quiet down.)In this and subsequent respites from her usual frenetic existence Kay describes long walks on the moors, beautiful ceremonies in ancient Celtic universities and cathedrals, and elegant dinner parties...she evokes moods in the reader, touches one with her sense of beauty and the poetry she quotes. But she does not describe what she feels. Compared to the sensate, immediate language she has for her highs and lows, it is as though she has a selective alexithymia (an inability to find words to describe feelings) when it comes to life in the middle. At first I thought this was due to the requirements of a writer's craft: Joseph Conrad, for instance, doesn't say "the storm was powerful," he reveals its power by its effects. But this, I believe, is not the whole story.

Now why is Kay Redfield's feeling for emotional life lived in the middle such a big deal? Consider the recent perspective of Akiskal (1992) and Siever (1991) that episodes of Axis I symptomatic illness often emerge from an affective, temperamental matrix of Axis II personality styles, and that personality styles themselves emerge from a related instability of modulation of affect., Dysthymia, for instance, is not a matter of episodes alone. Dysthymics tend to have a gloomy and inhibited style between episodes, and there are those who have the style without the episodes but probably have the same underlying disorder. Considering all this, should we not be very interested in the micro-emotional anatomy, or at least the good old Kraepelinian clinical descriptions of what bipolar patients are like when they are not at the extremes of either pole?? The section on recovery/remission in the definitive text on MD illness by Goodwin and Jamison (1990) is

amazingly almost without a palpable, sensate description of what these patients feel when they consider themselves normal.

But perhaps this should not amaze us: major depression and mania are so traumatic in themselves that the textbook description of the recovery phase is mostly about remorse over what the patients did or were like during the last episode, and dread over what will be next.....very hard to live in the present when you are always post-traumatic, so to speak. The physicians and therapists who are concerned with trying to manage the life-threatening depressions and manias can also be forgiven for not having the luxury of focusing on what is going on between the episodes of frank illness. Additionally, Capturing the feel and nuances of a person's temperament is often better done in a sketch by Chekhov than by a clinician, but even Chekhov needs novelty to stay interested, and people just aren't that interesting when they are too well modulated. But Kay Redfield's basic temperament seems to be "mercurial (quick, quick-witted, volatile, changeable, fickle - the god Mercury was additionally shrewd and thievish), and several of the bipolar II patients I have treated were also mercurial.. so if constant change, mercurialness are in the basic nature of bipolarity, this would make it more interesting but perhaps harder to capture as a baseline or normal state. But dare I even use the word normal here? Kay Redfield uses it herself in the introduction to *touched by Fire* (1993), her book on MD illness and the artistic temperament:

> "Many are unaware of the milder temperamental expressions of the disease or do not know that most people that have manic-depressive illness are, in fact, without symptoms(that is, they are psychologically normal)most of the time." (p. 5)

An Unquiet Mind (1995) tells a very different story: she relates a vignette about a blind student she had tutored, and whom she had come to believe she had "some small notion, however small, of what life was like for him." One day she went to meet with him in the blind reading room of the library:

> "I tracked down the reading room with some difficulty and started to go in. I stopped suddenly when I realized with horror that the room was almost dark. It was dead silent, no lights were on, and yet there were half a dozen students bending over their books or listening intently to the audiotapes of the professors' lectures that they had recorded. A total chill went down my spine at the eeriness of the scene. My student heard me come in, got up, walked over to the light switch, and turned on the lights for me. it was one of those still, clear moments when you realize that you haven't understood anything at all, that you have had no real comprehension of the other person's world...(she continues, now as a woman of 40, ten years ago). As I gradually entered into the world of more stable moods and more predictable life, I began to realize that I knew very little about it and had no real idea of what it would be like to live in such a place. In many ways, I was a stranger to the normal world." (p. 166)

I was shaken by this paragraph, with a quick sense that despite reading and rereading her book, Kay Redfield is as incomprehensible to me as both the blind student and the normal world are to Kay herself. So my transferential reason for trying to find her, tarry with her, abide with her in mid-

orbit (what I have have been calling life in the middle), is my desire to be with Kay Redfield in a state of affective attunement...in a shared universe of inter-subjectivity, to paraphrase Daniel Stern (1985). But I have less embarrassing reasons: I also believe that no one is listening to Prozac here. I do not have time to refer to the text, but there is ample evidence that to the end of this book, that is about a year ago, Kay Redfield is unable to experience pleasure in response to ordinary events (for the moment let's forget that ordinariness exists in the eye of the beholder) and experiences. Because data from the middle is so sparse, it is not clear what combination of low psychobiological ability to experience pleasure as a trait, might be combined with what I feel are tenacious narcissistic features in Kay Redfield which make ordinary life boring. I believe that Kay Redfield's rendering of this is that the magical and magnificent highs of her illness would make ordinary reality boring to anyone. She may be correct, but I am suggesting that part of the problem is that she has a primary impaired ability to experience ordinary pleasures. If this were the case, Kay Redfield might have felt both better and more stable on a combination of lithium and Prozac. Prozac, as you know, quite specifically increases hedonic capacity in some patients, and has been found useful in combination with lithium in stabilizing mood disorders for some years. Prozac, however may be quite unacceptable to Kay Redfield. It has after all been touted as the elixer for everyman's neurosis

Kay Redfield conveys the poignancy of her suffering, the awful ways it has taken over big pieces of the life and self she valued as a young girl. We feel with her the shame and ugliness as well as the magnificence bestowed on her by one and the same illness. She is clear that her chaotic, impossibly divergent moods and behaviors could not be contained in an ongoing cohesive sense of self. It is not clear, for instance, whether she slows down and is on level ground long enough to feel ambivalence towards anyone. As Kay herself puts it:

> "I was confused and frightened and terribly shattered in all my notions of myself.....What did I do? Why? and most hauntingly, when will it happen again? Which of my feelings are real? Which of the me's is me?" (p. 85)

It bears repeating that the point in presenting her book is not so much to figure out who Kay Redfield really is...it is hard enough to do this with patients we see regularly or even with spouses with whom we spend a lifetime. The point, as I have said, is to better understand the issues raised by her story, to play with the material, and hopefully to better grasp the pathologies of self and self-esteem that evolve out of and interact with the bipolar matrix.

In Kay Redfield's case, the pull of the high moods, the drag of the excessive lithium, and the tenacity of her self-reliant New England values are conveyed with humor, heart and clarity. What is not told to us, is the shame, humiliation and self-loathing which I believe Kay Redfield experienced when anything suggested that she was an ordinary as opposed to an extraordinary human being. For instance, that she required medication for her illness, just like all the other people with her illness whose outcome studies she knew and taught to her residents and interns - admonishing them that it was tantamount to malpractice to treat bipolar illness without lithium.

Kay Redfield herself seems to be looking for the missing piece:

> "What on earth could I have been thinking...Why didn't I see how absurd my defiance really was?" (p. 100)

Now all of us want to follow Dr. Himmelhoch's advice that we medicate a given bipolar patient in such a way that they find the optimal adaptive mood state. I wonder how many of you have found that, even with severe bipolar patients, this is much more likely to happen if the patient's psyche is not at war with and specifically humiliated both by the narcissistic significance of taking a mood stabilizer, and, additionally by the direct and side effects of the medication itself? I have found it important to confront what ever the character issues are which contribute to the perfectionism, drivenness or other qualities which prevent the bipolar patient from following sound advise such as get your rest, don't abuse substances, balance your work and play...who among us has the inner peace to follow such directions?

I do not know if such a direct approach was possible with Kay Redfield. She was in therapy for many years with the same psychiatrist, one to three times a week. He sounds, as I said earlier, much better than most of us could have hoped to be at compassionately but firmly keeping Kay alive. He certainly does not seem to have come close to suggesting that life in a slower, less agitating lane, spent now and then with less than dazzling people...was boring to her because she had a problem with her ego ideal...But then he himself was dazzling...you figure it out.

I have not worked with any bipolar patients whose moods swing out as dangerously far as Kay Redfield's; they are more in the bipolar II range. But a number of them share with her a need to be extraordinary and to improve on ordinary life...a need so compelling that there is very little peace or contentment for them in the life that they have.

CLINICAL VIGNETTES

My patient Joe was like this. A foreign markets trader and professional gambler (the same thing?!), Joe, when I met him, spent l6-18 hour days in a near manic, single-minded passionate attempt to beat the odds in life...whether at horse-racing, the money markets or contract bridge he was O.K., aided and abetted by plenty of caffeine and nicotine, as long as his racing mind could manipulate reality, have it on his own terms. His mind could do anything, even bet on the long shot, the underdog for whom he had a special empathy, and still win. But, then, in order to make the world a loving enough place to soothe his existential pain, he would scatter his winnings, "lending" money which he never saw again, picking up too many checks, in a poignant but futile attempt to win affection. The world did not return his generosity however, and he eventually became depleted, disillusioned and depressed. Always in debt, he suffered his painful winter depression, and as his mood picked up towards spring, his comet lifted off and the striving continued. Slowly,

over several years, Joe was able to "surrender to something bigger than me...I am not God...I can't think my way out of this"....He takes his lithium and Prozac regularly, even when he is feeling better. Sometimes he is not sure how he is feeling; his wife and some friends are more comfortable with him and will perceive him as feeling well, while he feels a touch depressed and dull. He has been able to more adequately grieve the death of a beloved brother fifteen years ago, whose severe bipolar illness led to his suicide: The grief is more personal, less existential. He also is better able to say "no" to people, go to bed on time, drink less coffee and alcohol, and spend more time in life's medium fast lane: at this speed he sometimes gets withdrawn and self-doubtful, but more often now, he says, is able to "relish his somber, melancholy days."

Before closing, I want to note that there is in the literature a clinical vignette or chapter very much along these same lines. I am referring to and highly recommending "Witty Ticky Ray", by Oliver Sachs (1970), the neurologist, written some twenty-five years ago and well known to many of you from his book "the Man Who Mistook his Wife for a Hat. Although Ray's illness, Tourette's syndrome, is quite different from bipolar disorder, I found remarkable similarities in his and Kay Redfield's struggle:

In Tourette's, Sachs points out:

> "There is excitement of the emotions and the passions, a disorder of the primal, instinctual bases of behavior. The disturbance seems to involve, among other areas, the limbic system and amygdala, such that Tourettes seems to be a 'missing link' between body and mind, and lies, so to speak, between chorea (an illness characterized by chaotic, fragmentary quasi-actions) and mania." (p. 95)

Ray, like Kay Redfield both suffered terribly and was exceptionally endowed by his illness: Afflicted since age four, why would he have wanted to lose the brilliant chutzpah which was his signature- notably as a musician and a player of games? Ray initially reacted poorly (his movements became enormously slow and extended in time) to an experimental dose of Haldol, commenting afterward to Dr. Sachs, "Suppose you could take away the tics - what would be left? I consist of tics - there is nothing else." (p. 95) But Sachs had seen that when patients were able to lead "richer and fuller" lives, the balance or poise of such a life could overcome a severe physiological imbalance. So he and Ray agreed to meet weekly for 3 months:

> "During this time we would try to imagine life without Tourette's. We would explore how much life could offer him...without the perverse attractions and attentions of Tourette's (which Sachs felt were giving Ray a fair amount of narcissistic, exhibitionistic gain) we would examine the role and economic importance of Tourette's to him, and how he might get on without these...and then we would give Haldol another trial. There followed three months of deep and patient exploration in which (often against much resistance and spite and lack of faith in self and life) all sorts of healthy and human potentials came to light: potentials which had somehow survived twenty years of Tourette's, hidden in the deepest and strongest core of the personality.. When Ray then tried the same

> minute dose of Haldol, the result was excellent and has remained so for the past nine years." (p. 99)

The nature of Tourette's and of Haldol enabled Ray and Dr. Sachs to make a wonderful compromise which has not been available to Kay Redfield: during the week Ray took his Haldol and was a tender and stable husband, father and friend; on the weekends...no Haldol. Ray 'let fly', and became once more 'witty tic-y Ray', the frivolous, frenetic and inspired jazz musician. Lithium and bipolar illness, however, do not responsibly lend themselves to such an arrangement. I believe that, because he had the luxury of having it both ways, Ray was able to see a simple truth:

> "Having Tourette's is wild, like being drunk all the while. Being on Haldol is dull, makes one square and sober, and neither state is really free...You 'normals', who have the right transmitters in the right places at the right times in your brains, have all feelings, all styles, available all the time - gravity, levity, whatever is appropriate. We Touretters don't: we are forced into levity by our Tourette's and forced into gravity when we take Haldol. You *are* free, you have a natural balance: we must make the best of an artificial balance." (p. 101)

CODA

Preparing to close, Sachs says "only great pain is the ultimate liberator of the spirit" (p. 101). Kay Redfield, my patient Joe, and Ray all have been deprived of the birthright of a natural freedom which most of us enjoy. But they have all three achieved what Sachs tells us that Nietzsche liked to call "'The Great Health' - rare humor, valor, and resilience of spirit - despite, or because of their affliction."

This was originally to be about Kay Redfield's story; she gets the last word:

> "I long ago abandoned the notion of a life without storms, or a world without dry and killing seasons. Life is too complicated, too constantly changing to be anything but what it is. And I am, by nature, too mercurial to be anything but deeply wary of the grave unnaturalness involved in any attempt to exert too much control over essentially uncontrollable forces. There will always be propelling, disturbing elements, and they will be there until, as Lowell put it, the watch is taken from the wrist. It is, at the end of the day, the individual moments of restlessness, of bleakness, of strong persuasions and maddened enthusiasms, that inform one's life, change the nature and direction of one's work, and give final meaning and color to one's loves and friendships." (p. 213)

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