The Great Breath of Hell

Algis Valiunas

What is madness, and how is a civilized liberal society to treat the mad among us? In the name of compassion and progress, the very word *madness* has fallen into desuetude. It evokes the bad old days of snake-pit lunatic asylums and barbarous therapies, not to say tortures: the chaining of madhouse inmates to the walls or to their beds; the use of patients as agricultural beasts of burden, with the moral lessons of killing work reinforced by terrible blows; the dungeons where rats came up from the sewers to gnaw on the insane captives; the ice pick passed through the eye socket to extinguish not only the pains of frenzy but also the hope of normal function. There is good cause to want these atrocities forgotten, to prefer the anodyne term *mental illness* for the worst torments of the mind and the emotions, and to congratulate ourselves on our admirable humanity in dealing with the strangest of our fellow men.

Yet even to be marked as mentally ill still carries a stigma, like the branded thumb or notched earlobe of a convicted criminal in times past. Sufferers from the major mental illnesses—schizophrenia, schizoaffective disorder, bipolar disorder, depression—remain wary of announcing their condition. To be frank and open about one's bizarrerie, whether it happens to be an occasional thing or a full-time concern, invites the fear and scorn of the healthy-minded. Coming clean can cost you a job or a friend or a lover. Even in Prozac Nation under the Americans with Disabilities Act, where antidepressants are the most frequently prescribed drugs and discrimination against the mentally ill is prohibited, the defective nevertheless prefer for the most part to keep their defect under wraps.

Four recent books, each in its distinctive way, address the medical and social questions that mental illness raises. *Mania: A Short History of Bipolar Disorder*, by David Healy, a professor of psychiatry at Cardiff University in Wales and the author of several previous books on psychopharmacology, is a learned and

polemical volume in the series Biographies of Disease published by the Johns Hopkins University Press. *Hurry Down Sunshine*, by Michael Greenberg, a columnist for the *Times Literary Supplement* and a writer of fiction, criticism, and travel pieces, tells of his fifteen-year-old daughter's first bout of mania and his middle-aged brother's lifelong struggle with some debilitating but indeterminate mental affliction. *The Center Cannot Hold: My Journey Through Madness*, by Elyn R. Saks, a professor of law at the University of Southern California, an adjunct professor of psychiatry at the University of California at San Diego medical school, and a psychoanalyst who no longer practices since her newfound literary fame has taken away an analyst's requisite impersonality, relates her ravaging experience with schizoaffective disorder and her battling it to a draw, after numerous relapses, through psychotropic drug therapy and psychoanalysis (which Freud pontificated did not work in cases of psychosis). *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens*, by E. Fuller Torrey, a psychiatrist who heads the Treatment Advocacy Center, has served as special assistant to the director of the National Institute of Mental Health, and has written or edited twenty books, makes the case—unpopular, to put it mildly, among the so-called mental health community today—for a connection between psychosis and violence in a significant number of the mentally ill.

Mania: A Short History of Bipolar Disorder
By David Healy
Johns Hopkins ~ 2008 ~ 320 pp.
$24.95 (cloth)

The Center Cannot Hold: My Journey Through Madness
By Elyn R. Saks
Hyperion ~ 2007 ~ 368 pp.
$24.95 (cloth) $14.95 (paper)

Hurry Down Sunshine
By Michael Greenberg
Other Press ~ 2008 ~ 240 pp.
$22 (cloth)

The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens
By E. Fuller Torrey
W. W. Norton ~ 2008 ~ 288 pp.
$24.95 (cloth)

Psychosis is the overpowering of the real world by the unreal, the shattering of normal consciousness into fragments that then align themselves in disorienting kaleidoscopic patterns. Schizophrenia and schizoaffective disorder are defined by psychosis, while mania and depression can sometimes take on psychotic features. Elyn Saks describes with blunt concision the symptoms of schizophrenia and the prospects for the schizophrenic:

> Schizophrenia is a brain disease which entails a profound loss of connection to reality. It is often accompanied with delusions, which are fixed yet false beliefs—such as you have killed thousands of people—and hallucinations, which are false sensory perceptions—such as you have just seen a man with a knife. Often speech and reason can become disorganized to the point of incoherence. The prognosis: I would largely lose the capacity to care for myself. I wasn't expected to have a career, or even a job that might bring in a paycheck. I wouldn't be able to form attachments, or keep friendships, or find someone to love me, or have a family of my own—in short, I'd never have a *life*.

Making a life can be equally difficult for sufferers from bipolar disorder, who cycle between mania and depression. The throes of manic psychosis can be as bewitching as your sweetest fantasy come true, or more terrifying than your worst nightmare; depressive psychosis is a forced march through precincts of hell unimagined even by Dante.

David Healy begins his history of bipolar disorder with Hippocrates, whose case study of the woman of Thasos modern psychiatrists regard as the *locus classicus* of manic-depression. But what Hippocrates described, Healy writes, was actually a febrile delirium that was likely the result of an infection, contracted perhaps by drinking standing water. "Before the antibiotics, high fevers gave rise to agitated and raving states far more commonly than any 'mental' disorder did." So by mania Hippocrates, and by implication the Greeks in general, did not mean what we mean today.

Yet Healy ignores an even more famous instance of ancient Greek mania: the madness of Ajax in Sophocles' tragedy of that name. Ajax was the strongest of the Greeks fighting at Troy, and one of the proudest; when the goddess Athena was watching over him in battle, he made the mistake of telling her to go help someone else, as he could take perfectly good care of himself. His impious grandiosity brought swift retribution. Athena made him utterly psychotic, and he slaughtered a herd of sheep and their herdsmen, believing they were his enemies among his fellow Greeks. Restored to reason, Ajax killed himself in shame at what he had done. As the

Chorus laments, "Yet frenzy comes / When the gods will." In fact, Ajax is manically supercharged—well out of his mind—even before Athena strikes him down: no sane man tells a goddess what to do. His murderous frenzy is the just consequence and the natural emotional extension of his mad insolence. Sophocles presents the mystery of madness in its full horror: a man who cannot help being what he is leveled by divine fury. Even for those Athenians too reasonable to believe in the gods of their city, the connection between inborn temperament and full-bore disease remains one of the inscrutable aspects of madness. *Ajax* offers a much richer depiction of Greek attitudes toward mania than the puddle theory advanced by Hippocrates and Healy.

The main argument of Healy's book involves the role of commerce—meaning the pharmaceutical industry—in the diagnosis and treatment of manic-depression, and even purports to explain how manic-depression became bipolar disorder. As far back as the time of Galen, Hippocrates' great successor, the drug trade helped determine the prevailing medical understanding of illness. Theriac, a compound medicine made up of as many as a hundred ingredients, was the treatment of choice for emotional disorders for fifteen hundred years; its supposed efficacy was based on the theory of humors, and it became known as a trademark Galen product. Theriac and other compounds were big items in the European marketplace, especially that of Venice, and this salability helped assure the longevity of Galen's misguided theorizing. "There is little reason to believe that the merchant classes of the late Roman period or the Middle Ages would have welcomed a new science of disease any more readily than the makers of H-2 blocking antihistamines in the 1980s welcomed news that ulcers, then the most lucrative area of therapeutics, might be completely eliminated by antibiotics."

The sixteenth-century renegade sage Paracelsus publicly burned Galen's books, and was sacked from a distinguished professorial chair at Basel for doing so; but his fiery action turned medicine away from aping authority and toward reliance on experience and reason. Paracelsus focused on the most practical aspect of medicine—finding cures for disease—rather than on elaborate theory. As he wrote, "What sense would it make for a physician if he discovered the origin of diseases but could not cure or alleviate them?" His advocacy of specific remedies for specific ailments, replacing compounds such as Theriac with metals and refined chemicals, led gradually to the shouldering out of Galenic doctrine by a new empirical approach. "Medicine did so because ultimately it followed the money. In boxing parlance, this was the equivalent of hitting the body to get the

head to fall. Change the practice, and the thinking will follow. It has ever been thus, although medical history has almost exclusively focused on the scientific head and rarely on the commercial body."

The new emphasis on paying close attention to individual cases brought medicine a long way toward modernity. In 1590 William Thoner of Basel described the onset of melancholy—noting that it can seem to appear out of nowhere—in terms that mid-twentieth-century psychiatry could appreciate. In 1680 Christian Vater of Wittenberg observed the passage of melancholia into mania and vice versa. "The melancholics themselves now laugh, now are saddened, now express numberless other absurd gestures and forms of behavior.... It is vain to look to humors, or spirits for an explanation of this [change]." Healy draws an audacious inference from Vater's rejection of the theory of humors, which "arguably deals as much of a setback to modern notions on the biology of mood disorders or emotional change. While it is easy to relate the invariant rigidity of Parkinson's disease to lowered dopamine in the brain, it is not clear what it is about the multiform presentations of depression, both between individuals and even within the one subject, that could conceivably correspond to a lowering of serotonin." According to Healy, the current theories of the etiology of depression, involving misfiring neurotransmitters, are a fiction constructed on the serendipitous discovery that certain drugs happen to be effective against the illness.

As for manic-depression, which seems to be what Vater was describing, Healy notes that "few if any patients in the Western world [were] described as having manic-depressive disorder before the 1920s. In the United States, few patients had this disease before the 1960s." That is not to say that there were not persons in bygone times who would have been diagnosed with manic-depression were they alive today. But Healy argues that the illness was so rare that most doctors would not have been familiar with it. The mid-nineteenth century French alienists Jules Baillarger and Jean-Pierre Falret competed for precedence in identifying an illness in which melancholia and mania succeeded each other in cycles. Baillarger called his discovery *folie à double forme*, and Falret his, *folie circulaire.* This illness evidently was quite rare; neither doctor could cite more than four active cases in his researches, although they had two large asylums to draw upon for their patients. And neither quite got the presentation precise enough to make it stick.

The German doctor Emil Kraepelin failed to cite either of his French predecessors in his 1899 path-breaking textbook that differentiated between dementia praecox (later known as schizophrenia) and manic-depressive

insanity. Kraepelin favored manic-depressive over manic-melancholic, Healy says, because "he had a partiality for novelty." The term melancholia was passing out of use as depression was beginning to catch on. But Kraepelin's attempt to define manic-depression did not take among his contemporaries. "Retrospectively, the disorder Kraepelin had in mind would arguably have been more appropriately termed severe affective disorder rather than manic-depressive disorder. Finally in opting for manic-depressive disorder rather than manic-melancholic disorder, Kraepelin wittingly or unwittingly endorsed the notion of a relatively discrete mood disorder, when most turn-of-the-century alienists saw insanity as involving a disorder of the rational faculty." Yet Kraepelin's fundamental distinction between schizophrenia and mood disorders is established today as a tenet of psychiatric diagnosis; and his identifying subtle cases that appeared at once schizophrenic and manic-depressive has been certified by the recognition of schizoaffective disorder as a separate and complicated illness.

Lithium is so commonly associated with manic-depression that its mere mention sends a ripple of laughter through several Woody Allen movies. But its heyday in the treatment of mania lasted only about twenty years, from the late 1940s to the late 1960s. The poet Robert Lowell, who ran wild on manic jets for years, remarked on his successful response to lithium, "You mean all that commotion was caused by the lack of a little salt?" The widespread success of lithium in the treatment of mania led to more delicate differentiation between manic-depression and schizophrenia. In a sense, lithium defined manic-depression until valproate appeared on the scene and defined bipolar disorder.

Healy ungraciously gives the back of his hand to the work of Kay Redfield Jamison, a clinical psychologist and a professor of psychiatry at Johns Hopkins, who coauthored in 1990 the definitive textbook on manic-depression, and whose books for a lay audience made manic-depression "fashionable," as Healy puts it, in the 1990s. *Touched with Fire* is a study of manic-depression in some of the leading poets and other artists in the past three centuries, and *An Unquiet Mind* is a horripilating memoir of Jamison's own manic-depression. Healy says that thanks to Jamison, manic-depression displaced schizophrenia as the chosen affliction of genius, and drug salesmen marketing mood stabilizers in the late 1990s cited every supposedly manic-depressive artist they could think of in their informational literature for patients.

Soon the marketing people would convince clinicians and the public to render "manic-depression" defunct and to introduce "bipolar disorder" into common parlance. Healy sugg-

ests that new medications—valproate and the other anticonvulsants that also worked as mood stabilizers, displacing lithium as the sterling treatment—called for a new nomenclature for the illness they treated: bipolar disorder was more amenable to the new drugs than manic-depression had been to lithium, and the name change heralded a new age in triumphant psychopharmacology.

What Healy surprisingly overlooks here is the sea-change in the larger culture that has undertaken to make everyone feel good about himself. Bipolar disorder is a kinder, gentler diagnosis than manic-depression. *Mania* after all suggests *maniacal*—at the mention of manic-depression the image arises in the public mind of a murderer's ax dripping blood or a woman being pushed under the wheels of a subway train. Bipolar disorder, on the other hand, sounds blessedly free of the taint of insane violence. Indeed, it seems innocuous enough, a mere annoyance, the hangnail of mental illnesses. The savage realities of uncontrollable frenzy, bottomless despondency, and hellish terror are neatly papered over. (In recent years, some doctors have begun to resist this trend, arguing that "bipolar" does not aptly describe a condition in which both extremes may manifest themselves at once, such as psychosis during a depressive episode or suicidal intent during mania.)

Not that Healy is wrong about the connection between drug salesmen and clinicians. He comes down hard on what he sees as the perverse triumph of drug marketing, which has sold some psychiatrists on the idea of identifying and treating bipolar disorder in children as young as two. A 2002 *Time* cover story, "Young and Bipolar," freaked out parents of difficult children and sent them running to the doctor to get their kids some Depakote. The democratization of psychiatry, in which the patient presumes to know as much as the doctor, has loosed the public clamor for eradicating bipolar disorder in American youth. "But now criteria [for diagnosis] of all sorts have proliferated and can be readily accessed on the Internet, so that we can all readily find we meet criteria for a disorder, and that our children have ADHD, bipolar disorder, Asperger's syndrome, or autistic spectrum disorder and sometimes several of these disorders simultaneously, and nobody has the authority to gainsay us." Healy likens this mania, as he calls it, for drugging every impulsive or fretful child to the Dutch Tulip Mania of the seventeenth century. As an alternative to the one-pill-fits-all mentality that is coming to predominate in child psychiatry, he proposes the reconsideration of the immemorial wisdom that children differ in their temperaments and ought to be handled accordingly. "Furthermore, an acceptance that there are differences in temperaments does not bring with it an

expectation of drug treatment in the way that ADHD and bipolar disorder do, with their 'chemical imbalances' that stem from 'genetic sources' and can be put right only by pharmacological means. Temperament calls for management—it gives parents and others something they can understand and work with; in contrast bipolar disorder calls for correction or even extirpation by an expert." Although Healy scuttles away from the suggestion that "modern clinical practice has it wrong," saying he is just exploring the historical possibilities that have been overlooked, his disclaimer is not quite convincing. Healy is an intellectual bomb-thrower, a most erudite and clever doctor with an anarchic streak that he cannot quite reconcile with disinterested historical inquiry. He is interesting precisely for the subtle detonations that he sets off in the reader's mind, rattling the received ideas too comfortably ensconced there.

On July 5, 1996, my daughter was struck mad." The opening sentence of Michael Greenberg's *Hurry Down Sunshine* is captivatingly simple though somewhat old-fashioned. To write instead that "my daughter became ill with bipolar disorder" would sound more up-to-date, and would perhaps soften the blow. But Greenberg will have none of that: he wants the reader to understand the full wretchedness of a child's insanity and a father's helpless plight. The old words do better than the new ones here.

In the early stages of the illness, which gathered force over several weeks, the fifteen-year-old Sally Greenberg's mind crackled with energy; but it was energy that sprayed incoherently in all directions, and would soon explode in wild abandon. Reading Shakespeare became a delving into arcane knowledge, impenetrable to any but the initiate into manic hyper-acuity. When Michael has a look at Sally's copy of *The Sonnets*, he discovers "a blinding crisscross of arrows, definitions, circled words. Sonnet 13 looks like a page from the Talmud, the margins crowded with so much commentary the original text is little more than a speck at the center." And there are poems of Sally's own, which she told her father arrived like birds flying in through a window:

> And when everything should be quiet
> your fire fights to burn a river of sleep.
> Why should the great breath of hell kiss
> what you see, my love?

Michael sees the late nights Sally is spending rapt in Bach and Shakespeare and her own writing as a joyous fruitfulness following a childhood made difficult by a learning disability. Rampant craziness shatters the idyll. One night the police bring Sally home. She had been accosting strangers in the street, and she ran hell-bent into Manhattan traffic, confident that she could stop oncoming cars by force of mind. When the

police arrived, she unloaded on them her loony palaver.

Sally had had a vision at the Bleecker Street playground: every human being is gifted with genius in childhood, but has the marvelous ground out of him as he ages. The sadness of the people she addresses in the street comes of their knowing their genius is extinguished. It is Sally's unique and heroic destiny to reanimate the masses suffering from this loss. Full of her mission, she raves and trembles with a pathological overabundance of life force. "Spinoza spoke of vitality as the purest virtue, the only virtue. The drive to persist, to flourish, he said, is the absolute quality shared by all living beings. What happens, however, when vitality grows so powerful that Spinoza's virtue is inverted, and instead of flourishing, one is driven to eat oneself alive?"

When Sally tries to run out of the apartment, Michael rushes to stop her, and her nails gouge furrows in his cheek. Despite the horror of the situation, however, he entertains the notion that Sally's vision has much in common with esoteric wisdom traditions—with the Balinese, who believe that infants are literally gods for the first six months of life, before they descend into unfortunate humanity, and with gnostic teaching, which has it that we are gods who fell unhappily in love with Nature, so that "we spend our lives yearning to recapture a state we only vaguely recall. What is Sally's vision if not the expression of that yearning?"

Michael's wife, Pat—he is divorced from Sally's mother, Robin—talks sense into him. She has consulted a Reichian therapist who makes a habit of ragging the psychopharmacological approach to mental illness, a term he uses in scare quotes to denote "a social myth invented to silence a potentially subversive sector of the population." But even he told Pat to take Sally to the nearest emergency room: the customary contrarian advice does not apply to acute psychosis. "Acute psychosis. The phrase shocks me. By comparison 'mental illness' sounds benign."

The malignity of Sally's condition shakes her father profoundly. He cannot bear the thought that his daughter should be a mental patient; her being locked up in isolation on admission to the hospital eats at him; he fears the deadening effect of the psychotropic medication she will be required to take. His brother Steve suffers from tardive dyskinesia, a terrible disfiguring side effect of thirty years of antipsychotic medication. That Steve's strangeness and Sally's might have some hereditary connection is a source of anxiety. "I keep asking myself the obvious question, the helpless question. How did this happen? And why? One has cancer or AIDS, but one *is* schizophrenic, one *is* manic-depressive, as if they were innate attributes of being, part

of the human spectrum, no more curable than one's temperament or the color of one's eyes. How can something so inherent be a treatable disease? And how does one defeat such a disease without defeating oneself?" Sally will necessarily have the beguiling enchantment of mania kicked out of her, and that may seem like a defeat. The potent neuroleptic haloperidol performs a "chemical lobotomy," gradually dissipating the core delusions of Sally's illness, but also slowing her mind to a crawl as well as causing her body to go rigid, so that she "walks with a Parkinsonian shuffle, tentative and stiff."

Hurry Down Sunshine details the impact of Sally's illness not just on her but on the healthy members of the family. Michael keeps his daughter's madness a secret from one of his closest friends, Eric. Had Sally been injured in an accident or stricken with a physical illness, he would have had no trouble telling Eric all about it, and he knows Eric would have responded with the utmost compassion. "But psychosis defies empathy; few people who have not experienced it up close buy the idea of a *behavioral disease*. It has the ring of an excuse, a license for self-absorption on the most extreme scale. It suggests that one chooses madness and not the other way around. When Eric refers to someone as 'crazy,' he means uninhibited, rebellious, creative. It's a form of praise." Pat joins her husband in advocating a wall of silence around Sally. Should their friends find out, she says, it would only make Sally's life harder: "People would start thinking of her as weird. Stained."

The family members torment themselves wondering whether something they once did might have brought on Sally's breakdown. Her brother, Aaron, a successful college student, wonders if his childhood teasing could have somehow caused the damage. Her mother, Robin, recalls a night when she let her month-old daughter cry herself to perdition for half an hour when she laid her down to sleep. Michael assures her that this did not make Sally go mad, but he is at a loss to know what did. "Nothing seems directly connected to it; there is no event or even series of events I can point to that might have definitively forewarned us, no obvious cause other than the most obvious one that Sally, like Steve, has always been what she has become, that it was inside her from the beginning, incubating, waiting to mature." Michael's mother, Helen, tries to soothe him by saying Sally is nothing like Steve—that Steve is what he is because she resented him and never showed him love. Michael tells his mother she might have had a case of postpartum depression through no fault of her own, but he cannot stop her pummeling herself with guilt. He pummels himself as well. A psychiatrist's anecdote about another patient

whose parents overwhelmed her with plans for healthy-minded activities when she got out of the hospital—"Yeah, all the things that put me here in the first place"—makes Michael feel judged and condemned once and for all. "The humiliating assumption is that when we take Sally home she will be returning, in the parlance of mental hygiene workers, to 'a situation that is not working.' As the architects of this 'situation,' we are promoters of psychosis. We are guilty on both counts, it seems, nature *and* nurture." Here is the endless round of questioning that attends mental illness in the family: who could be responsible for this suffering?

The bafflement extends beyond the family to the doctors. There is only so much that psychiatry in its current condition can do, and Michael notes the resignation in experienced clinicians, "the psychiatrist's cross to bear. It's easy to imagine how dispiriting it must be to administer a series of unrewarding treatments that have not progressed much since Lady Macbeth's doctor observed: 'This disease is beyond my practice.... More needs she the divine than the physician.'" Michael's intuition of the doctor's despair might sound literary and overheated—developments in psychopharmacology have after all saved many thousands of psychotic patients from earthly damnation—but there is some truth in it: a psychiatrist recently told me that reducing a psychotic patient's symptoms by 30 percent was considered a success.

Released from the hospital, Sally got better, little by little, with psychotherapy and medication. She started the tenth grade and made fast friends with three of her classmates; when she summoned the nerve to tell them about her illness, they responded with acceptance and even admiration. "Being an alumna of the psych ward confers social status on Sally. It's a kind of credential. She has been where they have not been. It becomes their secret." After graduating from high school with honors, she attended a Manhattan liberal arts college while living at home; in 2000, the spring of her freshman year, she broke down again, and several hospitalizations ensued. In 2001 she began her first love affair with a former high school classmate, and they married in 2004. Two years later, when health reasons compelled her to stop taking the antipsychotic Zyprexa—it had controlled her psychosis wonderfully, but it can cause diabetes—madness resurfaced. She and her husband separated, and she went to work in Vermont at a bakery and nearby farm, tending cows and goats. Psychosis remains a part of her life, and she is learning to deflect the worst of it. When her father told her he was writing a book about her first bout of madness, she told him to use her real name. Michael Greenberg has written a memoir of loving sorrow that searches an entire family's pain at

its members' mental illness. It leaves his still-young daughter's condition sadly unresolved, with madness ever at the margins, waiting to burst in and smash everything in sight. With the psychoses, it is almost ever thus.

Elyn R. Saks, in *The Center Cannot Hold*, brings to light her first intimation of schizophrenic "disorganization," as she calls it, which occurred when her father reprimanded her for interrupting him while he was working. "Consciousness gradually loses its coherence. One's center gives way. The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a sturdy vantage point from which to look out, take things in, assess what's happening. No core holds things together, providing the lens through which to see the world, to make judgments and comprehend risk. Random moments of time follow one another. Sights, sounds, thoughts, and feelings don't go together." This frightening slippage from normal consciousness first occurred when she was eight, and she knew she could not tell anyone about it.

When, several years later, she made the tactical error of telling her parents that she had smoked marijuana and would do it again if she wanted to—she had also dropped mescaline, but did not inform them of that—they hustled her off to an outpatient drug rehab program notable for its tough love approach. The program worked—she would never use illicit drugs again—but it also made her aware of how weird and withdrawn she was. That she should presume to speak at all, she believed, was an imposition on others; she had nothing to say that deserved to be heard. "Perhaps this was the beginning of my estrangement from the world, the very first inkling of my illness, something I'd never really experienced before, and a habit of mind that would intermittently mark me for the rest of my life." Yet she came to love the people at the rehab center, and took to heart its essential teaching—that determination can overcome any obstacle, that every illness or weakness can be fought and defeated. It would take the devastation of full-blown insanity many times over to make her realize that willpower could not conquer all afflictions. "There are forces of nature and circumstance that are beyond our control, let alone our understanding, and to insist on victory in the face of this, to accept nothing less, is just asking for a soul-pummeling. The simple truth is, not every fight can be won." But this truth is not meant to be simply disheartening. Not every fight can be won, but every fight can be fought with grit and courage, even when one's own nature is the enemy. Full recovery from schizoaffective disorder will never be hers, Saks writes; the most accomplished psychiatric

exterminators cannot rid her of a lifelong demonic infestation. But she has made herself a life well worth living all the same, with a high-powered intellectual career, a happy marriage, and rich friendships.

Such a life did not seem possible during many years of her struggle with madness. After a brilliant undergraduate career as a philosophy major at Vanderbilt—salted with several episodes of balminess, among them daring herself to swallow a whole bottle of aspirin—she rode a prestigious fellowship to Oxford, where she proceeded to fall to pieces. She nearly stopped eating or speaking, except for talking to herself in the street; the essays she wrote for her tutor were pure sludge. When a friend suggested she see a psychiatrist, she thought, "I am bad, not mad. Even if I were sick, which I'm not, I don't deserve to get help. I am unworthy." The conviction that she was stupid and evil and deserved to die consumed her, until finally she realized that if she tried to kill herself she would succeed, and she could not bear the thought of the pain her suicide would cause the people who loved her. She went to the psychiatric division of the Oxford medical school, and when the doctors there recommended she be admitted to the day hospital—that is, she would be allowed to return to her dormitory at night—she refused and bolted. But a night spent repeating over and over, "I am a piece of shit and I deserve to die," convinced her to follow the doctors' advice. She still balked, however, at following it all the way. Taking medication was unacceptable, contrary to the anti-drug teachings of her former rehab center. Only when she had a good look at herself in a mirror and saw a gaunt, disheveled mad hag did the realization come that she needed all the help she could get. The antidepressant amitriptyline seasoned with talk therapy restored her to sanity—normal eating, sleeping, talking to people, doing good schoolwork—but eight months later suicide again became a fixed idea, and she was back in the hospital. The way the English doctors treated her, never ordering but always recommending, even when she was desperately out of her mind, made her feel respected. She agreed to most of their recommendations, but when they suggested that she drop out of Oxford after her hospital stay, she absolutely refused: earning her degree was essential. It would take her four years, twice as long as is customary, but she got the diploma in 1981, and with flying colors: her examiners said that her master's essay on Aristotle's philosophy of mind was of the quality of a doctoral thesis.

Saks continued to function in the normal world even while she was delusional and hallucinating. "For example, I was getting my schoolwork done, and I vaguely understood the rule that in a social setting, even

with the people I most trusted, I could not ramble on about my psychotic thoughts. To talk about killing children, or burning whole worlds, or being able to destroy cities with my mind was not part of polite conversation." Sometimes she felt so crazy that she would simply lock herself in her room and turn off the lights. The only person in whom she could confide her true state of mind was her psychoanalyst, Elizabeth Jones; Mrs. Jones, whom she had consulted at the behest of the famed psychiatrist Anthony Storr, was a Kleinian analyst, an apostate from strict Freudian doctrine and a believer in the benefits of psychoanalysis for psychotics. "It was [Melanie Klein's] theory that psychotic individuals are filled with (even driven by) great anxiety, and that the way to provide relief is to focus directly on the deepest sources of that anxiety." The Kleinian analyst speaks the patient's language of primitive fantasy, where these anxieties have their origin, and the exchanges about private parts and actions generally considered shameful sometimes sound crazy on both ends. Where the hospital psychiatrists focused on coaxing Saks into passing for normal, Mrs. Jones penetrated to the bloody matrix of her insanity. This penetration terrified Saks, who feared Mrs. Jones would kill her, and she started carrying a kitchen knife and a box cutter to their sessions. Saks loved and depended upon Mrs. Jones all the same. She stayed on in Oxford for a year after taking her degree, mostly so she could continue her daily analysis. When the time came for Saks to return to the United States, she wept and screamed and refused to part from Mrs. Jones. "She had been the tether that held me to the outside world, the repository for my darkest thoughts, the person who tolerated all the bad and evil that lay within me, and never judged. She was my translator, in a world where I felt most often like an alien. How could I survive in this world without her?"

Saks nearly did not survive without her. At Yale Law School, without continued therapy or medication, she went roaring around the bend. "There were days that I feared that my brain was actually heating up and might explode. I visualized brain matter flying all over the room, spattering the walls." A chat with her roommate was interrupted by the apparition of a bearded lunatic with a large knife about to slit her throat. She gasped in terror, and the hallucination promptly vanished. The roommate asked what was wrong; Saks said it was nothing.

Soon afterward—two weeks into her first semester—Saks wound up in a hospital emergency room with a length of telephone wire that she brandished as a whip and a large nail she was unwilling to part with. A burly attendant pried the nail from her grasp, and she was presently instructed in a basic difference between English and American han-

dling of raving psychotics. "Within seconds, The Doctor and his whole team of goons swooped down, grabbed me, lifted me out of the chair, and slammed me down on a nearby bed with such force that I saw stars. Then they bound both my legs and arms to the metal bed, with thick leather straps." Saks maintained the presence of mind to ask The Doctor to remove the restraints, which were painful and humiliating; the ability to remain lucid in some part of one's mind even in the midst of overwhelming derangement is often a freakish characteristic of psychosis. The Doctor refused this request, which seemed so reasonable to Saks but which evidently did not to those confronted by a madwoman who just a moment before had been wielding a whip and a nail. A nurse forced a liquid dose of antipsychotic medication down Saks's throat, and The Doctor committed her to the hospital for fifteen days, as a danger to herself and others. The medical powers at Yale Psychiatric Institute kept her in restraints, including a net covering her whole body, off and on for two days. Saks observes that she learned later that a hundred patients a year in the United States die in restraints. When she was transferred to another hospital, Yale-New Haven, Memorial Unit 10, she hoped for gentler treatment, but found herself frequently in restraints over the next three weeks. Accustomed to the liberality of psychoanalysis, which encouraged her to say whatever she was thinking, however demented, Saks had a hard time adjusting to hospital protocol, which insisted that mad people behave as though they were sane. To do otherwise meant getting strapped down. "The conundrum: Say what's on your mind and there'll be consequences; struggle to keep the delusions to yourself, and it's likely you won't get the help you need."

The diagnosis of chronic paranoid schizophrenia with acute exacerbation flummoxed Saks. All along she had considered herself not mentally ill but weak-minded and deficient in will. The future looked dire. In large part, the future *was* dire. Medication dispersed the demons, but Saks habitually wanted to discontinue the medication once she felt better; when she did go off the meds, she inevitably got worse. Yet she placed her faith in psychoanalysis, and fought the illness on her terms. A year after her breakdown, she negotiated readmission to Yale Law School, and once there promptly crashed. "It would take me another fifteen years to learn the lesson of what happened each time I withdrew from drugs. It had been much easier to learn ancient Greek, and not nearly as self-destructive." Saks had legitimate reasons to want to be free of medication: prior to the introduction of a new generation of antipsychotics in the 1990s, the danger of tardive dyskinesia as a side-effect was ever present. "People with TD twitch and jerk—in

short, they *look* like mental patients, and once they've got TD, it generally doesn't go away." (The danger is still there even with the new drugs, though it is not as great.)

When clear-headed, Saks was an academic marvel. She wrote a final exam that was the best her favorite professor had seen in twenty-five years; she published a Note in the *Yale Law Journal* in 1986, "The Use of Mechanical Restraints in Psychiatric Hospitals," which the Bazelon Center for Mental Health Law used in presenting a class action lawsuit against a Midwestern hospital; she scored in the ninety-ninth percentile on her bar exam. Yet she knew her condition precluded her performing as a litigator, and after a detour into legal aid work, she chose to pursue a career teaching law. Not that she was ever confident she could make it as a professor, but she got a choice job at the University of Southern California.

The most intractable symptom of psychotic illness—and her psychiatrist at Yale had changed her diagnosis to schizoaffective disorder with depressive emphasis—plagued her continually: the belief that she wasn't really sick. She and her new doctor in Los Angeles entered into a protracted negotiation regarding her illness: "how much medication he thought I needed vs. how little medication I thought I needed." The refusal—or inability—to understand and to do the prudent thing about her own condition colored her legal scholarship. "It was my argument that many people (more than we might think) should be allowed to refuse medication. As someone who benefits from medication, I know that the question of when one should be allowed to refuse is a complicated one. But I also believe that individual autonomy is vitally important, even precious—after all, it's central to who we are as humans on the planet, with free will and self-ownership." This declaration of independence is fragrant with cant. How far a patient in the throes of psychosis can be said to be an autonomous person exercising free will is the question, and Saks's own mad behavior as described in her memoir suggests an answer: not very. Reason is the foundation of free will, and a person bereft of reason is a wood chip tumbling over a waterfall.

Whatever ambivalence or hesitancy Saks shows on this matter seems likely to stem from her discovery of a medication that worked as no other had for her. When her doctor took her off Navane, which carried a high risk of breast cancer—and Saks would indeed get breast cancer thereafter—he put her on the new drug Zyprexa.

> The clinical result was, not to overstate it, like daylight dawning after a long night—I could see the world in a way I'd never seen it before. While Navane had helped keep my psychosis "tamed," I'd

> always had to remain vigilant. The psychotic thoughts were always present, and I often experienced "breakthrough symptoms"—fleeting psychotic thoughts—many times each day. With Zyprexa, though, I shut that door and, for the first time in years, it stayed shut. I could take a break, go off duty, relax a little. I couldn't deceive myself—the illness was still there—but it wasn't pushing me around as much as it once did.

And it was Zyprexa's effectiveness that finally convinced her she had a real illness—the greatest breakthrough in the course of the disease. The Zyprexa helped carry her through her fight with breast cancer and ovarian cancer, her marriage to a loving man, her elevation to an endowed professorial chair, and her becoming a psychoanalyst. Even so, she thought she could do with a lower dose than the doctor prescribed, and the horrors returned.

But in time normality, or something like it, took its own back. Saks admits that she will never be blueberry-pie normal, but she has made as fine a life for herself as this frightful illness will allow. While many sufferers from mood disorders—depression and manic-depression—thrive in spite of their illness, she writes, and can look for inspiration to distinguished fellow sufferers down the years—Lincoln, van Gogh, Samuel Johnson—the same is not true for persons with thought disorders such as schizophrenia. "Comparatively few schizophrenics lead happy and productive lives; those who do aren't in any hurry to tell the world about themselves." One can only be grateful that Elyn Saks chose to tell her story. It testifies to the virtue indispensable to facing the hardest trials as they come in unstoppable swarms: fortitude. Triumph over schizophrenia may be impossible, but Saks's life demonstrates the glory of a fight well fought.

In *The Insanity Offense*, E. Fuller Torrey cuts against the grain of public health practice of the past forty years, which has resulted in the deinstitutionalization of psychotic patients without anything like adequate treatment for them outside the hospitals. Between the mid-1960s and the mid-1980s, Torrey writes, "Deinstitutionalization emptied the patients from the hospitals, and the civil rights lawyers ensured that many of the patients would not be treated or rehospitalized. These two movements were like two flooding streams coming together, complementing each other and synergistically causing much more damage than either could have done alone. Downstream, the devastating effects—homelessness, incarceration, victimization, violence, and homicides—are clearly visible today."

Torrey treats several of the more egregious cases of devastation at length, among them that of Bryan

Stanley, a Wisconsin man and a schizophrenic who, in 1985, outraged that girls were allowed to read the Epistles at the Catholic church in his town, received instructions to kill three devils at the church, and gunned down a priest, a lay minister, and a janitor. When police arrested him, Stanley said he was Elijah and had to see the Pope. Although Stanley had been hospitalized several times and had had outbursts of violence in the past few years, he did not believe he was mentally ill and invariably went off his medication as soon as he was released from the hospital. Involuntary hospitalization for Stanley as he got sicker was not in the cards; the *Lessard* decision by a U.S. District Court in 1972 was the basis of Wisconsin mental health law, and that law insisted on proof "that there is an *extreme* likelihood that if the person is not confined he will do *immediate* harm to himself or others…and dangerousness is based upon a finding of a *recent* overt act, attempt or threat to do *substantial* harm to oneself or another." [Torrey's italics.] Prior to *Lessard* the criteria for commitment were far more loosely construed: "clear and convincing evidence" that the person was "mentally ill" sufficed for involuntary hospitalization. The judges deciding *Lessard* found doctors under the earlier statute endowed with sinister powers they were likely to abuse: "The diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there." This is to assume that doctors act with the capriciousness of liberal federal judges; the reasonableness of the earlier law contrasts starkly with the ideological ardor of the later. *Lessard* became the foundation for mental illness law in nearly every state, and, in Torrey's words, "precipitated a human disaster. The three-judge panel had essentially reversed seven hundred years of English civil law that established government's responsibility to protect individuals who are unable to protect themselves, the principle of *parens patriae*."

There are many who would only benefit from the law's parental protection. Torrey's estimate that there are four million Americans with the most severe mental illnesses—schizophrenia, bipolar disorder with psychosis, and depression with psychosis—is not an exaggerated figure; the National Institute of Mental Health tots up 8.8 million with schizophrenia or bipolar disorder. Of Torrey's four million, some 400,000 are homeless or imprisoned; most of them are unaware they are sick and consequently do not take medication. And then there are those mentally ill with a history of violence—some 40,000. Torrey believes that with medication most of them can live peaceably on the outside.

As they are, however, unmedicated and unsupervised, they form a

dangerous cohort, responsible for many horrific crimes. Torrey's file of "preventable tragedies" contains three thousand clippings from the past eight years. To shock the reader into outrage and even perhaps into political action is Torrey's plain intention. Convincing the public that psychotics can be as murderous as psychopaths goes contrary to prevailing psychiatric doctrine, but Torrey makes his case with a sickening array of examples. According to two studies he cites, three-quarters of matricides and two-thirds of patricides are seriously mentally ill. An untreated schizophrenic woman in Los Angeles, with her eleven-year-old son in tow dressed as a girl, stabbed and shot to death her seventy-eight-year-old mother, who she believed had murdered nine people and buried them in the desert. A Virginia man diagnosed with schizophrenia rammed his mother's front door with his car, then beat her to death. An Indianapolis man diagnosed with schizophrenia stabbed his father, whom he believed to be the devil, dismembered the corpse, and ate part of his brain. The families of many—if not most—mad killers have sought medical help, but the doctors have declared themselves helpless to intervene because the psychotics were not overtly dangerous. Sometimes the profoundly mad prove their doctors wrong by killing *them*. Others draw a bead on public figures: a psychotic killed John Lennon and another tried to assassinate Ronald Reagan. Clergy, too, make popular targets for the unhinged.

Torrey calls for changes in the law and in psychiatric practice that would get help for those who need it most. A prominent feature of schizophrenia and bipolar disorder is anosognosia, a sick person's unawareness that he is sick. Many persons with these illnesses will therefore refuse drug treatment; as Torrey puts it in a chapter title, "God Does Not Take Medication." The authorities so far tend to come down on the side of those who suppose themselves God or His near associates. Legislators and judges have come to hold that involuntary treatment of the mentally ill for their own good is "indefensible," as a California Republican lawmaker largely responsible for the mental health fiasco in his state put it. The public has a sharp disagreement with the authorities on this matter. "A national survey reported that 87 percent of public respondents 'said that mentally ill homeless should be sent to mental hospitals even when they don't want to go.'"

Nevertheless, despite the apparent attractiveness of common sense prescriptions for mental health law prior to *Lessard*, the enforcement of common sense in forced hospitalization does not make for an open and shut case. The fifth edition of the *Diagnostic and Statistical Manual*, the handbook of the psychiatric profession, will run to over 1,200 pages when it is published in 2012.

The varieties of recognized mental illness have so multiplied that the pre-*Lessard* legal criteria for commitment would be dangerously open-ended if reintroduced today. New and prudent guidelines might limit involuntary hospitalization to, say, the obviously psychotic, uncontrollably manic, sepulchrally depressed, and self-destructively anorexic or bulimic. And there is a corollary need to examine the treatment that psychiatric hospitals provide for their patients, for some treatments make an already fearsome condition all the more terrifying. Elyn Saks writes that at Yale she was put into restraints for appearing agitated as she walked down the halls; soothing conversation with one of the staff might have better calmed her than being spread-eagled and strapped to a bed. Saks points out that in England, restraints have not been used for the past two hundred years. While one can readily imagine behavior that calls for restraints, including some of Saks's own, distinguishing the therapeutic from the punitive is essential to humane and effective treatment, and not every hospitalized psychotic patient gets such treatment.

Torrey proposes sensible and compassionate remedies for the broken system and broken lives. "The treatment of severe mental illness involves, first and foremost, the use of antipsychotic medication." There are ways to make sure that psychotic patients living among normal people take the drugs they need to be sane: making receipt of their disability payments or availability of decent housing dependent on drug compliance; establishing conservatorships, under which a court-appointed person makes decisions for a mental patient deemed legally incompetent; making release from the hospital conditional upon the patient's continuing to take medication and follow all treatment instructions, with involuntary rehospitalization for the refractory; assisted outpatient treatment, or AOT, which is similar to conditional release, but is not limited to patients who have just been in the hospital. AOT has effectively doubled the rate of medication compliance and significantly reduced hospital stays, homelessness, arrests, and violent behavior.

Psychosis is an affliction as agonizing in its way as intractable physical pain. To be mad and homeless is hell on earth. Torrey quotes Supreme Court Justice Anthony Kennedy on the meaning of unfreedom for the mentally ill: "It must be remembered that for the person with severe mental illness who has no treatment, the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our powers to describe." How our society treats the mad is a measure of our decency. At present, our

permitting hundreds of thousands of psychotics to wander the streets or rot in jail is a telling measure of our indecency. These are persons who have done nothing to deserve their illness, and many of them, perhaps most of them, could have decent lives, given the necessary medical treatment. To deny them that care in the name of freedom is to show no compassion in the name of compassion. It is an ideologue's heedless folly.

E. Fuller Torrey's is an indispensable book at this time, a prescription to restore sanity to a legal system gone insane. The memoirs of madness by Elyn R. Saks and Michael Greenberg are necessary companions to Torrey, making the reader feel the terror of life in a psychic earthquake zone, where the ground is never solid under your feet and the Big One could be coming any time now. Along with Kay Redfield Jamison's books and Andrew Solomon's *The Noonday Demon: An Atlas of Depression*, these three volumes provide an essential overview of desolate and forbidding country most readers are fortunate enough never to have traversed for themselves. To know something of madness, if only through books, is a requirement for entrance into one's full humanity.

***Algis Valiunas**, a* New Atlantis *contributing editor, is a literary journalist and the author of* Churchill's Military Histories.