

INTERVIEW:

# ALTERED FATES

The preeminent expert on bipolar disorder discusses poetry, Prozac, and the tormenting mixed states that have changed our understanding of the disease

Interview by **Pamela Weintraub** Photographs by **Miles Ladin**

**I**F BIPOLAR disorder has a voice, it belongs to Kay Redfield Jamison, professor of psychiatry and director of research at the Mood Disorders Program at Johns Hopkins University in Baltimore. In 1995 Jamison, then at UCLA, burst onto the national scene with her memoir, *An Unquiet Mind*, about her personal experience with the disease. It was surprising that a university professor, a clinical psychologist who treated patients no less, might be so open about her life, but it was more shocking still to hear her actual account, a marathon of psychosis and despair long hidden from view. From her early manias to her bout with suicide to her uneasy détente with a savior, lithium, Jamison revealed all.

Rather than steamrolling her career, the confessional vested Jamison with a new authority as someone who scientifically studied her own illness. Over the years she has written other acclaimed books: *Touched With Fire*, about manic-depressive illness and the artistic temperament; *Night Falls Fast*, about suicide; and *Exuberance*, about people on the bipolar spectrum who live lives of high-voltage energy without ever getting depressed.

But Jamison's greatest accomplishment may be the tome *Manic-Depressive Illness*, the seminal work on the disease, which she cowrote with colleague Frederick K. Goodwin. The first version was published in 1990; in 2007, with advances in neurobiology, psychology, and psychopharmacology, a revision presents manic-depressive illness in a radically altered light.

Jamison took time from correcting galleys to meet with DISCOVER writer Pamela Weintraub.



Tea and sympathy:  
Jamison at a café near her  
home in Washington, D.C.

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**Explain the decision to discuss your illness openly.**

I did it because one of the problems of having this kind of illness is that people don’t talk about it. As a result people don’t understand it, don’t realize it can be treated, and don’t know how devastating it is. When I first got ill, my mother, who is a great mother, had no idea what was going on. She said, “I really wish I could understand what it feels like.” She’s so normal that she had no idea.

**How does the illness manifest itself?**

Manic-depressive illness magnifies common human experiences to larger-than-life proportions. Among the symptoms are exaggerations of normal sadness and joy, profoundly altered thinking, irritability and rage, psychosis and violence, and deeply disrupted patterns of energy and sleep.

**You’re both going through and studying this condition. Does that alter your scientific lens?**

It gives a different perspective. My research has focused on the areas that I deem important—first and foremost how lethal the illness is. It is very deadly. Suicide is as much a result of bipolar illness and severe depression as heart attacks are a result of cardiovascular disease. At the same time, people with the illness can find parts of it seductive, making long-term treatment difficult. For people who have a euphoric kind of mania, it is addictive. You are asking people to give up states that they have enjoyed and want to recapture.

**Who would want to give up the heightened energy and awareness?**

People tend to forget the worst part of the illness. Your mind goes from being wonderfully engaged with everything at the start of mania to being fragmented and out of control. You have

no control over what you see, hear, or think. It’s worse than depression, where you have no hope and no energy and you want to die. As bad as that is, it isn’t as terrifying as losing your mind.

**Are changing mood states integral to some art?**

I give lectures in the department of English once a year at St. Andrews in Scotland, in a department permeated with poets. Four of the top Scottish poets are in the department. They are actually pretty normal, but two are moodier than the others. If you look at the pedigree of these people, their family history is full of manic depression. These disorders are on a spectrum with a range of milder states like hypomania [elation or irritability without the psychosis; a mild form of mania], cyclothymia [alternating hypomania and depression], and hyperthymia, which is somewhere between cyclothymia and exuberance. Poetry requires a primitive



cadence and rhythm and intensity of experience, so poets are more likely than other writers to appear on the spectrum or have mood disorders. Some produce their best work in their twenties and thirties, before the illness has taken its full toll, then many of them die young.

**You prefer the term manic depression to bipolar disorder, even though "bipolar" is currently in vogue. Why?**

Bipolar disorder involves polarity—periods of euphoric mood or extreme irritability and paranoia with high energy alternating with periods of despair and profound lassitude. But the presence or absence of mania is just one aspect of the illness. The other important aspect is cyclicity. The more recurrent one's depression, the more it looks like bipolar illness, whether mania is present or not. Beyond this, mania and depression can coexist in the same person at once. These mixed states have been observed for hundreds of years as the transition points between mania, depression, and normalcy. People can have mixed states, not just as transition points but as the essence of the illness.

**It sounds excruciating.**

These patients are incredibly uncomfortable because they experience the worst of mania and depression at the same time. Hopelessness and despair combine with a restless energy. When people get into mixed states, they experience an electrically wired sensation. They are agitated, perturbed, restless, and desperate—it is a kind of energy that you can't walk off. There are many types of mixed states, but the one I've just described, agitated depression, is the most common and the most lethal.

**Comment on the uproar over antidepressants and suicide.**

For a number of years the onus has been put on the drugs, but the real issue is the diagnosis of the different kinds of depression. People with bipolar depression usually need mood stabilizers like lithium or anticonvulsants like Depakote. Antidepressants like Prozac can agitate them and can push them toward suicidal thought. Unfortunately, the state of the science is such that you cannot always say for certain which people belong in which group. I was put on antidepressants by a superb doctor and I went nuts.

**Are we getting better at detecting mental illness at its earliest stages?**

We are doing in psychiatry what has been done in hypertension—looking at less symptomatic people earlier in the game. It is always easier to treat something earlier in a milder form, and that's what we're trying to do. In general, you want to treat kids before there is much chance for their brain to be adversely affected by disease.

**But you now have people who are less pathological and who have been treated with antidepressants earlier.**

Kids in college may be depressed and be put on an antidepressant. The doctors involved may or may not know what they are doing. The kid can then get full-blown mania or mixed states. When we intervene in psychiatric illness much earlier, there is that risk. I always say that I had the great advantage of not having been treated for many years. I wasn't made worse by an antidepressant. Even though when I got into treatment it was an emergency and I was crazy as a hoodoo and totally manic, at least for the 10 years before that I had not been made worse by antidepressants. I was fortunate in having a pure response to lithium, uncomplicated by antidepressants.

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**Do you think we've gone too far?**

No. There are two columns. Before there was any treatment, you were spending your time in asylums, you were killing yourself right, left, and center, you were dying of psychotic exhaustion and cardiovascular disease, which is associated with bipolar illness. The second column is that of psychopharmacology; thanks to treatment, suicide is down, hospitalization is down, and we save many more lives than we lose. Patients treated with antidepressants may be pushed to mixed states and more rapid cycling. Their cases are now more complicated and difficult to treat, but we can still treat them, and they still do better than in the days when there wasn't any treatment at all. This is where the practice of medicine varies enormously in how carefully patients are watched for everything from suicidal thinking to agitation to all those things we know are the possible effects of the drugs.

**Does environment play a role in these disorders?**

External stresses—and on occasion, medication—can precipitate initial instances of the illness, but after a while episodes occur spontaneously. There are also seasonal stimulants. We are first and foremost mammals, and we respond acutely to changes in light, which correspond with temperature and the seasons. The highest rate of hospitalization is around the equinoxes, but for depression it is in the winter and for mania, end of summer or fall. It has to do with the quest for food. Whether you're a squirrel or a farmer, you need higher energy to bring the food in during spring and summer. During winter months mammals have fewer food resources, so they can expend less energy. This explains why one person might get manic every first week of July and another person might get depressed every October as the sun wanes.

**Why do humans maintain bipolar genes?**

Evolutionary biologists speculate that the high rate of the genes might confer an advantage in terms of risk taking, recklessness, and bad judgment—all the things that can be extremely damaging might also be important in terms of making great leaps.

**What do you see for the future?**

I would like to see a blood test that says this person is responsive to antidepressants and that another one is going to get worse.  $\Omega$

