BIOPOLITICS

Module 2

Mental Illness and Leadership

Annotations

Abstract

From the character of Carrie Mathieson in *Homeland* to studies of historical figures such as Abraham Lincoln, there has recently been a series of popular and scholarly representations of the presence—and even benefits—of mental illness in individuals in leadership positions. In this video dialogue, Nassir Ghaemi—a clinical psychiatrist and author of the book *A First-Rate Madness—discusses* the relationship between leadership and mental illness with historian of medicine Howard I. Kushner.
The dialogue begins by examining the pitfalls and possibilities of using contemporary psychiatric diagnoses to understand past historical figures. It then branches out into an extensive discussion of how mental illness has influenced the decisions of past historical leaders, as well as the potential benefits of mental illness and mental disability for professionals today. Ghaemi and Kushner conclude by considering how biological and humanistic approaches to mental illness can be combined to design better approaches to mental health.

ANNOTATION

Richard Noll
Tribal Epistemologies

Who is a "legitimate" or "professional" historian? What is to be regarded as legitimate historical research? Can those of us who do not have graduate degrees in history or academic appointments in history departments ever be regarded as "legitimate" historians?

As I have learned, these are questions that "professional" historians cannot easily answer. Similarly, as I have learned from sad experience, a state license to practice psychiatry or clinical psychology (my original profession) also does not guarantee the clinical competence of such a credentialed individual. Anyone who identifies themselves as working within a particular academic discipline or profession is aware of the diversity of competencies of their colleagues within their field, and, as part of our professional initiation process, we are

all conditioned in our youth to assume that there are behavioral norms and jurisdictional boundaries that must be policed. The tensions between "professional" historians and transgressors stem from one source: the inevitable cognitive dissonance created by differing tribal epistemologies and their resultant moral economies. What intellectual behavior is "allowed" and what is not? Where are the lines between "us" and "them?"

For those of us with credentials from the medical/mental health/public health professions, there is an acute sensitivity to the fact that we may be transgressing some sort of boundary when we conduct, and publish, historical research. We have not been properly "disciplined" by the mentors and machinery of a doctoral program in history. We sometimes wonder if our manners are perceived as proper, if our style of writing history is "acceptable," if our selection of topic or interpretive framework is "in fashion" or not — hoping all the while that our scholarship will be acknowledged by "professional" historians who, we all acknowledge, have the advantage of extensive schooling in the historical arts.

I have often found myself admitting to my professional historian colleagues that I am "practicing history without a license" as a polite bow to their extensive training and expertise. However—and I wonder if Dr. Ghaemi secretly shares this conviction—I firmly believe that the source of whatever creativity I may exhibit as a historian of medicine and psychiatry emerges precisely from my perspective as an outsider to the historical profession. I do not have a chorus of internalized history professors who threaten intrapsychic punishment for my immature shibboleths. And, unlike many "professional" historians, I write in order to be read—not simply to be cited—and by the widest population of readers that I can reach.

William Cronon, the President of the American Historical Association, recently issued a warning to his colleagues about the moral economy of "professional boredom" accepted and promoted by the members of his tribe. In the March 2012 issue of *Perspectives in History,* he made the point that some of the most widely read historians had no doctoral degrees or academic appointments in the profession (individuals such as the documentarian Ken Burns and writer Barbara Tuchman were cited as examples). As remedies for the "boring" and self-referential products of professional historians he suggested "welcoming into our community anyone and everyone who shares our passion for the past and who cherishes good history," writing in an "interesting, even intriguing" style, communicating "clearly" and "engagingly," and "by telling good stories."

In 2005 Steven Shapin published a similar cry of alarm in an article published in *Isis* entitled "Hyperprofessionalism and the Crisis of Readership in the History of Science." The "cause" of this crisis of readership was "a pathological form of the professionalism which we so greatly value," he wrote. Shapin's use of a medical metaphor to get his point across about the moral economy of historians is very revealing indeed.

As both Howard Kushner and Nassir Ghaemi have abundantly demonstrated in their many publications over the years, one way to revivify historical scholarship is to infuse it with psychiatric, neurological, and psychological perspectives. There is no shortage of good stories to tell if we do this. And such medical subjects often spark an immediate, intimate

connection with reader. For, after all, these are points of tangency with our everyday experience of health and illness, and they affect us all.

Dr. Ghaemi remarked that academic history is "antipsychiatrically reductionistic," and acknowledged that one quite valid reason for this was the lack of psychiatric expertise among historians. With no formal medical, psychiatric, or clinical psychological training, and no clinical experience with patients, they naturally side-step such perspectives and choose those that are congruent with their areas of knowledge. But there is another reason for this, and it derives from the norms of the moral economy of the historical profession that distinguishes "good history" from everything else.

In a follow-up essay in the April 2012 issue of *Perspectives in History,* Cronon argued that there are "two fundamentally competing orientations for approaching history." One involves "imagining that people in the past existed only to become us." Historians regard this as the familiar sin of "presentism." Without explicitly saying so, Cronon identifies this as "bad history." The other, which is of course "good history," is meeting the past on its own terms as a "foreign country" where people "do things differently there." In other words, striving to write history within the cognitive categories of actors acting within cognitive categories of the past.

If we use Cronon's dichotomy as a revelation of how professional historians set up jurisdictional limits for their discipline and police perceived boundary violations, we immediately see the source of their criticisms. Any application to historical evidence of 21st century psychiatric cognitive categories derived from *DSM-IV—such* as the bipolar disorders, the melancholic type of major depressive disorder, or schizophrenia—would be a boundary violation indicating "bad history." From the perspective of scientific medicine, these three mental disorders are indeed the closest things to natural biological disease processes that contemporary psychiatry can offer, and hence the understandable argument that they exist "in nature" and must have existed "in nature" in the past just as tuberculosis, syphilis, and typhus did. Therefore, the argument would follow, the application of such concepts to historical evidence is legitimate and "good history." Dr. Ghaemi especially makes such historical claims regarding the mood disorders—the true "heartland" of psychiatry—because of textual evidence dating back to Hippocrates, and wisely knows that any such claims about our era's schizophrenia would be a historically weak argument.

Additionally, for many professional historians, even the biography as a literary form is a stylistic boundary violation of tribal norms. Adding a psychiatric or psychological interpretive framework to biographical historical evidence thus becomes a doubly dubious practice.

So, do those of us who "practice history without a license" publish "good history"? Professional historians would prefer that we employ the language of the past— madness, insanity, mania, melancholia, frenzy, dementia praecox and so on—and not attempt to deconstruct the meanings of these variable and complex concepts through the prism of DSM mental disorders. This is a rational norm and we should respect the wisdom of professional historians who hold to it and, in my opinion, strive to do the same.

But is this fair to us? After all, historians write stories about the past for the purposes of the present. Objectivity is an elusive ideal, a noble dream, and no historian is completely immune from the taint of presentism. Communicating with their readers, who live in the present, would be impossible otherwise.

Where do we draw the line? Let the negotiations continue....

ANNOTATION

Margaret Price

I'm Margaret Price, and I'm very appreciative that Harold [Braswell] asked me to record an annotation for the dialogue between Dr. Ghaemi and Dr. Kushner. I'm an associate professor of rhetoric and composition at Spelman College in Atlanta, Georgia, and my specialization as a researcher is the rhetorics of disability—specifically, mental disability.

Mental disability is a term that was coined, in the way that I use it, by Cynthia Lewiecki-Wilson, who argues that using the term *mental disability* as opposed to *mental illness* indicates a number of different things that are useful in terms of understanding this sort of disability. First, that it is a disability, something that, from a disability-studies perspective, is influenced—some would even say "constructed"—through social context, rather than being something that inheres in an individual body.

I should also mention, though, that I'm pretty flexible about language, and so as I go through this response, I'll be periodically using terms such as *mental illness, labeled with mental illnesses, diagnosed.* I think that these are all terms that do specific different kinds of cultural work in specific contexts. And as a rhetorician, I'm less interested in trying to find some mythical "right term," and I'm certainly not interested in trying to mandate what terms other people use—with the exception of hate speech, I guess. Rather, I'm interested in thinking about, as Tanya Titchkosky has said, what our articulations of disability are saying in the here and now. So, what cultural work are specific terms doing, and for what reasons?

So that's sort of a *précis* of why I use *mental disability.* And I explain that at more length at my book, which is titled *Mad at School: Rhetorics of Mental Disability and Academic Life.* Now, as I read this dialogue—I first read the transcript, and I then viewed the dialogue on my computer—I was struck by a lot of different things. I think it's a fascinating treatment of what it means to attempt to talk about psychiatric disabilities in history, and what it means to question notions like "normal." I think that some very rich points come up in the course of this.

I also think that the dialogue as a whole tends to, tends to set up two different camps, in a sense. One camp is people who are not diagnosed mentally ill, and in the other camp are people who are diagnosed in that way. And these camps are demarcated, I believe, through the use of pronouns. I was very struck when I was first reading the dialogue, and then listening to it, by the way that the pronouns operated here.

So, for example, early in the dialogue—I'm reading from the transcript now—Dr. Kushner said, "It's this odd thing that we can't talk about the best examples of what it is we see on a current basis." And Dr. Ghaemi responds, agreeing, saying, "Right. We can't talk about our current patients." And they go on to discuss this point. The issue that they're discussing at that time is the need to maintain confidentiality in case histories, and they're talking about the fact that psychiatric case histories are rarely published anymore. What we mostly see are large statistical studies, because confidentiality is all but impossible to maintain in a truly detailed case history. And that's true; I agree with them on that point. I'm very struck by the fact that here, and pretty much throughout this dialogue, the two interlocutors are "we," which presumably are doctors, and not mentally disabled people. And the "they" is the patients, who are mentally disabled.

So one thing I'm hoping to do in this response is to suggest that this perspective might benefit from the joining to it of the perspectives of those who do have lived experience of mental disability, such as myself. I've received a number of mental-illness diagnoses over the years. Most people with diagnoses have this sort of array [laughs] of different diagnoses that have come to us. And my diagnoses range from the relatively mundane (depression, anxiety) to the more unusual and, to some, sort of dramatic (such as borderline personality disorder).

And I mention this because I think it would be easy, in listening to this commentary, to assume that I too am one of the "we" who is not mentally disabled unless I specifically mark myself as a mentally disabled person—which I do do in professional contexts, but which is also a very difficult decision, obviously, and a decision that is very complicated in its effects.

Now, that issue, the one of disclosure, is one that's of great interest to me as a rhetorician, and in fact my next book project is focused on the rhetorical event, if you will, or the rhetorical situation, of disclosure of mental disability. What does it mean to disclose such ability [shakes head]—such disability? What happens when such disclosures are made inadvertently and nonverbally? For example, if one has a panic attack in front of one's colleagues, we could say that something has been disclosed, although not intentionally. In what ways do different audiences take up disclosures of mental disability? And what are the contexts—cultural, political, medical, scholarly— that circulate around these disclosures? With Mark Salzer of Temple University, a psychologist, and Stephanie Kerschbaum, a rhetorician at the University of Delaware, I am working on a mixed-methods study, both a quantitative and qualitative study, that aims to gather more information about disclosures of this kind.

Now, I would suggest, to Professor Ghaemi and Professor Kushner, some of the issues they run into in their dialogue might benefit from a disability perspective, that is, the perspective of people with mental disability. For example, later in the dialogue, Dr. Ghaemi is talking about the problem of stigma, and the issue that mental illnesses are heavily, heavily stigmatized. And he argues that his work, *A First-Rate Madness,* posits that mental illnesses may have beneficial effects that enable one to be a better leader in times of crisis, for example—he argues that this might reduce stigma.

Now, again, as a person with lived experience, but also as a disability-studies scholar, I would encourage Dr. Ghaemi to complicate that question more. I think that holding up persons with mental illness as exemplars of leadership, as sort of super-people in times of crisis, might not have the stigma-reducing effects that he intends—that he hopes. Specifically, because to posit that a person with a disability is sort of "super," quote-unquote, because of that disability, is in some ways only the converse of saying that that person is "sub" because of the disability. In disability studies this would be referred to as the "supercrip myth," the notion that a person with a disability must be, or may be, wonderful in other areas specifically because of that disability, that they may have these savant-like capabilities.

So that's a question that I would pose to Dr. Ghaemi and Dr. Kushner both.

Overall, I'm really very, very appreciative that this book was written. I'm really excited about all the different approaches to mental disability that have emerged in psychiatry and postpsychiatry, particularly in the last decade. I think that the work is becoming very interesting, very complex. And I also think that the disciplines of psychiatry, and humanities-based disciplines, and then also social science disciplines, are starting to work together in really interesting, rich ways.

But there is a trend that concerns me, which is that still, people diagnosed with mental illness, so often in these rich collaborations, seem not to be a part of it—seem still to be part of the "them" instead of the "us." And so in composing this response, I am hoping to broaden who that might be, and to say I think everyone can have a productive part in this dialogue, and it will make the dialogue better overall.

INTERVIEW

Emily Martin

BP: In *Bipolar Expeditions* you write of your own experience as a successful professional with bipolar disorder. How do you feel about recent literature and popular representations (such as, among others, the television show *Homeland)* that claim that mental illness can provide professional benefits for those in leadership positions?

EM: It's a good question. It's one I address in [*Bipolar Expeditions]* in some detail. I think it's not inaccurate to depict Carrie in *Homeland* as having creativity connected with being quite manic. It doesn't seem totally misleading to depict a manic burst of energy that seems fairly consistent with what some people do experience. And I understand— not from any research, but just on the anecdotal circuit—that the writer, producer, or somebody involved in the show has a relative or somebody close to her or him who has this diagnosis, so that depiction does seem more well-rounded than many.

Most of the time, the assertions about Ted Turner, about Jim Carey, et cetera, having their success flow from their bipolar disorder strike me as a very double-edged sword, because it's such a partial picture. It assumes that, whatever leads to such a diagnosis, you could take that condition and make it just the way you wanted it—optimize it, by means of drugs, or therapy, or just luck. You could make it perfect so you could be a fount of energy, creativity, humor, great acting, or great leadership. And, wow, who wouldn't want that?

But that isn't how it usually is, so it's a double-edged sword. There's never or rarely— *Homeland* is an exception—a depiction of the depressed side, the other pole of the mood spectrum, because that's associated with inertia, lack of energy, stasis, failure, unproductivity, and all the rest—the bad things that we don't like to think about. So, it's very partial.

It's also partial in that it's a myth, one promoted actively by the pharmaceutical industry, that the medications we have are effective for everybody. Some people do well on them, and some people do very badly on them, or don't find much help on them, or have to keep trying to change dose and combinations in an effort to wrestle their life into some kind of shape. So these depictions are more like reflections of the *zeitgeist* or mythologies or fantasies than they're related to anything that's a true, accurate portrait of living with this diagnosis.

I would also say that I asked a lot of my interlocutors who are frequenters of support groups for bipolar disorder what they thought of these media depictions. And almost universally people said, "Oh, it's great because it's destigmatizing." So if Ted Turner or Robin Williams, comes out and says "I have bipolar disorder"—they don't usually do that, but if they did— it helps us feel less like an outcast, less dehumanized, or stigmatized because the name of the condition can be said, it can be uttered. And I don't discount that. I think that if people feel that, experience that, then that's another thing on the plus side.

BP: There has been a recent series of historical writings attempting to apply contemporary psychiatric diagnoses to historical figures, such as Abraham Lincoln, Adolf Hitler, or John F. Kennedy. From a scholarly perspective, what do you see as the advantages and limitations of using current psychiatric categories to better understand historical figures?

EM: It's a really common thing. It's happening all over the place, from psychiatrists to psychologists, you come across it all the time and there are countless websites listing all the people who are said to have had bipolar disorder or manic depression.

I think that there are problems with it. There's an incoherence to it. It's only a coherent claim if you think it's believable that bipolar disorder or manic-depression is simply a brain disease. If that's what you think—you believe that there's a reasonable case to be made that it's only a brain disease, only a physical disease like perhaps high blood pressure or arthritis or something like that—then I guess you could look back and say that, [Abraham Lincoln's] knuckles are kind of enlarged and he writes in his diary about feeling stiff so, he probably had arthritis. And there's some coherence to that. It's coherent because theoretically you could do an autopsy if we had his body and you could look and see whether the physical signs of arthritis are there. So the claim may be true or false, but at least it's coherent. And for any problem of the mind or problem of the psyche, like a mood disorder, or any of the other psychiatric conditions, if you think these things only are lived in particular cultural contexts and only have sense in certain historical contexts, then it becomes incoherent because—pick your person, Lincoln, Kennedy, any of the usual suspects— they lived at a time when either there was no such diagnosis or it meant something different than it does today. So, at the time Emil Kraepelin pulled together a lot of his case studies and came up with the nosology [for manic depression] that's still very influential today, there wasn't a strong sense of cycling. There was much more of a sense of a progressive one-way direction as the disease moved through a person's lifetime. But, rather than cycle, he thought it involved large periods of time when the person was basically fine he or she could go home, could be in a prolonged lucid [state]. I was just in France, and there's a historian there who's gone into this in great detail and who's [determined that], for Kraepelin, it was about six weeks per year that the person was hampered. So, rather than a cycle, it was more like a month and a half of difficulty per year. So if you had the diagnosis at that time, and this is what you were told, and how people understood it, it wouldn't have the same meaning as it does today. People wouldn't react to you the same way they do today, where it's monitored by daily mood charts and controlled by a large pharmakon. Because of the very detailed micromanagement that people give their moods, they're aware all the time that they *are bipolar.* Dip into depression or break into mania—the experience of having this condition is completely different.

One big caveat: I myself might not want to say that Lincoln had Bipolar disorder, but I would definitely say that he did not live under the description of Bipolar disorder. I have a lot of doubts about both of these moves. The disadvantages are that it is another way of valorizing certain kinds of figures, successful leaders—Teddy Roosevelt is another real favorite. What I would want to do is step back from that valorizing and ask why that particular set of traits is attracting so much interest and is given such value today. I have my own thoughts about that but I think it is a historically and culturally specific question. Asking what is happening today to make us want to see bipolarity in important people, living or dead, [is a] more productive and salient question than simply identifying people from the past to add to the bipolar pantheon.

BP: In light of the recent shooting at Sandy Hook Elementary School, mental illness has emerged at the forefront of media discussions about gun violence. If you could direct the public conversation, what would be a good starting point for a national dialogue about mental illness in America today?

EM: It's a really great question. Like many others, I have been thinking about this a lot lately. You didn't ask what was realistic. You gave me a *blank slate,* meaning *I* get to direct the public conversation. So I'm not saying this is realistic, but I would start by thinking of an automobile, which many people need to conduct their daily lives, to get to work, to do the shopping and so on. And it's a piece of technology that has the potential for killing other people. It has the potential for deadly force. And, we regulate it. At first, it wasn't regulated at all—when the Model T was invented, if you could afford it, you could drive it. But over time we learned to regulate it for the common good—a certain age limit, drinking limit, eyesight limit and so on. And we do that because, basically, it's a public health issue, to keep highway fatalities lower. So I would use that as a model.

And forget about the Second Amendment. I really think that should be tabled. All the Second Amendment says is that we have the right to *bear* arms; it doesn't say we can't regulate who bears arms. And it doesn't raise the question of who *needs* a gun. There would be cases to be made, lots of cases, where people *need* guns: for subsistence, for defense, and so on. But I think that the burden of proof should go on the person who wants a gun: If you want a gun, what's the case to be made for you to have a gun? And that would shift the dynamic away from these sort of primitive rights discussions of the Second Amendment to a discussion of how we live in society, who needs a gun, and when are the risks of gun ownership outweighed by peoples' needs.

So, in relation to mental illness, it's very distressing to me to see the response on the part of many, many people [who say] "well, here's how we'll avoid another Newtown, we'll make sure guns don't get into the hands of mentally ill people." Where do you even begin? Such a statement adds to the apparently sharp line between the mentally healthy and the mentally ill, a line that I think is spurious. And so it doesn't actually contribute to public health and public safety necessarily. It allows us to ignore conditions that usually don't end up with a diagnosis of mental illness—like alcoholism, social drinking, sociopathologies, psychopathologies. There are many people who have tendencies that would not make you want them to have a gun. They don't usually fetch up in a psychiatrist's office for reasons I'm sure you're very aware of. So, people who are extremely emotionally labile, get angry easily, and on and on and on, [are on] the list of people I wouldn't want to have a gun handy. It does not coincide with a diagnosis of mental illness. I would just want to question again whether that line, between those that live under the description of a diagnosis and those who don't, is an appropriate one for these issues.

INTERVIEW

Contributors

S. NASSIR GHAEMI, MD, MPH is an academic psychiatrist specializing in mood illnesses, especially bipolar disorder. He is Professor of Psychiatry and Pharmacology at Tufts Medical Center in Boston, where he directs the Mood Disorders Program. He is also a Clinical Lecturer at Harvard Medical School, and teaches at the Cambridge Health Alliance. His clinical work and research has focused on depression and manic- depressive

illness. In this work, he has published over 100 scientific articles, over 30 scientific book chapters, and he has written or edited a number of books. His most recent book is *A First-Rate Madness: Uncovering the Links between Leadership and Mental Illness* (Penguin, 2012).

HOWARD I. KUSHNER is the Robertson Professor of Science and Society at Emory University, where he holds joint appointments in the School of Public Health, Institute of Liberal Arts, and Program in Neuroscience and Behavioral Biology. He has published histories of American suicide, Tourette's syndrome, and Kawasaki disease. His current book project is a global history of left-handedness and deviance from the early 20th century through the present.

RICHARD NOLL, Ph.D, a clinical psychologist, is Associate Professor of Psychology at DeSales University in Center Valley, PA. His most recent book, *American Madness: The Rise and Fall of Dementia Praecox* (Harvard University Press, 2011) was the winner of the 2012 Cheiron Book Prize and a 2012 BMA Medical Book Award – Highly Commended in Psychiatry, from the British Medical Association.

MARGARET PRICE's research interests within rhetoric and composition include disability studies, discourse analysis, and digital composition. Her book *Mad at School: Rhetorics of Mental Disability and Academic Life* (University of Michigan Press, 2011) won the Outstanding Book Award from College Composition and Communication. Price's work has appeared in venues including the *Journal of Literary and Cultural Disability Studies, Profession, Disability Studies Quarterly,* and *Bitch: Feminist Response to Pop Culture.*

EMILY MARTIN is a Professor of Anthropology at New York University. She is the author of many articles and books on medical anthropology and feminist studies of science and technology. Her most recent book is *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton University Press, 2009) is currently at work on a new project on the history of the human subject in experimental psychiatry.