BIOPOLITICS

Module 2

Mental Illness and Leadership

Transcript

2.1 Introductions

NG: I'm Nassir Ghaemi, I'm a Professor of Psychiatry at Tufts University and Director of the Mood Disorders Program at Tufts Center in Boston.

HK: I'm Howard Kushner, Professor in the Rollins School of Public Health at Emory and in the Neurosciences and Behavioral Biology Department at Emory University. So, how did we meet?

NG: I had an appointment at the School of Public Health here at Emory and then through that I started to meet faculty. I think that's how we met.

HK: But we got to know each other pretty well and about 5 years ago we taught a course together; I think it was Mental Health and Public Health—or maybe it was The Brain, Culture and Madness—something like that. And we've been in touch ever since.

2.2 "Practicing history without a license"

HK: So I guess Nassir has just written a new book called *A First-Rate Madness.* It's his fourth book and its gotten a lot of publicity and we wanted to talk about that but also to talk more about how the work we both do intersects. One particular issue is that my own training is in history whereas your training is in psychiatry—although you did Philosophy after [your] MPH [Master of Public Health degree]?

NG: Right.

HK: And then I began doing much more postdoctoral work in neuropsychiatry and so it's ironic in the sense that my interests are much more in using neuropsychiatry to explain history--and you're using history to explain neuropsychiatry. It's a kind of odd turn of events. There's a joke we always tell in the history of medicine which is, a senior neurosurgeon comes up to us and says, "when I retire, I'd like to become an historian of medicine." And the historian of medicine says, "when I retire, I'm going to be a neurosurgeon." And the neurosurgeon says, "you can't do that!" And he says, "yeah, I know."

So in one of the reviews you were accused of "practicing history without a license"— which I guess is the rest of the story. So how do you use history?

NG: Well, it's interesting that the accusation came from a novelist; it's not [from] someone who was an historian himself. But I have a bachelor's degree in history; so I have a degree in it. And graduate degrees, as you said, in Philosophy and Public Health. And history of psychiatry has been something that grew out of those interests. You know as a psychiatrist and an expert in mood disorders I and many of the colleagues that I have with similar expertise treat people with bipolar disorder and depression that are very well-known, very prominent, very successful—politicians, businessmen, lawyers—but we can't talk about it because of confidentiality. One reason to go into history is because it's one way you can talk about this; this is publicly available information about public figures. And if you go back 50 years like I did and you have the documentation that you need, you can do it legitimately. So that's one reason I use history.

HK: You know it's interesting; as an historian of neuropsychiatry, when I go back and look at – because I go back and look at these early cases to see if we can find clues to how we can solve current problems in neurology and psychiatry and see if there's something there and read over the old cases—one of the things that's really striking is 50 years ago in medical journals, almost all the publications were cases. Right? And now, all the publications are really essentially statistical surveys—putatively "evidence-based medicine"—good, bad, or indifferent. And as a result, if you want to publish about an individual patient you have to hide so much about them that if you're using current patients, you're writing fiction.

NG: Mm-hm.

HK: It's this odd thing that we can't talk about the best examples of what it is we see on a current basis.

NG: Right. We can't talk about our current patients. You either use historical figures or nobody.

HK: Or you make somebody up. But you got to make sure you can't trace their zip code, right?

NG: Right.

HK: Or anything about them that somebody on a journey from Mars might be able to figure out. You can't talk about it, and as a result I wonder whether our understanding of psychiatry has been negatively affected—if what we want to do when we talk about conditions of mania, we have to go back to get our examples from people who've been dead for 100 years?

NG: Well, mania's a good example because living patients, 50% of the time falsely deny their manic symptoms. So it's a perception based on the lack of understanding of psychiatry to think that if you don't have a living patient, you can't make a diagnosis. Beside that issue,

of course we have a lot of primary sources. All of the diagnoses I made in *A First-Rate Madness* were based on primary sources in every single case—including not just the memoirs of others, which gives you the outside information that you need— and letters and medical records—but the historical figures themselves, usually. And that's like talking to the person.

HK: How do we know—you have a fuller picture about [John F.] Kennedy, for instance, than anyone so far has in psychiatry, because you've got his use of drugs that other people haven't talked about. I remember years ago when the Freud archives were slowly published that it turned out people had written volumes on Freud and some of Freud's patients, but so many things had been left out that it was all wrong. Even Freud's notion of conversion hysteria—it turned out these original patients didn't say anything the way Freud said they did. But this couldn't be published because the people that controlled the archives kept it out. In the Kennedy situation, is it possible that there are more things being held back?

NG: I think so, because his medical records have only been available in the last 10 years and I'm the first psychiatrist to go through them. I think only a handful of physicians have looked at them. And you know, archival research in history is a lot like research in medicine or psychiatry: you're looking for facts, and facts that nobody knew before. And it's documented right there in front of you. For instance, I found that Kennedy was treated with antipsychotics in the White House. This is a fact nobody ever knew before, we discovered it, and it's going to be fact until the end of time. So I think I'm qualified to do that kind of historical research.

The interesting thing is that I've talked to other historians, like Michael Fellman, who's our friend, and did the great biography of William Sherman that got me started on this project. And after 100 years of Sherman being dead—and Sherman wrote lengthy memoirs and there's been lots of personal letters that people dug up—nobody was able to put it together and say that look, Sherman had psychotic mania: that's why he was removed from command, and the headlines say, "General Sherman Insane." And he had severe recurrent depression; that's why in his letters he constantly talked about killing himself. Fellman was willing to do that; most historians weren't. And it wasn't because the facts weren't there. It isn't because historical scholarship didn't allow it; Fellman is as much a card-carrying historian as you can get. It's because in the discipline of history, they've systematically excluded psychiatry or any kind of psychiatric thinking from most of this discussion—in the way that I talk about the biology of psychiatry for instance. Not in psychoanalytic thinking, because it has been discussed some.

HK: Two things. One, I think there are a lot of biographies that do what Fellman did. For instance, there's a new biography of George Kennan and it doesn't practice psychology but in fact it's descriptive in the same way that Fellman's book is, so that someone could then read into [it]. And then there's the old-fashioned thing which you've rejected—or you say you have—which is psychoanalytic history.

NG: Right. All history practices psychology because all historians are making common-sense psychological judgment about why historical figures did x, y or z. But they're actually not trained to see when those judgments might have been influenced by psychiatric illness.

So in fact the historians who are practicing without a license are historians who are not psychiatrists like me. And I'm bringing in something here that historians have been—as many have told me themselves—uneducated about, unable to make judgments because of their lack of education.

HK: I think one could say about humanists in general—but historians as well—is that it's not just psychiatry they don't talk about, it never occurred to them to talk about, until recently, epidemic disease as a factor in history, or just regular physiological disorders.

NG: Right.

HK: We had a President of the United States who had polio myelitis and most of the country didn't understand what that really meant. They still don't understand what that meant. There's another issue with historians. If there were 6 historians in this room right now, and you were to say you'd found a fact, they would dispute that. They would say that you've interpreted a document. And their argument is that history is a series of interpretations. That's why there's so many books over time. Because the interpretations change, new evidence comes in—but it's actually less evidence-driven then it is truly the notion that we have new ways of doing history. And in a way that's parallel in medicine.

NG: Yes it is.

HK: Because many things that were done in medicine work—[just] like the explanations of historians were good at that time. And they solved a lot of the problems. For example, an antacid can actually control an ulcer, especially if it has antibiotic properties to it. But giving antacids for depression is not going to get anywhere close to the root cause. So what we have in medicine is always a tentative intervention, and that's its strength— which is that it's not ideologically based, everyone understands it's tentative. Which is what you consider postmodern—

NG: No. That's the nature of science, that truth is corrected error.

HK: I think that's probably what historians are doing. Now you can always add in more tools to do history.

2.3 "The way people have practiced history is antipsychiatrically reductionistic."

NG: Right. Now the way people have practiced history is antipsychiatrically reductionistic. They want to leave out everything that's psychiatric or even generally psychological. And the facts are obviously to be interpreted; that's the case with everything. But it's a mistake when you ignore facts so that you make no interpretation of them. For instance, Martin Luther King and Mahatma Ghandi made suicide attempts when they were preteens; that's been ignored by everybody. We may differ on the interpretation of it, but we shouldn't ignore it.

HK: I agree. But most historians don't do biographies; now, a small number of some of them do biographies and some of them do them very well. And some them have psychological insights; it depends on when they were done and what's expected, etc. But most historians write about cultural groups and those sort of things. So I guess a question would be how can we use kinds of insights you're brought in your new book to serve social and cultural history? How would we be able to carry them over?

NG: I think my contribution here is consistent with social and cultural history. What I'm saying is that in times of crisis, people with mania, depression, or mild versions of those symptoms, are better leaders than average healthy people. And that in times of non- crisis, it's the opposite: normal healthy leaders are better than the mentally ill. So that it's not just having the mental illness that's what's needed, but it's the interaction with the crisis—with the social circumstances. So people who are doing social and cultural history—to the extent that that history is relating to specific individuals—this would be another factor, the biology and how it interacts.

HK: You know, it's interesting when you talk about mental health—we work in the other program, Predictive Health, and nobody can define what we mean by health—it's sort of a big black box. But you actually draw on a definition by a very famous psychoanalyst, Roy Grinker, Sr—and when you read what's normal from Grinker's approach, which I think you more or less endorse—

NG: Mm-hm.

HK: they seem like the most boring, uninteresting—I mean, who'd want to be normal if that's what normality is? I have a PhD student who's working in addiction. And one of the things that's clear in the history of addiction is that humans have constantly tried to alter their consciousness through substances. So therefore, is there such a thing as normal? Because if normal means that you're not trying to alter your consciousness, it means essentially you're going to have a very boring existence. So maybe this whole notion of normal needs more investigation.

NG: I think that is part of what I'm getting at here. People have had positive and negative reactions to my ideas, almost in an allergic, immediate way. And I think that in the negative side they have to do with a stigma against mental illness, kind of a prejudice, like racism, that's unconscious. But there's another aspect that may be more philosophical, because there's been a long philosophical discussion about what health is and what illness is, and also specifically what mental health and mental illness are. And one general idea is that illness is inherently harmful, and health is inherently good. In other words, there's a value judgment, an ethical judgment that we attach to these concepts, which is debatable. You could defend it; but you can also defend the notion that illness and health could be seen from a purely biological scientific perspective, and that our ethical judgments are extra, so that we can have diseases or illnesses that are harmful, or diseases or illnesses that are not harmful. And you can have both at the same time: some harms and some benefits. And that's essentially what I'm describing. And because that goes against this common but simplistic connection of the value judgment to illness is negative, and the value judgment to health is good, it's confusing.

2.4 The benefits of madness

HK: It might depend, though. Exposure to certain sorts of bacteria create a certain kind of physical resilience and protection. But certain kinds of exposures kill. And if you're dead, that's not a good thing, right? So the word "disease" itself can be almost anything, but strictly speaking it means something which can do harm to your body— pathophysiology and etiology, as opposed to say, syndromes, where say psychiatrists are looking at signs and symptoms. So from that point of view, you can understand where no exposure to illness can create a much greater [threat] than if exposure takes place. Take for example, Epstein Barr: you're going to have a much worse outcome if you get it when you're 40. The same is true of chicken pox. So can we make the same analogy with mental illnesses, with these syndromes, that there's a better time to have exposure? So that maybe Gandhi--and others who had a severe childhood disorders fairly young—it became something that protected them instead of something that attached to them forever?

NG: I think these are the questions we should be asking. And it's also just like in physical illnesses—not all physical illnesses have benefits. Many don't. Many have almost no benefits. Same thing with mental illnesses. I'm focusing on mania and depression, not on schizophrenia.

HK: So the title of your book—I understand [it] from a marketing point of view—but normally when people use the term madness, especially lately (and historically), they're often talking about much more severe mental disorders, schizophrenia—

NG: Right.

HK: --bipolar disorder, of course, is a serious illness. So we have this category now, major depressive disorder, which is a grab-bag of depressive disorders. I wonder whether by lumping these things together for one person, we're really missing the nuance. We call them the same thing, but we don't really know they're the same thing. We don't know that all schizophrenia's the same thing.

NG: No.

HK: So it's pretty helpful to know which ones you'd want to be exposed to early and which ones you wouldn't.

NG: Right. I think in the popular mind madness can connote psychosis, which means delusions or hallucinations. And we're not focusing on that, that's not what I'm talking about here.

HK: It is your title, right?

NG: On the other hand, [with] manic depression, up to 50% of patients will have brief psychotic symptoms during their lifetime, so it's consistent with that, it's just they're not chronically psychotic all the time like schizophrenics are. So you have to know the nuances

of it. You know there was an article a few years ago called, "What is the heartland of psychiatry?" And the heartland of psychiatry has been schizophrenia; that's what people have focused on the last 100 years. To some extent depression recently, but you could make the argument that it should be manic depression or bipolar disorder. It's very common; it happens in 1 or 2% of the population at least, maybe up to 5% if you define it broadly—severe depression happens in 5-10% of the population. All that is 5-10 times more than schizophrenia, so it's much more common. And when you go back and look at how the term "madness" has been used over centuries, usually writers are referring to melancholia—severe depression—or mania. They're not describing the chronic psychosis that we call schizophrenia. So I think it's a legitimate use of the term, both historically and scientifically.

HK: So, what about resilience? You write about resilience. In my course, we look at post-traumatic stress disorder, and the more you look at it, the more it becomes clear that sometimes you make the diagnosis so prematurely that anyone who's gone through a serious, stressful event—you know, it's possible that people can go through serious stressful events and then find ways to deal with them without being given a diagnosis— and it would be a little weird if you went through a stressful event and had *no* negative results. Then there's the argument in the new DSM that we're going to change the time at which we consider treatment for [grief]. So what do you think about this? Are we moving to make diagnoses too quickly?

NG: I'm not sure where I stand on that; I don't have a general stance on it. In terms of the specific grief issue, I'm sympathetic to the changes in the DSM-V. I think the cutoffs are arbitrary and people are devising the cutoffs based on whether they want people to be treated, which I think is the wrong way to approach it to begin with; we should let the science guide it and then clinicians should be educated about when it's appropriate to treat or not. These are two separate issues.

HK: We both know that given the wide variety of talents in any profession, that some people are just going to do it by the book. And so the net result will be just—

NG: I have to say that I'm sympathetic to critics of the DSM, but not for the usual reasons. I think that the idea that we have to have a book that enforces ideas on things like that is excessive; I think there should be more clinical freedom.

HK: That's very difficult in the litigious world in which we live. What about posttraumatic stress disorder? Do you think we over-treat or under-treat that? We used to consider posttraumatic stress an event—now it's a repressed memory for some people.

NG: Well, as you know Howard, the way I think about psychiatry is that there are essentially two classes of patients or people. One class is more biological-- and I sort of insist on using the word "disease"-based—and that would be schizophrenia and bipolar disorder and severe depression, which is what I'm writing about in *A First-rate Madness.* But the other group is everything else—a lot of PTSD patients, people with personality abnormalities, anxiety conditions, what I term stress-related problems. Those probably are not genetic; in fact, we know they're not genetic very much, they're much more environmental. And I think

in our culture today we use drugs for all those classes. And in my view, if we're talking about the non-biological, less disease-oriented conditions, we should use drugs a lot less. But in the disease-oriented conditions, in fact we might not be using the drugs enough, or the right ones at least. So in my view in the PTSD case, we're probably overusing the drugs.

HK: Another thing with PTSD is that there are probably people who come with prior condition that we don't know about. In fact the military is supposed to exclude people with bipolar disorder from service; they're supposed to.

NG: Are they really?

HK: Mm-hm. But the way they do it depends upon the market conditions.

NG: We did a study and found that people with bipolar disorder had *less* PTSD than people who don't have bipolar disorder.

HK: Well I mean just in general they keep bipolar people out because of the high suicide rate. But then with the PTSD there may be just a life history that we don't know about that would make some people more vulnerable and others not.
But the interesting thing about the pharmacology of psychiatry is that we spend a lot of time carefully making a diagnosis to separate out different disorders. And then move from one drug to the other, pretty much using the exact same drugs for different conditions. So what's going on here?

NG: I don't think we spend a lot of time carefully making diagnoses. Doctors tend to take a symptom-oriented approach. They treat the symptoms with drugs; that's what psychiatrists routinely do these days, as opposed to carefully getting a diagnosis and figuring out which ones need drugs and which ones don't need drugs.

HK: The drugs themselves though-- it is odd that we call them "atypicals," assumed that the "typicals" were based on a hypothesis that we no longer accept, which is the amine hypothesis—that somehow or other the reason you're depressed is that you don't have enough serotonin.

NG: In my view, that's very speculative. Even though it's biology and it sounds like science, it's very speculative.

HK: So where are we with these sorts of things? How do you understand the mechanisms of depression?

NG: Well, depression is not a disease. As you said, major depressive disorder is a very broad category. So when part of that category—people who have very severe, episodic, melancholic depression (used to be called manic depression)—and the biology of their depression is really not so much the biology of the depression [itself], it's the biology of cycling into and out of the episodes. And so we have at least some research suggesting that circadian rhythms may be relevant, clock genes may be relevant, and it's the abnormality of

the circadian rhythms that may be sending people into periods of under-activity and then over-activity.

2.5 What about learning disabilities? Are there benefits to those?

HK: I know you don't work with these so much, but I've been very involved lately with looking at the kinds of mechanisms that are called learning disabilities. Would you consider learning disabilities –the major ones being attentional disorders, things like autisms, Tourette's syndrome, stuttering disorders, dyslexias—would they fit your model? From my point of view, these are disorders of laterality.

NG: There's a range of neurodevelopmental disorders in children. They could fit my model in terms of the disease model, in that they may just represent abnormalities of the body or the brain at that early age in life. Sometimes it's a stepping stage to something else, like a lot of people have attentional impairment as kids, even OCD symptoms, sometimes Tourette's, and then later develop bipolar disorder. Probably there's something neurodevelopmentally abnormal that, over time, changes in its presentation. But in other people, that's what they have. And in some other people, they have it for a while, and then the brain changes and it goes away. So I think it does fit the disease model but maybe with those nuances.

HK: Developmental disorders are really interesting things, and I think probably understanding the brain better than we do is going to make a really big difference in making sense of these. And there may be a spectrum, as you suggest, which makes the analogy to normal kinds of the infectious diseases not so good—because you don't normally move from cold to pneumonia. You're not going to get the chicken pox because you had a fever. But it's interesting that even in the issues you're talking about, which go back to childhood, there hasn't been much discussion from the psychiatric point of view about neural development. Remember when bedwetting used to be seen as a psychiatric disorder? Now we see it as a neurofunctional disorder of late development. So how are we going to be able to put these things together? Because I feel that what I'm doing [in studying laterality and neural development] doesn't really carry over [to psychiatry]. What I'm looking at are language disorders. What you're looking at are not so much language disorders. Maybe there's a different class.

NG: I wouldn't be surprised if there's a different class—or even a different part of the brain involved. More prefrontal, less language-related.

HK: So maybe schizophrenia is not on the spectrum on biopolar disorder.

NG: I'm not a believer in that theory. I think they are different. There's a good deal of work, as you know, on the neurodevelopmental hypothesis of schizophrenia. There's even some work on bipolar disorder. The overlap that exists between the two is very little from an epidemiological perspective. And even from a biological perspective, it's very little when you

look at the fact that one illness is recurrent and episodic—it comes and goes—and the other is not.

HK: Schizophrenia is somewhat recurrent, but over a longer period of time. Some people get better—but maybe their diagnosis is wrong. It's possible. But there is a difference in language. Although it may sound like a bipolar patient is using language in a sort of bizarre and florid way, they make much more sense than schizophrenics using language.

NG: Yes. Except maybe at the height of very severe manic symptoms.

HK: So there's still a lot of work to be done.

NG: Mm-hm.

2.6 Left-wing hypocrisy and mental illness

HK: So I look forward to seeing how historians react.

NG: Well I think I was expecting to have some historical criticism from historians who were just disinclined to include psychiatry and psychology in history. But instead what we've had is a very immediate reaction from people in the world of arts and letters who seem disinclined in general to let science be part of the discussion.

HK: Well I think when we talk about creativity, they have made this connection many times—with Fitzgerald, Hemingway or other people—that there's a relationship between their creativity and their depression. But the idea that this would carry over to politics, I don't think they want.

NG: Well, it's interesting, because it's been well proven also in studies that artists and writers have much higher levels mood disorders than the general population or control groups. So I expected writers and artists to be able to understand what I was saying. But maybe one factor is just as you've said that people may be more willing to accept that people on the periphery of society, the writers and the artists, can have these conditions—but to say that it's the political leaders, business leaders, military leaders, the ones in the very center of society—since they hold the power, it's more disconcerting.

HK: Although it seems surprising that these people would be critical of that as they're very critical of people in leadership to begin with, and they often think they're crazy. How many more humanists think that Richard Nixon's crazy than think John Kennedy is?

NG: What's interesting about this is that people who are in the left-liberal wing of our culture—I don't disagree with them socially or culturally—they're very open and progressive about racism, sexism, homosexuality for instance. But they don't even think twice about making prejudicial statements in relation to mental illness.

HK: Well, it's not that surprising. If you think about [it], we work in public health, and [there are] two illnesses we're trying to cure all the time. One is cigarette smoking, and [public health professionals] discriminate against cigarette smoking, even though [smokers] are using nicotine as self-medication and they turn out to be poor, non-white, and in desperate need of medication, the solution is to charge them more for healthcare and make it harder for them to get the healthcare they need. The other is the obesity epidemic. I had a student who went around and tried to explain to all the other public health students that if someone is morbidly obese, it's not because they ate themselves there. In terms of overweight, the evidence shows that being overweight is not a health threat, in fact it can be protective—and also the reason that most people have the [associated] illnesses has to do with their genetics, it has almost nothing to do with their behaviors. Nevertheless, even though they want to "stop obesity," they're [the public health students] very bigoted against these people. So there's a kind of discomfort among the left—I think it's fair to say that the school of public health is more socially oriented than interventionist in general—there's a kind of stigmatization of these people, who also by the way—overweight people who are discriminated against also suffer from mental illness in part because the effects of discrimination are quite bad. And cigarette smokers are certainly among those who have higher rates of mental disorders. So although they pretend to care about them, they don't really like them and they make their lives miserable. So I wonder if there's not some way if we thought about it long enough, that this is also what's going on with mental illness. That is, that people can all talk about how we care about the mentally ill, but they're very uncomfortable around them. And they're very uncomfortable around obese people, and they're very uncomfortable around cigarette smokers. And so they tend to segregate them—not necessarily through a conscious process, but through a kind of dynamic. Maybe that's part of the pushback you're feeling.

NG: I wonder if part of the stigma I've observed is that people might be willing to say superficially that being against mental illness is morally wrong, but when you show them the evidence that it's *scientifically wrong,* that it's *historically wrong,* they fight back. Which means that they haven't really absorbed the notion that stigma is not right.

HK: I think most people who've had experience with the mentally ill feel pretty helpless around it. And though they see it as an illness, it's pretty hard to separate the illness from the personality themselves. So there is a kind of continued segregation. There's an accepted kind of way we're supposed to look and act in our society, and the curious thing is that the people who keep arguing for diversity seem to be less open to [challenging this expectation] than the people who don't [argue for diversity].

NG: It's curious.

HK: It is curious. But maybe these breakdowns are just about finished.

NG: They may not explain these issues. Some of it may also be that the mainstream media establishment in our country is a little more liberal than not, and the outside [society] is a little more conservative. And so part of it might be that when you're an insider, you tend to

reject new ideas and when you're an outsider, you tend to be a little more open to it, irrespective of what your specific ideology is.

HK: In this new biography of George Kennan, Kennan spent his whole life trying to deal with American foreign policy, but he spent almost no time in America—he didn't like the average American very much. So there's this kind of old liberal bias—there's a kind of caring for people, but there's also a kind of contempt for the ordinary.

NG: Loving humanity, but not loving human beings.

HK: So it probably hasn't changed much, but it does seem to me that trying to set everything on the liberal or conservative side—we have a more complicated universe now.

NG: I'm not sure how much of this is right, but I do know that in the reaction to my book that I've observed, it's been very complicated and there's no simple way of understanding why people hit on one side or the other of this question.

HK: You may have hit it. The establishment maintains itself as the establishment, despite whether it's on the left or the right, it's much more comfortable with other representatives of the establishment.

NG: Yep.

HK: Well, thanks.

NG: Thanks.