Chapter 10

Bipolar Disorder and Western Anosognosia

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INTRODUCTION

Mood disorders—principally forms of depression and bipolar disorder—constitute some of the most ravaging illnesses of the modern world. The morbidity and mortality is comparable to such diseases as hypertension, coronary artery disease, and diabetes mellitus. The suffering that results in diminished work productivity, familial stress or loss, and, frequently, suicide, wreaks a tremendous toll not only on individuals but also on families and society.

Research by Gerald Klerman and colleagues (1985) suggests that the incidence of mood disorders may be increasing, especially in the younger age groups, and that this may be associated with the rising rates of alcohol and substance abuse. In addition, both depression and bipolar disorder are now being seen and diagnosed more frequently in children as well.

Major depression has a lifetime prevalence of about 10 to 25 percent for women, and 5 to 12 percent for men (Blazer et al., 1994). Bipolar disorder, in contrast, has a lifetime prevalence of about 2 percent and manifests relatively evenly in both men and women, but typically has a more devastating course. This means that about 5 mil-

lion people in the United States alone suffer from bipolar disorder. Fifteen to 20 percent of these people will commit suicide eventually, and many more than that will make repeated, unsuccessful attempts to end their lives. Even without suicide, a woman who is diagnosed with the illness at age twenty-five will lose, on average, about fourteen years of effective lifetime functioning (Sadock and Sadock, 2000).

In this chapter, I outline our peculiarly Western anosognosia as it bears on traditional conceptions and treatments of psychiatric illness—in this case, bipolar disorder—and point in a direction that I find theoretically useful. I will describe some of the relatively unexamined assumptions that have influenced current approaches and then illustrate how these approaches, though important, do not always account for the whole picture or what people actually experience. A narrow Western ontology often introduces unnecessary resistance into the relationship between the doctor and his or her patient and leaves many patients feeling lost or unfairly pathologized. As a result, patients feel bereft, without a path that reconciles their deep inner longings with the need for a concrete and well-grounded life.

BIPOLAR DISORDER AND THE HISTORICAL STRENGTHS AND LIMITS OF WESTERN THOUGHT

Ancient writings clearly indicate that disorders of mood have existed for thousands of years and that few illnesses plague human life and culture with such regularity. Hippocrates (460-377 B.C.) distinguished melancholia from mania and argued that melancholia was a biochemical abnormality related to the overproduction of one of the dark humors (black bile). Under the influence of the planet Saturn, the melancholic temperament made the spleen secrete black bile, and this resulted in a darkened mood.

Mania, or a state of raving madness with exalted mood, was also described by the ancient Greeks. Although a few others commented briefly on it, Aretaeus of Cappadocia (ca. A.D. 150) is generally credited with making the clearest connection between melancholia and mania. His description shows how little has changed:

> There are infinite forms of mania but the disease is one. If mania is associated with joy, the patient may laugh, play, dance night and day, and go to the market crowned as if victor in some contest of skill. The ideas the patients have are infinite. They believe they are experts in astronomy, philosophy, or poetry. . . . The patient may become excitable, suspicious, and irritable; hearing may become sharp . . . [he may hear] noises and buzzing [in] the ears; or may have visual hallucinations; bad dreams and his sexual desires may get uncontrollable; aroused to anger, he may become wholly mad and run unrestrainedly, roar aloud; kill his keepers, and lay violent hands upon himself. . . . They are prone to change their mind readily; to become base, mean-spirited, illiberal, and in a little time extravagant, munificent, not from any virtue of the soul, but from the changeableness of the disease. (cited in Sadock and Sadock, 2000, p. 1286)

The Greeks based their concepts of health and illness on the harmony and balance of the four humors (Sadock and Sadock, 2000, p. 1287). The sanguine humor (blood), which was thought to promote amiability and activity, could in excess lead to mania, as could a mixture of black and yellow bile (yellow bile was thought to make people choleric; e.g., irritable and hostile).

Over the course of the following centuries, discussions about mania and depression, and of illness in general, occurred in the context of the developing intellectual categories that over time have come to characterize Western culture. The Cartesian crystallization of this approach that took root during the Enlightenment in seventeenth-century Europe posited, in its quest for clear, indubitable knowledge and freedom from ecclesiastical heteronomy, that truth about the natural world could be obtained only from the evidence of the five senses. This not only liberated scientists to explore the natural world, but also sharply separated different spheres of knowledge from one another.

This shift occurred over the course of several centuries and was captured in some of its most dramatic moments by such men as Copernicus or Galileo, when they argued for theories of the natural world to be based on physical evidence rather than theological decree. This bid was important because of the way in which, over a period of many centuries, truth about the natural and spiritual worlds

had devolved to decisions made by ecclesiastical authorities that were then externally imposed on people's lives. The essential correlation between the inner longings of the heart to know God and an institutional structure that supports and nourishes those longings was lost, at least to some degree, and truth about either oneself or the natural world was no longer rooted in personal experience as much as in papal bulls. So, as the following will show, the integration of matters psychiatric and spiritual should not just be about the correlation of psychiatric and theological knowledge. One must also ask how these disciplines and their institutional commitments, particularly in regard to their conceptions about the locus of power and authority, bear on the individual human person.

The bid for a new medicine that was devoted to both the evidence of the five senses and to human rights found one of its clearest expressions in Philippe Pinel's (1745-1826) advocacy for humane treatment of the mentally ill. This advance paved the way for a medicine and psychiatry based on observation and descriptive nosology rather than on externally imposed moral and theological categories. The modern approach to bipolar disorder was then firmly established on clinical grounds by the painstaking methodology and longitudinal observations of Emil Kraepelin (1856-1926). In 1899, he described manic depression in a form that matches most of the criteria used to diagnose bipolar I disorder today. Since then, the biological basis of bipolar disorder and its susceptibility to medical treatment have received considerable attention. Given the deeply human tendency to place moral judgments on what is not adequately understood, there has fortunately been relatively less emphasis on etiologies that root bipolar disorder simply in debauchery, drunkenness, or immoderate lifestyles.

TRADITIONAL DIAGNOSIS

Mood disorders are diagnosed more frequently than they used to be, not only because they seem to be more prevalent but also because symptoms that used to be subscribed under the rubric of schizophrenia or character disorders are now considered to have an underlying basis in mood. This conceptual shift is due to several factors. First, a

comparison of diagnostic practices and patterns in the United States and Britain yielded the surprising result that patients in the United States had a higher likelihood of being diagnosed with schizophrenia than their British counterparts, even though the symptoms were similar. This awareness helped shift the diagnostic landscape. In addition, the discovery that many patients thought to have relatively intractable character disorders respond positively to the newer antidepressants also has led psychiatrists to believe that what were formerly considered problems of character are actually disorders of mood (Akiskal and McKinney, 1973).

Mood disorders are usually distinguished, most broadly, by their polarity: unipolar (depressive episodes only) and bipolar (depressive episodes alternating with manic, hypomanic, or mixed episodes).[1] It is not unusual for a person who was originally diagnosed with unipolar depression to eventually have, usually during a time of severe personal stress, a first episode of mania, and to subsequently suffer from bipolar disorder. Thereafter, the bipolar highs and lows typically become more extreme and more frequent, with greater devastation not only in the patient's life but also in the lives of loved ones. It used to be thought that manic or hypomanic symptoms were found, by definition, only in the context of preceding depressive episodes. In fact a small minority of patients do experience manic or hypomanic symptoms without clear episodes of depression. Most patients with periods of elevated mood, however, do have an identifiable history of experiencing symptoms at the depressive "pole."

Although depression and mixed states are more common in women than men (about 2:1), frank mania occurs more often in men. In addition, although depression is more common during the dark months of winter, during the spring hospital wards swell with people experiencing manic exacerbations ("springtime madness"). Bipolar disorder also occurs more frequently and at an earlier age of onset in those who have suffered sexual, physical, or mental abuse during childhood.

The DSM-IV-TR discusses four different bipolar disorders: bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder NOS (or "not otherwise specified"). They are diagnosed when at least one episode of mania, hypomania, or mixed symptoms has occurred. Bipolar I disorder is the classic form of bipolar disorder that is sufficiently severe to markedly impair occupational and social

functioning, often requires hospitalization to prevent harm to oneself or others, and may include psychotic features (see Exhibit 10.1). The mania often escalates over a period of one or two weeks and may include grandiosity or inflated self-esteem, as well as a diminished need for sleep. The person may talk, seemingly without end, and often with pressured speech. The person's thoughts may seem to race wildly from one topic to another, and he or she may run from activity

EXHIBIT 10.1. Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   (1) inflated self-esteem or grandiosity
   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   (3) more talkative than usual or pressure to keep talking
   (4) flight of ideas or subjective experience that thoughts are racing
   (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a Mixed Episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

to activity with either euphoria or agitation and hostility. Often an increase in risky behaviors occurs that has a high likelihood of bringing about painful consequences to the person, such as excessive spending, poor business decisions, or sexual indiscretions. A person may become frankly psychotic, for example, believing that he or she can fly or that the FBI is tracking every move. Suicidal actions are often precipitated, either as accidents that result from the person's poor decision making or because of the sheer suffering associated with being unable to sleep for days on end.

The other forms of bipolar disorder vary from type I only in that the symptoms are less extreme (type II), less severe but more chronic (cyclothymia), or either less classic in their presentation or during a situation when the exact etiology is still being determined (NOS). To make a diagnosis of bipolar disorder, one must first rule out medical or substance abuse-related causes as well as the influence of other medicines, and adequately differentiate the bipolar symptoms from other mood or thought disorders.

Before moving on, a few comments should be made about the genetic and neurobiological correlates of bipolar disorder. The evidence for a genetic basis for bipolar disorder is stronger than that for major depression. A more robust connection exists between the incidence of the disorder in individuals and its occurrence in their biological parents. Also, when monozygotic and dizygotic twins are considered, a higher concordance rate for bipolar disorder is found among monozygotic twins.

Recent advances indicate the presence of multiple areas of neurobiological vulnerability in bipolar disorder, not only in the arena of mood but also in cognition, motor skills, and reward mechanisms. PET scans and functional MRIs reveal changes in blood flow and glucose utilization. Also, alterations occur in the thalamic output of corticotropin-releasing hormones involved in the release of stress hormones.

TRADITIONAL TREATMENT

Although the research and clinical literature is abundant with both psychotherapeutic and psychopharmacological strategies for the treat-

ment of major depression, the literature for bipolar disorder deals almost exclusively with pharmacological solutions. This is most likely due not only to the fact that modern bipolar treatment began with the discovery of lithium's dramatic efficacy in the treatment of mania, but also because it is rarely easy nor possible to have a productive discussion with someone who is manic. Psychotherapeutic approaches are critical to the care and management of bipolar disorder but in many cases cannot become a central part of treatment until the person can tolerate useful discussions.

Treatment has evolved in recent years from a model that emphasizes the degree to which bipolar disorder is related to matters of consciousness and will to a model more akin to that of modern cancer treatment. In the latter model, early diagnosis and aggressive techniques are considered the mainstays of treatment. Patients typically do not recognize that their poor judgment and sexual or financial risk-taking behaviors are actually symptoms of a medical illness that requires rapid and aggressive treatment. Many patients, particularly during the early stages of mania, feel smarter and love how they feel, and they often prefer to stay as far away as possible from the terrible hopelessness of depression. They feel adamant that, with a little less sleep or a little "extra energy," they can join just one more committee or perform just a little better at work. Unfortunately, in many cases, sustained hypomania is the goal but frank mania is the inevitable result.

Because the personal and familial costs associated with bipolar disorder are so high, good treatment is critically related to early detection and rapid intervention. Because it is a chronic illness that often worsens over time, especially without intervention, treatments frequently are long term and prophylactic in nature. Some of the research suggests that a person with a first bipolar episode who has a positive family history should be started on long-term prophylactic treatment, and that doing so actually has a neuroprotective effect against the brain changes that occur with subsequent episodes.

The modern era of bipolar disorder treatment began when lithium, a natural element found in the periodic table of elements, was found to be dramatically helpful in the treatment of bipolar symptoms. This discovery revolutionized treatment during the second half of the twentieth century, though the past twenty years have seen its use

relativized by growing concerns about its safety and the discovery of other effective medicines. The long-term effects on the kidney and the need for patients to undergo blood draws as often as every month to ensure that the lithium remains within a narrow therapeutic window renders its use difficult in many situations. In addition, in recent years, lithium use has been offset by several other medicines. Depakote or Tegretol, for example, seem to do a better job at stabilizing rapid cycling, dysphoric, or paranoid mania as well as recurrent episodes. A variety of medicines are used when combination pharmacotherapy is indicated. Benzodiazepines and antipsychotics are frequently prescribed, especially for the acute stabilization of mood. The newer serotonin-dopamine antagonists, such as Zyprexa, Seroquel, Clozapine, Risperdal, and occasionally Abilify are also proving to be quite helpful.

Treatment is often divided into the three general phases of acute care, continuation treatment, and long-term prophylaxis. Somewhat well-established standards exist for the kinds of treatment that research and clinical lore suggest are most helpful during each of these phases. The patient and his or her family need to be thoroughly educated about each of these stages in an ongoing manner, and the clinician should expect that patients will, for a longer or shorter period of time, experiment with the need for medicines, particularly when they feel euthymic (the medications no longer seem necessary) or manic (they like how they feel). Patients and families require a great deal of assistance in understanding how morbid or lethal the consequences can be of not taking the medications and sometimes are helped by knowing that approximately 50 percent of patients relapse within the first five months after discontinuing their medications, and 80 to 90 percent within the first 1.5 years (Sadock and Sadock, 2000). They also should know that going off and on medicines repeatedly seems to breed medication-resistant symptoms.

Both the patient and his or her family need to become as clear as possible about the early warning signs and predictors of relapse. For some people, this will be two nights in a row with less than four hours of sleep. For others, the patient's concentration will become poor or he or she will begin joining extra committees at work. Whatever it is for that particular individual, the signs must be recognized as soon as possible so that a full relapse can be averted.

Assistance in developing self-care skills is also critical, since the normalization of sleep, diet, and exercise as well as the reestablishment of healthy relationships go a long way toward stabilizing the mood. After the person has begun to stabilize, it is important to help him or her gain insight into the illness and take appropriate responsibility for the actions that have already occurred, as well as for what can be done to develop problem-solving and communication skills that will avert damage when symptoms recur in the future.

One approach that is particularly helpful involves the use of mood charts that record the relative highs and lows of mood as well as the frequency of fluctuations over the individual's lifetime. These charts can contain a great quantity of information and their pictorial nature often facilitates patients' understanding of how the illness affects them, as well as how mood symptoms have fluctuated with major life events, stressors, holidays, or different seasons. One of the most difficult aspects of treating bipolar disorder is the split that often occurs between subjective perception and the relatively objective observations by others. These charts help reintegrate the subjective and objective aspects of the illness because the patients are often surprised to recognize—often on their own as they construct the chart—that things were not quite as they thought, that a medicine that did not feel helpful at the time actually was associated with one of their better periods of functioning, in spite of significant stress, etc. Also, as the completion of the chart requires consultation on the part of the patient with other family members or friends, past events become clarified and agreement is more easily reached on the relationship of the person's mood to these events.

AN INTEGRATIVE APPROACH

When I was a medical student and on the neurology rotation, I took care of a woman who had suffered a stroke in her right hemisphere. She had what is called anosognosia, which means that she was not aware that she had a neurological deficit. In her case, because of the particular location of her stroke, she was unaware that the left half of the world existed. When I asked her to draw a clock, she drew only its right half. When I lifted her left arm and held it in front of her eyes so

that she could see it, she thought that the arm was mine. When I tried to show her that the arm was hers, she repeatedly insisted that that was impossible. She kept her head turned to the right side of the room and at that time had no mental construct for comprehending or even learning that a left half of the world or a left half of her body existed.

This, I believe, is not too far from the situation in which the Western mind currently finds itself in regard to understanding some of the capacities that for the most part remain latent within the human psyche. Modern science has had a profound influence on the Western mind, to such an extent that many people find it nearly impossible to come to grips with any aspects of reality that do not conform to a strictly materialist vision. This, in spite of the fact that a careful reading of the great minds who established the intellectual basis for Western culture (e.g., Plato's Socrates, the teachers in the Greek mystery schools, and even Aristotle) reveals quite clearly that, for them, the epistemological quest, even in regard to knowledge of the physical world, contains an irreducible contribution from the knowing subject that transcends the evidence of the five senses. Modern physics and the autobiographies of great scientists also demonstrate how limited objectivist epistemologies have been. They cannot find a central place for a human person in flourishing and complex interaction with a real world.

One of the main theses of this chapter is that many things are going on in the world outside of the narrow band of reality so well defined by the Western intellectual tradition and that was, for example, such a central part of my medical school, residency, and even seminary trainings. My clinical experience indicates that many individuals live double lives, with experiences that they dare not tell psychiatrists or other clinicians, and even their families, for fear of being regarded as crazy. As I have listened to them, I have come to believe that some of them do not suffer from a mental illness, and that numinous or spiritual experiences, with adequate integration, can be overwhelmingly positive in their effects. These experiences often hold tremendous authority in individual lives because of the compelling beauty and luminosity with which they are associated or the way in which the experience is felt to have been uniquely crafted for them. They can facilitate surprising and dramatic shifts in the individual toward health and wholeness and sharply increase a person's capacity to give and re-

ceive love from others and work productively. The phenomenology of these experiences appear to transcend particular religious or cultural commitments. In other words, the external details of belief for a Jew, Muslim, or Christian may vary, but persons in any of these traditions or others may have experiences that follow surprisingly comparable patterns.

William James (1842-1910) was one of the earlier and more prominent Western thinkers to systematically explore states of healthy and higher consciousness. Since then, as Eastern philosophy has slowly devolved into the West, what is now called a transpersonal approach to psychiatry has developed. This approach accepts that more dimensions to human consciousness are present than have been readily acknowledged by the Western mind. James Fadiman described this approach to the human mind as follows:

> Transpersonal psychotherapy includes the full range of behavioral, emotional, and intellectual disorders as in traditional psychotherapies, as well as uncovering and supporting strivings for full self-actualization. The end state of psychotherapy is not seen as successful adjustment to the prevailing culture but rather the daily experience of that state called liberation, enlightenment, individuation, certainty or gnosis according to various [spiritual] traditions. (As cited by Boorstein, 1996, p. 3)

The orientation and scope of this type of spiritual psychology is different. The point is not to become "normal" but to seek the conditions that promote self-liberation so that one can become the self that one truly is within the context of a much larger ontology.

How does all of this relate to bipolar disorder? First, by this brief review of the history of the relationship between science and religion I hope to draw out some of the strengths and limits of current conceptual schemas for bipolar disorder. I am also trying to expose the vulnerability of all epistemological maps when inflexibly applied: They reduce the richness and mystery of human experience to something less than it actually is.

Current conceptions of bipolar disorder, helpful as they may be, are rooted in a Cartesian conceptual framework that falsely dichotomizes body from mind and analyzes various aspects of the person to

the neglect of adequate attention to the whole person. This type of problem plagues every aspect of modern medicine and especially in hospitals where, for example, the daily retinue of renal, neurological, and cardiac specialists contribute their sophisticated recommendations, but no one attends to the fact that the person is not eating or misunderstands the diagnosis and what he or she can be doing to help himself or herself.

From the perspective of ordinary medical science, bipolar disorder represents a cluster of symptoms that should be expunged. From the transpersonal or spiritual perspective discussed here, two issues place treatment in a larger context: first, the person is a person first and this, rather than any particular diagnosis or disease process, is the primary reality; second, even when the diagnostic criteria have been satisfied, higher levels of being and functioning occasionally reconfigure how bipolar symptoms are best understood.

The primacy of personhood is not merely a theoretical abstraction. Patients sense immediately—almost as soon as they walk in the door—whether they are seen primarily as individuals or as a "disease process," and if they sense the former, some sort of natural healing resources are galvanized within them. The patient is so much more than his or her symptoms. Understanding this generates a healthy ambivalence about current diagnostic classifications, not because of any particular problem with the diagnostic nomenclature, but because of the overwhelming tendency of modern medicine to focus on parts to the exclusion of the whole.

We have become accustomed to relegating apparent physical problems to the physician, psychological difficulties to the psychologist, and spiritual problems to the priest or minister. Though such distinctions are useful and have been critical to the development of Western capacities for specialization, what is generally not accounted for is the overarching reciprocity and interconnection that supercedes and overcomes all such distinctions. For it is the human person who stands behind all aspects of his or her personage and integrates them into a complex whole.

A person is not just his or her disease. He or she is also a spouse or an employee, a grandparent or a PTA parent, a person much like ourselves with aspirations, longings, and fears. The illness is more than a disease process; it is also an existential crisis in that person's life, and

in a way goes far beyond being simply an emotional response to the fact that they have been struck with an illness. Our illnesses often are more related to the consciousness with which we live our lives, with how we live and what we fear or are trying to learn than is easily understood within our current conceptual schemas. For example, the heart is more than a pump; it is also the vital epistemological organ with which we establish some sort of feeling connection with the world. Is it just coincidence that an overly analytical culture, which is relatively "cut off below the neck," also tops the list for incidence of heart disease? What we think, believe, feel, and commit ourselves to has a dramatic impact on what eventuates in our bodies.[2]

For complex historical reasons, the Western mind developed in such a way that emphasizes the persona that one reveals to the world over a more deeply ontological understanding of personhood. In other words, we tend to ascribe a relatively high ontological rank to appearances and rank-order them on a sort of hierarchy rather than paying primary attention to the reality that, from a spiritual perspective, all human beings are God's children, or children of the Divine Life. What tends to take relative primacy, then, is whether one is young or old, attractive or plain, successful or less so, sick or healthy—i.e., where one falls on the hierarchy. In such a setting, what matters is that one be "normal" and have as many attributes as possible that are regarded as desirable according to the hierarchy. What everyone privately knows at some level, however, is that the hierarchy is untrue and in fact rooted in fear. From a larger spiritual perspective, all persons are just that—persons—and the hierarchy of fear has no ontological reality.

In my experience, even Western theological systems have difficulty seeing the person from a larger perspective.[3] In the more mystical traditions, the human spirit (e.g., the "spiritual life") is not another aspect of the person as much as it is that which vitalizes the whole. The influence of Eastern spiritual writings (in this case, Eastern orthodox writings) helped me begin to see that the spiritual life of the human being has to do with that which surrounds and permeates both body and mind. In other words, spirit animates all other aspects of the person and is the life and meaning that the person brings to the world. This category is more human than theological, as theological is typically understood, in juxtaposition to the psychological and medical.

In a certain sense, it is the Life behind life. It is the unrepeatable, flourishing vitality that makes the person who he or she is.[4]

An approach to the world that emphasizes the wholeness of the human person has effects that radiate through all levels of theory and practice. In Eastern traditions, for example, insight and experience often weigh in over rational analysis and extended periods of psychotherapy. Unlike Western thought in which the psychological, ethical, and spiritual spheres are kept relatively separate, the Eastern traditions are full of stories in which these dimensions exist in a natural integration, which more easily promotes reflection and insight. For example:

> A Sufi sage once asked his disciples to tell him what their vanities had been before they began to study with him.
>
> The first said, "I imagined that I was the most handsome man in the world."
>
> The second said, "I believed that, since I was religious, I was one of the elect."
>
> The third said, "I believed I could teach."
>
> And the fourth said, "My vanity was greater than all these; for I believed that I could learn."
>
> The sage remarked: "And the fourth disciple's vanity remains the greatest, for his vanity is to show that he once had the greatest vanity." (Shah, 1972, p. 47)

Because the classical spiritual writings, particularly in the East, place relatively more emphasis on the common humanity shared by all, rather than ascribing much importance to the persona that one wears, overly sharp distinctions between the physician and the one who is ill lose their meaning. The first step of the fourfold path of Buddhist spirituality is to recognize that all is despair. In other words, although it may be less obvious in some rather than others, the existential situation is the same for all; only the details vary.[5]

A medicine rooted in this kind of ontology would look dramatically different. For such a medicine of the person to become a reality, physicians and clinicians would themselves need to undergo a particular type of inner development so that they could better understand both themselves and their patients. Many situations of mutual resis-

tance between doctor and patient would be eliminated with the simple understanding that their common humanity trumps the roles that they are each playing, in this case, of doctor and patient. The roles have their place in the same way that actors need to play their parts for the play to move forward; however, the astute clinician always senses when to lay aside the white coat and speak not as a doctor but as a human person.

The previous discussion mentioned that this type of spiritual psychology, or transpersonal approaches in general, accept that consciousness contains dimensions that are not readily accepted by traditional worldviews, and that such experiences are not necessarily pathological or symptoms that should simply be eliminated with medication. To begin seeing this is to have one's world begin to open.

For example, one of my first conscious encounters with a situation that went beyond the way I was used to thinking at that time was as follows. Approximately three years ago, when I was still a resident in psychiatry, a young man diagnosed with bipolar disorder began to see me shortly after becoming clean and sober for the first time. As I began to get to know him, I was surprised by how dedicated he was to sobriety and to obtaining a college degree. He had one of the most violent histories that I had seen. He was repeatedly beaten bloody by his alcoholic ex-Marine father until the day came when his father left the family forever. During the next few years he crouched in a corner while his mother repeatedly gave herself to different men in exchange for heroin—sometimes several times during the same evening. He left home after his mother approached him sexually. While living at his father's, his stepmother leveled a shotgun on him at one point and reportedly cheered his father on during the fistfights that occurred between them. At fifteen, he ran away from his father as well and spent the next ten years dealing drugs and fighting in gangs.

He was known on the service as a "difficult patient." I knew that he had had years of involvement with the mental health system—sometimes court-ordered—and that he also had a history of difficult relationships with the psychiatrists and clinicians who had been assigned to his care. I asked him why things were different now and what had helped him attain sobriety and begin such clear efforts for a new life. What he said surprised me.

He told me that he gave up the drugs and alcohol after his dead Native American grandmother, who herself had been alcoholic, appeared to him one night in a dream, sat down on the edge of his bed, and told him to give up the alcohol. He had been particularly struck by what he took to be her surprise at his tattoos, which he had not had during the years when she had been alive.

Shortly after that, he became clean and sober for the first time and began making plans for college. That dream did more for him in five minutes than ten years of regular contact with psychiatrists and other clinicians. With a few setbacks, the progress persisted, in spite of the fact that he continued to live in a slum with his mother and four angry and depressed, occasionally hard-drinking, veterans. He continued to see me for both low-dose medication and psychotherapy, but something essential had shifted and I was not so much treating an illness as I was helping him get to where he wanted to go. Accepting his experience as somehow important seemed to melt the resistances that had characterized many of his prior clinical relationships and allowed us to really get to work.

To understand his experience as being simply the reflection of psychotic or dissociative processes and of a reality that does not exist implies a pathologization of his experience and symptoms that was deeply aversive to him. What traditional psychiatry tends to view as symptoms to be removed, he viewed as the clarion call to a new life.

Since then, I have listened to other patients or people involved in our research at the institute report experiences that I am not sure can be adequately accounted for within the framework of traditional psychiatric or medical assumptions. Stories in the classic spiritual writings also raise difficult questions for the Western maps of reality and consciousness that have been too quickly adopted in psychiatry, even by some of its finest minds. Jean-Martin Charcot (1825-1893), for example, director of the famous Salpetriere mental hospital for women in Paris, photographed the women he was treating for hysteria in poses labeled "Ecstatic State" and "Beatitude" and argued that such women were across the board suffering from delusions. And Sigmund Freud's colleague, Josef Breuer, dubbed Saint Teresa of Avila the "patron saint of hysteria," though he did admit that she was "a woman of genius with great practical capacity" (Medwick, 1999, p. xv). The reader can decide whether Saint Teresa's experiences

added or detracted from her immensely fruitful and busy life, and whether psychiatry has understood her well. Following is an excerpt of Saint Teresa's writing:

> It pleased our Lord that I should sometimes see this vision. Very close to me, on my left, an angel appeared in human form, which is not how I usually perceive them—though I do once in a while. Even though angels often appear to me, I don't actually see them, except in the way I mentioned earlier. But our Lord willed that I should see this vision in the following way: he was not tall but short, and very beautiful, and his face was so aflame that he seemed to be one of those superior angels who look like they are completely on fire. They must be the ones called cherubim—they don't tell me their names—but I am very aware that in heaven there is such a difference between some angels and others, and between these and still others, that I would not know how to explain it. In his hands I saw a large golden spear, and at its iron tip there seemed to be a point of fire. I felt as if he plunged this into my heart several times, so that it penetrated all the way to my entrails. When he drew it out, he seemed to draw them out with it, and left me totally inflamed with a great love for God. The pain was so severe, it made me moan several times. The sweetness of this intense pain is so extreme, there is no wanting it to end, and the soul isn't satisfied with anything less than God. This pain is not physical, but spiritual, even though the body has a share in it—in fact, a large share. So delicate is this exchange between God and the soul that I pray God, in his goodness, to give a taste of it to anyone who thinks I am lying. (as quoted in Medwick, 1999, pp. 56-57)

Of course one could argue that she was a master of illusion and an unparalleled, charismatic manipulator of power. One would need to explain a number of things, not least of which is the perilous and life-risking position such experiences placed one in during the years of the Inquisition, especially since she was a woman. In spite of these dangers, she wove a path that preserved her complex inner life in the context of perilous circumstances, and also founded an order, was an outstanding administrator, and wrote with such beauty that she con-

tinues to find a large readership, even today, 800 years later. To this day, only two women have been honored as "doctors" of the Catholic Church, and she is one of them. Delusional or not, her autobiographical *Vida,* filled as it is with passages like this, has inspired a wide variety of responses, from George Eliot, who made her the *genius loci* of her novel *Middlemarch,* to Gian Lorenzo Bernini, who immortalized her in his famous sculpture *The Ecstasy of Saint Teresa* in the Cornaro Chapel of Santa Maria della Vittoria, Rome.

On the basis of accounts like this and my repeated clinical experience, I believe that it is worth examining whether some mystical experiences actually have a beneficial impact on the recipient and increase his or her capacities for healthy love and work. Some individuals seem to function better than others and do so in part *because* of their untraditional experiences.

Because people suffering from acute mania often are hyperreligious, therapists need to distinguish a genuine religious impulse from manifestations of illness. In mania, the religiosity is driven, and close examination reveals that it is a flight not toward oneself (which is the sign of a true spirituality) but away from the self that one truly is. Soren Kierkegaard's *Sickness unto Death* provides, in my opinion, one of the best descriptions of the self that I have seen—important both for its phenomenological relevance and theoretical power:

> The self is the conscious synthesis of infinitude and finitude which relates itself to itself, whose task is to become itself, a task which can be performed only by means of a relationship to God. But to become oneself is to become concrete. But to become concrete means neither to become finite nor infinite, for that which is to become concrete is a synthesis. Accordingly, the development consists in moving away from oneself infinitely by the process of infinitizing oneself, and in returning to oneself infinitely by the process of finitizing. (Kierkegaard, 1941, pp. 162-163)

He then describes how any human existence that wills to become infinite is in despair, for the self is a synthesis of both the infinite and the finite. The finite is the limiting factor and the infinite is the expanding factor. Infinitude's despair is the fantastical, the limitless; finitude's

despair, on the other hand, is to lose one's self, not by evaporation into the infinite, but by becoming entirely finitized, by having become, instead of a self, a number, "just one man more, one more repetition of this ever-lasting *Einerlei*" (Kierkegaard, 1941, p. 166).

According to Kierkegaard, one's capacity for the infinite is a gift from God and an attribute of the divine. Imagination is one of the self's most sublime gifts:

> The fantastical is doubtless most closely related to fantasy, imagination, but imagination in turn is related to feeling, knowledge, and will, so that a person may have a fantastic feeling, or knowledge, or will. Generally speaking, imagination is the medium of the process of infinitizing; it is not one faculty on a par with others, but, if one would so speak, it is the faculty *instar omnium* [for all faculties]. What feeling, knowledge, or will a man has, depends in the last resort upon what imagination he has, that is to say, upon how these things are reflected, i.e., it depends upon imagination. . . . Imagination is the origin of the categories. The self is reflection, and imagination is reflection . . . which is the possibility of the self. (Kierkegaard, 1941, pp. 163-164)

Kierkegaard is saying, in part, that the intensity of the capacity for imagination is a reflection of the capacity for becoming a self. But the fantastical, lacking that dialectical concreteness that brings the self back to itself, so carries the self into the infinite that it cannot return to itself. In this way, the self is volatized more and more and at last the impulses in the self become such that one may love, but only with a sort of inhumane abstraction, as in the way that one may expound on his or her embracing love for all humanity, yet experience great difficulty in individual relationships. Too much undialectical infinity results in a form of inebriation.

The difficulty with typical conceptualizations of bipolar disorder is that patients know at some level—and very clearly feel—that their mania has at its core something that is important, even critical, for their lives. The mania is an untethered longing for ecstasy, for the infinite. To explain it as simply an illness that must be medicated away feels like a denial of the deepest longings in the soul. A mutual resis-

tance is soon formed between doctor and patient, with the doctor trying to remove the mania and the patient feeling like the doctor is trying to excise something vital.

Client Stories

Here is what one of my patients, Mary, said:

> I am definitely a more spiritual person since becoming bipolar, although I have been a "Christian" most of my life. Although I experience a far greater depth of emotions since becoming bipolar, I feel it also goes beyond emotions and I experience a deeper relationship with the Person of God. For this reason I would not trade bipolar even with all of its misery for "good" mental health.

Another patient, Tom, described his experience as follows. Note his tendency toward abstraction (infinitizing) and the absence of a similarly robust movement toward the concrete:

> From an early age, I have thought and felt about deeply abstract things. I'm sure that anybody with this disorder has to be deeply connected with his or her spiritual self. To me it almost seems like a rule. Haven't we all had thoughts when we feel totally detached from our bodies and are trying to grasp the meaning of life itself, or the significance of things outside us—whether it is other humans, or nature's little wonders? As I think about this, I can see that there is a silver lining to how this terrible disease affects us. Sometimes, I think that the really great spiritual leaders such as Buddha probably had bipolar disorder. I'm not trying to glorify this disease. But it does tell us one thing—so what if we can't be successful in the conventional sense. But we can do our utmost to make this world a better place. I really mean this. At the end of the day, often when my brain switches back to normal mode, I can see my actions and emotions as a third person—the way I sometimes hurt others and myself, or the needless thoughts I felt [*sic*]. At those rare and prized moments, I tell myself I will try to do my best to have some meaning to my life. I want to love myself and others around me. I even have a secret plan—one day when I make lots of money, I'm going to make a

> big anonymous donation. I know this all sounds like I'm blowing my own horn, but this is seriously how I have felt at times and I'm certain other people whom this disease affects, have felt something similar.

People feel great conviction when they say that they feel closer to God during periods of mania. They are so convinced of this that it is not an easily discussible issue, even after the mania is resolved, and it should not be easily dismissed or pathologized. Unfortunately, neither the church nor most clinicians are able to articulate a conceptual pathway that adequately accounts for the patient's experience and points the direction forward in a way that fits for both the patient and the clinician. Here is Mary again:

> I have had several hypomanic episodes where I am elevated just to the point that life is exceedingly easy and joyful. I become consumed with reading my Bible, prayer, church, Bible studies, everything is about God and I am full of such hope. When in this state I inevitably believe I have turned some corner. I then view the whole diagnosis as possibly wrong. My problem seems only to be one of sin and lack of trust in God until it begins again with depression. I feel it coming on but am trying to hang on to my faith, but the ease of it is gone. After a couple weeks or so of crying out to God and trying to repent and asking a lot of forgiveness I seem to give up a bit, get lethargic and just unable to pray, not able to embrace His Word the same way. And I feel so guilty. And I start thinking "Maybe I really am bipolar" alternating with thoughts that I am using bipolar as an excuse somehow. I am so tired of this. It causes me to doubt the sincerity of my faith.

Mary's account shows how much individuals can feel torn between two different views of the world, neither of which provides an adequate understanding of their experiences. Such confusion can contribute to years of wasted energy and developmental moratorium. Unfortunately, science (and therefore psychiatry) and Western theology have developed in reaction to and in isolation from each other; this has led to a partial falsification of both.

I have had a number of clinical experiences in which a person clearly met the criteria for bipolar disorder type II but was also having

positive transcendent experiences of the type just described. These individuals have often been persons with well-developed ego strength and a clear ability to think clearly and rationally about their experiences. They are individuals who are able to live with an expanded consciousness without drowning in its deeper seas. The clinical task for these individuals is to get their feet back under them and to find a place where they talk about their experiences without being regarded *ipso facto* as crazy. In some situations medicine is helpful; in others, it is contraindicated and the person can do well without it. Although criteria for bipolar disorder may apply at one level, a different, higher order operates in these situations. In the same way, a child operating within the stage of concrete operations believes that the moon is actually moving along with the car, whereas an adult recontextualizes the same experience with the knowledge added by a capacity for formal operations.

The individuals who present with frank bipolar I disorder are often those with less ego strength or greater biological vulnerability. They become radically infinitized, to use Kierkegaard's language. These individuals are less likely to be able to manage their symptoms and cannot manage an expanded consciousness without distortion or loss of self. They need help not only getting grounded in a healthy and balanced lifestyle, but also require traditional psychopharmacology and associated therapies. Still, however, resistance can be significantly defused and development promoted by the type of understanding outlined previously.

Other forms of language and experience have a great deal to add to Western psychiatric conceptions. Eastern teachings about the Kundalini tradition, for example, seem to have great explanatory relevance for the kinds of symptoms that are occasionally misread as symptoms of mania. These symptoms can occur when meditation is too activating, as well as in other situations. Again, what the unpracticed eye may read as mania is occasionally about something else entirely (Sannella, 1987).

CONCLUSION

The incidence of bipolar disorder may well be increasing. It certainly is diagnosed much more frequently than in the past. This could be related to several factors, as discussed previously, but it may also

be connected with the revival of spirituality that is circling the world. A casual perusal of the top sellers in bookstores and at airport kiosks clearly indicates, in contrast to Nietzsche's statement, "God is dead," that interest in God and related matters is alive and well. In fact, it may be more appropriate to say instead that "Nietzsche is dead." As the longing for the spiritual life continues to grow, the incidence of bipolar disorder may also continue to increase, and it will therefore become increasingly important to understand the infinitizing fire that fuels it.

In the foregoing, I have made frequent reference to the perceptual difficulties—the anosognosia—that the Western mind faces in its efforts to understand phenomena that exist outside the narrow band of consciousness that it apprehends. The Western mind is brilliant and unparalleled in its elucidation of the area illuminated by Descartes' streetlamp. However, its further development and, in my opinion, survival depend on being willing to explore the larger world outside that sphere. The following story of conversations that occurred during three different epochs is a good example of where we have come from and where we are at the current time:

Conversation in the Fifth Century

> "It is said that silk is spun by insects, and does not grow on trees."
>
> "And diamonds are hatched from eggs, I suppose? Pay no attention to such an obvious lie."
>
> "But there are surely many wonders in remote islands?"
>
> "It is this very craving for the abnormal which produces fantastic invention."
>
> "Yes, I suppose it is obvious—when you think about it—that such things are all very well for the East, but could never take root in our logical and civilized society."

Conversation in the Sixth Century

> "A man has come from the East, bringing some small live grubs."

"Undoubtedly a charlatan of some kind. I suppose he says that they can cure toothache?"

"No, rather more amusing. He says that they can 'spin silk.' He has brought them with terrible sufferings, from one Court to another, having obtained them at the risk of his very life."

"This fellow has merely decided to exploit a superstition which was old in my great-grandfather's time."

"What shall we do with him, my Lord?"

"Throw his infernal grubs into the fire, and beat him for his pains until he recants. These fellows are wondrously bold. They need showing that we're not all ignorant peasants here, willing to listen to any wanderer from the East."

Conversation in the Twentieth Century

> You say that there is something in the East which we have not yet discovered here in the West? Everyone has been saying that for thousands of years. But in this century we'll try anything: our minds are not closed. Now give me a demonstration. You have fifteen minutes before my next appointment. If you prefer to write it down, here's a half-sheet of paper. (Shah, 1972, p. 25)

Although Western psychological understanding also has much to offer the East, I believe that Western psychology has a great deal to learn from these traditions, and that we would do well to pay particularly close attention to the esoteric teachings of these traditions and seek to correlate them with the findings of modern science. Their relevance may not be immediately obvious to a consciousness affixed to an overvaluation of material existence. But perseverance will bear a heavy fruit, well worth waiting for.

NOTES

1. Hypomania refers to manic symptoms that fall along the same trajectory of manic symptoms but are less severe. The usual dividing line is that hypomanic symptoms do not adversely disrupt one's work or social life. Mixed symptoms refer to a condition in which symptoms of both depression and mania coexist.

2. This kind of statement can be misunderstood in many ways because it makes sense only in the context of a different kind of cultural milieu. When I say that con-

sciousness impacts our bodily existence, I am referring to more than what our conscious selves know and accept. We carry many different types of knowing within us, much of which we live but at best with limited awareness. Particularly because of the current Western cultural milieu, we often know more than we can tell. We live between a dialectic of knowing and not knowing, and often do not allow ourselves to know what we really know or believe to be true. One part of this is that we do not know how to talk about or even allow ourselves to be aware of ways of knowing not legitimated by Western culture. We have conscious selves; however, we also have subconscious and superconscious selves and participate in a sort of "collective unconscious." These different "selves" can be in direct conflict with each other and the person may not be aware of what he or she really knows or believes. For example, a common clinical experience is to hear a person wax eloquent about what he or she believes—e.g., that God is love—when clearly, at a more primal and subconscious level, the person has organized his or her life around a deep fear that God is a judge out to get him or her.

3. I would like to make clear that this difficulty derives not from a failure within Christianity but from the way in which Christianity has changed as Western thought took hold. Christianity was originally a mystical faith.

4. This sort of approach to the human person presupposes that the "spiritual life" cannot be separated from any aspect of the person or his or her life. The route to "godliness" cannot be reached without attaining that which is universally human. That which may not be consciously spiritual often is, and intensely so. Paul Tillich (1957), for example, defined religion as "one's ultimate concern," whatever that may be for that particular person. One's ultimate concern is often different from what the person consciously believes his or her ultimate concern to be.

5. The Buddhist statement that "all is despair" is not the negative or despairing beginning that it may seem to be. It is a recognition, in part, that one cannot recover one's soul without recognizing that something is missing.

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