

CHAPTER ONE

THROUGH THE LOOKING GLASS

Twenty-two years ago, I lost my mind. Although I would not recommend it as a lifestyle, insanity is something I wish everyone could experience once. Now I understand why madness has fascinated artists and philosophers across millennia, and why the Surrealists, who strove to live life as poetry, considered madness the ultimate adventure in selfhood. For me, as for many others, the suspension of reason and judgment, before becoming dangerous, cast enchantments across perception, remaking the ordinary into the wonderful. As the mind loosens its grip on reality, daily life acquires the strange beauty of dream, fairytale, and myth—a world filled with marvelous characters, landscapes, and events. Exquisite. Astonishing. Occasionally frightening. When I went to see *The Walls*, a play about madness developed from psychotic women’s journals, I identified with a central character, who says about her hallucinations, “there are times when you just can’t imagine the impossible beauty of it.”¹ Although my experience of madness did not include hallucinations, it did include a condition for which the clinical term is *hyperacusis*—a state of heightened perception in which hearing becomes more acute, sight more vivid, and the faculties of taste, smell, and touch wildly responsive. Beauty strikes the senses in a deluge of glory. And terror can spring out of the most ordinary daily activities. Insanity initiates the mind into depths of beauty—and depths of terror—unimaginable to the sane. This aspect of madness deserves more airtime.

We live in an age of faith in science and medicine. So we take a biomedical approach to madness. We call madness *mental illness*, placing it firmly in the category of sickness, focusing single-mindedly on its

negative effects, which we try to eradicate with drugs. In our fascination with the chemistry of madness, we tend to ignore the *poetics* of madness—the connection of madness to beauty, truth, creativity, spirituality, and the sublime. In the three millennia of literature and philosophy that preceded psychiatry, madness was associated with all these things. Whenever poetry, creativity, love, and madness are mentioned in the same sentence, it raises the question of whether there is danger in romanticizing madness. There is. There is also a danger in de-romanticizing madness. Madness is dangerous, romanticized or otherwise. Experiencing madness is dangerous, and receiving treatment for madness is dangerous. There is no way to make madness or its treatment completely safe.

Romanticizing madness too much can result in a failure to provide medical care and personal safety for persons suffering madness. De-romanticizing madness too much can lead to oversimplification—reducing the experience to a chemical reaction that we try to subject to chemical control while ignoring its social, spiritual, and aesthetic dimensions. This oversimplification can result in a failure to perceive value in the experience, or to make the experience meaningful. When we are unable to find value and meaning in our most difficult experiences, we cannot integrate them into a process of personal development that leads to positive long-term outcomes such as suitable work, rewarding relationships, emotional stability, spiritual vitality, and a sense of belonging to the human community.

I use the term “madness” rather than “mental illness” not to insult anyone and not to be deliberately unfashionable or unscientific, but to restore the millennia-old associations between madness and various forms of intellectual and spiritual power. Shakespeare, whose plays frequently portray madness, wrote in *A Midsummer Night’s Dream*: “The lunatic, the lover, and the poet are of imagination all compact.”²² Shakespeare’s line connects madness with love and creativity—this is the connection at the heart of a *poetic* understanding of madness. A poetic approach assumes that madness, like literature and dreaming, contains meaning and offers insight into such central human concerns as love, desire, sex, adventure, work, fate, spirituality, and God. Madness—defined as any atypical mental state severe enough to cause social difficulty—has a history in literature long before Shakespeare. Faced with the task of

recovering from what looked like a manic episode, I balanced my use of the biomedical tools available to me with a poetic understanding of madness drawn from the long history of madness in literature, art, philosophy, and religious writing.

As I emerged from my mental health crisis, a psychiatrist offered me the label “bipolar,” along with dire predictions about my future. Without lifelong medication, he explained, I would suffer more episodes and hospitalizations, becoming chronically unstable and professionally unproductive. But that is not what happened when, against medical advice, but under medical supervision, I ended my use of medication after six months and began a process of religious reflection, psychotherapy, and behavioral change, guided by insights drawn from literature. Instead of becoming a career psychiatric patient, I completed a PhD, obtained a tenure-track job, traveled to Europe and Africa, published two books, earned tenure, married, gave birth to a son, bought and sold real estate, produced a film, learned a martial art, and, eventually, sought treatment for anxiety and substance abuse, two hallmarks of post-traumatic stress. These two psychological distress symptoms, which had dogged me since adolescence, had long prevented me from fully realizing my creative potential. Undertaking trauma recovery eventually resolved those symptoms and transformed my life, propelling me toward ever-increasing levels of productivity and contentment. During the two decades after my breakdown, I experienced two milder mental health challenges, both of which I managed with short-term medication, behavioral change, and talk therapy. With the exception of about a week—the same amount of time a flu keeps me down—I didn’t miss work or become unable to meet domestic, parental, and financial responsibilities. I don’t believe I would have recovered so fully and gone on to build a successful life had I not balanced biomedical technologies with poetic understanding.

I also don’t believe I would have recovered so completely and achieved my present level of health had I used long-term drugs. While there are certainly people whose wellness depends on lifelong drugs, there are others who can enjoy mental health without them. This second group, if they are more compliant patients than me, risk becoming victims of psychiatric overkill. Psychiatric drugs have side-effects ranging in

severity from dental caries and excess weight to obesity, sexual dysfunction, neurological damage, and death. They should be used only when necessary. My experience with overprescription illustrates a problem with late twentieth- and twenty-first-century psychiatry. Treatment protocols have become so uniform, drug-based, and aggressive that even people who are capable of recovering from breakdown and leading productive lives without long-term drug use are being urged to make illness a permanent part of their identity and to adopt lifelong, nonstop use of medications with serious side-effects. Prescribing long-term medication for people whose disturbances can be resolved with short-term medication and behavioral change is defensive medicine at its worst.

Becoming Ophelia

In literature and art, madwomen are often pictured with streaming tangles of hair wandering through natural landscapes filled with flowers. In William Shakespeare's *Hamlet*, the young woman Ophelia, driven mad by love and grief, wanders the countryside making garlands of flowers and singing. Decked with her flower-garlands and still singing, she falls into a brook overhung by willows, where she lets herself drown. John Everett Millais's painting *Ophelia* pictures the heroine floating downstream in a floral landscape, her golden gown and brown hair billowing in the water, amidst violet, buttercup, poppy, pansy, meadowsweet, and purple loosestrife. Jean-Martin Charcot, a nineteenth-century theorist of madness—then called “hysteria”—imagined his female patients as real-life Ophelias.³ Charcot photographed his female patients so frequently that he built a photography studio at the hospital where he worked and hired a professional photographer.⁴ Charcot's favorite photographic subject was his patient Augustine, whom he and his colleagues liked to photograph with long, wild hair falling across a bare shoulder, neck, or partially exposed breast—visual effects accomplished with a strategically loose-fitting hospital gown.⁵ Fifteen-year-old Augustine, who had been raped by her employer, cooperated enthusiastically, posing for her doctor's camera in attitudes drawn from French silent film and pre-Raphaelite paintings of Ophelia.⁶ The madwoman, as an image, or archetype,

often embodies a girlish innocence, with hints of an unknowing sexuality and blind, mindless trust.

In the moment my mind broke with reality, my arms were filled with roses. Roses, irises, lilies, peonies, and lilacs, feathered with ferns. They had been given to me by Mark Sandman, the hypnotic, crooning front man for Morphine, a minor indie-rock sensation of the early nineties. After creating a clinical-strength romantic fantasy about Sandman out of photographs and music, I met and reveled with him on the three consecutive nights of the band's 1995 engagement in Chicago—a series of events that inflamed my romantic obsession beyond reason and triggered ever-further departures from reality. On the third night of my revelry with Sandman and the other members of Morphine, I wore a blue dress so long it brushed the ground. Wild brown curls streamed over my shoulders and down my back, mingling with the flowers Sandman had given me after the last of his three shows in Chicago. The armful of blossoms practically buried my small body. Their fragrance transformed my taxi ride home into a mobile Garden of Eden. A friend sat beside me in the taxi. She was speaking, but I had ceased to be there. I could hear and understand her words, but she seemed far away, as if she lived in a parallel world that I could perceive but to which I did not belong. My mind had wandered into a paradise of its own design. Gazing out the window into the starry sky, intoxicated by flowers and fantasy, I lost myself to ecstasy. I could simulate normal behavior, so it appeared to my friend that I was there. In truth, my body was there, but my mind had spun off into bliss. I fancied myself in love with a rock star who had filled my arms with flowers.

At the height of my disturbance, I found myself wandering through neck-high Kentucky blue grass in a daisy-print sundress, captivated by buttercups and burying belongings in the forest. Having seen my rock star one last time, and imagining myself spurned in love, I had decided never to go home. I left my car at a truck stop and began hitchhiking south, feeling I could shrug off my old life like a sweater, disappear, and start a new life somewhere else. Somewhere warmer. Somewhere *south*. Maybe Mexico. Frightened by the riveted attention of the two men who gave me rides, I quit hitchhiking. In a moment of serious danger, I bolted into the woods and continued on foot. Wishing to

abolish all traces of my identity, I destroyed my credit cards, flushed my identification, and began using a new name. Concerned that my shoes might give away my true identity, I left them by a river and walked on, barefoot. Eventually, confused and out of cash, I started wandering around a small Kentucky city in a fugue, struck into ecstasies by early-blooming roses. I wandered into a private garden, drawn by the largest, most fragrant roses I had ever beheld. Thirsty, I helped myself to water from the garden hose. Tired, I wandered into the house in search of a sofa. The terrified homeowner, upon seeing me, escorted me promptly back outside and called the police. I sat on the porch, enjoying the fragrance of the flowers and petting the cat. The police arrived and, to their credit, drove me to a hospital, where I checked myself in.

Clinically speaking, my bizarre thinking, impulsive behavior, euphoria, and confusion—all fueled by sleeplessness and consumption of marijuana, caffeine, and nicotine—could rightly be called a “manic episode.” Despite the fact that I had never (and would never) experience clinical depression, a psychiatrist suggested the label “bipolar disorder” for what ailed me. That was a reasonable enough twentieth-century name for my condition. In an earlier time, it might have been called “hysteria complicated by ecstasy.”⁷ In an even earlier time, it might have been called “love madness.”⁸ If we were to depart altogether from medical description and draw for understanding from the world of myth, poetry, and Jungian psychology, we could say that I had brought to life an archetype—the madwoman—that has for millennia been an expression of feminine frustration and despair. I had turned myself, spontaneously, into an Ophelia.

Before I became Ophelia, I had become an English professor. I had not yet earned my PhD, but I had my master’s degree and was teaching literature and writing at DePaul University in Chicago. My symptoms began when a student in one of my classes turned in an essay describing the molestation she had experienced as a child. I became unaccountably anxious while helping her develop the essay, which was so strong she later published it in a newsletter for an organization that serves abuse survivors. My student, whom I’ll call Ruth, was fifteen years older than me. She had returned to college after having been a wife. When her financier husband ran off with his secretary, Ruth decided

to earn a degree in psychology in order to become a therapist specializing in treatment of abuse survivors, who often suffer psychological after-effects. (And who frequently marry unreliable or abusive partners.) Ruth told the story of growing up in India, where the family cook had repeatedly molested her. For reasons I could not understand at the time, my anxiety intensified throughout that semester.

I was moved by Ruth's life story and maintained our acquaintance after the course ended, listening to Ruth work through the pain of her divorce and supporting her as she undertook her new life as a college student in her forties. At some point, as a result of reading Ruth's work and listening to her describe her struggle with the after-effects of abuse, it struck me that I myself exhibited almost all the symptoms about which Ruth had written. The more Ruth educated me about abuse survivor symptoms, the more I realized they described certain aspects of my own history. I had begun experimenting with cigarettes, alcohol, and marijuana at the tender age of thirteen, stopping at age sixteen only because I contracted pneumonia. I had also suffered intermittently from insomnia, night terrors, panic attacks, difficulty swallowing, binge/starve behavior, body image problems, fear of darkness and home invasion, anxiety, and low self-esteem. I wanted to change my name. Although the symptoms fit, I had no recollection of ever having been molested. I didn't know how to act on the information and *didn't want* to act on the information, not wanting to see myself as an abuse survivor. The idea revolted me. I banished it from my mind, thinking the similarity between Ruth and me was probably imaginary.

At the same time that Ruth's essay began stirring these questions, two parts of my personal life reached a breaking point. I was involved at the time with a marriage-minded man who wished to build a life and a home with me. While he worked on a PhD, I worked to support our matrimonial and domestic hopes, unhappily underemployed as a bookstore manager, and then happily employed but woefully underpaid as an adjunct faculty member, scrambling every summer to find any work at all. There seemed no relief in sight for the punishing financial stress, which compounded my painful ambivalence about marriage. Even at thirty, I still lacked the emotional maturity and communication skills necessary for navigating conflict in a relationship. Unable to commit,

and unable to end the relationship responsibly, I remained paralyzed, awash in guilt and dread. Financial despair compounded this commitment anxiety.

To manage that anxiety, I began smoking marijuana—something I had not done since my teenage years. To combat the mental fog that came with marijuana use, I began drinking excessive amounts of coffee. This combination of drugs enabled me to stay up all night writing, drawing, and developing plans to remedy my dismal career prospects and financial insecurity. During these late nights, I discovered Morphine. The first time I popped in a Morphine CD, the sultry bass lead and melodious voice that slinked out of the speakers mesmerized me, seemingly offering to fulfill the opioid promise of the band's name. Soon, I couldn't stop listening. Soon after that, I heard music in my head even without listening. Nonstop Morphine songs took over my inner airwaves.

Obsession works like a tornado gathering speed. I became convinced that the band was a profoundly important cultural phenomenon that warranted scholarly attention. I wrote to their manager and asked to interview the band members for an article when they came to town. I nursed my obsession before the interview, listening to songs and memorizing lyrics. It took my mind off the inklings stirred by Ruth's story and enabled me to avoid my ambivalence about marriage and the appalling state of my career prospects as an MA in English without a private fortune. My excitement spiked the day Morphine came to town. I interviewed the band members during their sound check at the Metro and enjoyed their hospitality before and after the show. All three days they played the Chicago venue, I went to the shows, visited with the band members, and smoked the potent Brazilian marijuana circulating among the rabble backstage. Instead of slaking my excited curiosity, these experiences fed it. My thoughts started racing. I intoxicated myself with substances and experiences around the clock and, eventually, my mind gave way. I ran away from my life like a wayward child, fleeing home, job, and relationship without a word of explanation or warning to anyone. I saw Morphine one more time but, instead of chasing them to the East Coast, I headed south, dreaming of a new life in Mexico. My mind spun increasingly out of control, leading me to that Kentucky hospital, where I spent three days. After this, I went to my childhood

home in Connecticut to recover. Once there, I checked myself into a better hospital. Controlling my sleeplessness, confusion, impulsivity, and strange thinking with prescription drugs, I left the hospital after a week, and then spent a month in the country recuperating from the ordeal.

While I was recovering, I received a visit from a family friend who, after a black sheep adolescence and violent early adulthood, had become a man of faith. In an act of extraordinary courage, dignity, and grace, he confessed that he had molested me when I was a toddler, too young to talk, too young to remember. Deeply sorry for his actions, this penitent man offered the information because he was concerned that I had been misdiagnosed. The friend, who had himself been abused in childhood, had also been diagnosed initially as bipolar, and then later diagnosed with post-traumatic stress disorder when a therapist specializing in abuse recovery explained to him that abuse survivors are frequently misdiagnosed as bipolar, borderline, schizophrenic, or suffering from dissociative identity disorder, formerly termed “multiple personality disorder.” Much later in my own recovery from abuse and the trauma of psychiatric hospitalization, I learned that the issue of misdiagnosis is a pressing concern among clinicians who specialize in trauma recovery.

When I was sixteen, I almost died as a result of medical misdiagnosis. Having already been smoking for three years, I developed a chronic cough that turned into chest congestion and shortness of breath. Doctors at the small-town hospital where I was admitted decided to treat me for asthma. After all, I had a family history of asthma. My mother, who had long observed my brother’s asthmatic illnesses, insisted that my illness was not asthma. She argued and pleaded with the doctors to try a new treatment. They ignored her. While they continued to treat for asthma, my breathing constricted, my temperature soared, and one lung collapsed. Unsure what to do, the doctors transferred me to Yale University Hospital, where emergency room doctors found me near death. “How long has she been breathing like this?” they asked my mother, disgusted that any doctor or hospital would have continued to treat for asthma while my condition deteriorated so dangerously. Recognizing immediately that I had pneumonia, they intubated me, hooked me to a respirator, and pumped oxygen into my blood. I “breathed” like that for a week in intensive care. When the other lung threatened

to collapse, the doctors recommended that my brothers be brought to say goodbye. But I lived to tell the story. With the disease process correctly identified, and the appropriate treatment delivered, I healed.

Misdiagnosis of physical illness is life threatening. So is misdiagnosis of mental illness. With mental illness, as with physical illness, a set of symptoms can be read in more than one way. Often, it is prudent to question an initial diagnosis, seek additional opinions, and try different treatments. Unfortunately, patients diagnosed with a mental illness are sometimes said to be suffering from “denial” if they question an initial diagnosis, or if they think critically about their own treatment plan. If they decline a prescribed medication protocol, they might be labeled “noncompliant” and warned of disaster to follow. The real disaster, in cases of misdiagnosed mental illness, is that drug treatment can actually inhibit recovery. Asthma medications cannot cure pneumonia, and medication for bipolar disorder cannot cure or effectively manage the symptoms that can trouble the lives of abuse survivors, who may or may not have a chronic illness requiring preventive medication. Abuse survivors without a chronic illness may need medication in the short term to manage their anxiety and panic, but in the long term, they need the cognitive behavioral therapy that enables them to identify and change the behaviors, attitudes, and beliefs that follow from the abuse.⁹

Among the many developmental tasks of recovery, abuse survivors have to strengthen their capacity to feel and process emotion. When my abuser confessed, I felt nothing. Judging from the emotional intensity of my response, you would have thought he had just told me that although I didn’t remember it, he had owned a Chevrolet and used to take me driving. My lack of feeling may seem surprising, but it is typical: freezing or suppressing feeling is a child victim’s best psychological defense against the violation he or she is powerless to stop. Animals fight, flee, or freeze when threatened. Children, who experience the abuse as life threatening, freeze because they can’t flee or fight. Unfortunately, as these children grow into adulthood, they might continue to use numbing and freezing as a defense mechanism against emotional distress. Survivors may also avoid feelings by using substances that, even in relatively small amounts, further inhibit feeling. Without an ability to feel their emotions, survivors can compromise their own agency,

experiencing paralysis or confusion when life circumstances call for effective decision making and skillful action. In addition to my survivor's tendency to suppress emotion, I had an ample amount of sedative in my bloodstream when I received my abuser's revelation. I ignored the information, and set about recovering from what looked like a manic episode. Like a good victim, I told no one about the abuse. I sought no treatment for post-traumatic symptoms.

I carried the secret for thirteen years. During that time, I experienced stability, productivity, and substantial contentment. My run of good fortune was interrupted by an emotional event that knocked me farther off course than it should have. When my son was two years old, and my husband out of work, I found myself facing the loss of my marriage. Instead of taking effective action to address the situation, I numbed myself daily with two or three glasses of wine and so much work I could barely feel, sleep, or eat. I worked myself to exhaustion and relapsed into smoking cigarettes. I distracted myself from the pain of impending divorce with another romantic obsession—an imaginary emotional attachment of suspicious intensity. Although the tide of madness never rose and overtook me completely, as it had thirteen years before, the threat of instability scared me into seeking treatment, first for insomnia, agitation, and other hypomanic symptoms, and then for the after-effects of abuse. Using prescription drugs again for three months to stabilize, I stopped using all nonprescription drugs, including caffeine, wine, nicotine, and sugar. Finally, I sought treatment for abuse recovery. I learned through treatment how abuse issues had generated disastrous strategies for coping with anxiety and loss. Receiving treatment for the underlying problem—instead of for its surface symptoms—transformed my life.

Several years of trauma recovery work allowed me to release the feelings and alter the behaviors that can arise from childhood abuse. Anxiety symptoms that had troubled me periodically for three decades disappeared. I stopped using wine, caffeine, sugar, and overeating to soothe uncomfortable feelings and started using exercise, healthy relationships, and religious practices instead. My periodic use of marijuana and cigarettes ended. These lifestyle changes brought wonderful physical and socioemotional benefits—healthy weight, low cholesterol, low blood pressure, and considerable strength, as well as a level of peace,

productivity, prosperity, and fitness that, at thirty, I did not believe was possible. Life has gifted me with fulfilling work, a thriving child, a comfortable home, nurturing friendships, and a strong sense of community. Each day contains moments of joy, feelings of gratitude, and a pleasant anticipation of the future. Love circulates throughout my life in a variety of beautiful forms. This is mental health.

Eighteen years passed before a psychiatrist said to me: “You are not bipolar. You do not need preventive medication.” Had I been a compliant patient and accepted the initial diagnosis without question, I never would have undertaken to seek the roots of my distress, or learned how to heal the emotional wounds of abuse. I would have drugged myself indefinitely, having blood tests every three months to find out if the medicine was poisoning my liver. Since I am in recovery from an eating disorder, the weight gain caused by mood stabilizers might have triggered serious depression, so I would likely have needed an anti-depressant in order to endure obesity. But skepticism saved me. My academic training does not allow me to accept anything blindly, even if it is presented as scientific truth by a doctor.

Having escaped a lifetime of overmedication as a result of my unusually skeptical attitude toward diagnoses and prescriptions, I could not help but wonder how many people in my position simply do what they are told. American culture is infatuated with the sense of certainty and authority offered by science and medicine. This cultural climate of devout faith in science makes us reluctant to remember how much *error* haunts the history of medicine, especially psychiatry. In our search for certainty in the face of frightening infirmities, we are slow to acknowledge the fallibility of medical opinion. Even a nodding acquaintance with the history of psychiatry, however, should be enough to restore greater humility to the practice of this relatively new, incomparably complex discipline.

At one time, doctors considered it scientifically true that madness—famously called *hysteria* for its etymological root in the word *hyster*, the Greek word for “womb”—was caused by a woman’s womb detaching from the adjoining viscera and floating throughout her body. Quite rationally, therefore, doctors prescribed hysterectomy as a solution. At another time, doctors thought that drilling holes into the brain was an excellent way to treat mental illness. In 1949, Egas Moniz received a Nobel prize

for inventing prefrontal lobotomy.¹⁰ Walter Freeman, an exceptionally entrepreneurial psychiatrist, invented a more convenient “neurosurgical” technique in 1946: he could perform a lobotomy without anesthesia during an office visit by using electrical shock to knock the patient out, after which he would hammer an ice pick seven centimeters into the brain through the eye socket, then pull up on the ice pick to destroy frontal lobe nerve fiber.¹¹ Since this made patients “calmer,” mainstream psychiatrists considered the treatment a medical breakthrough. The *American Journal of Psychiatry* trumpeted the success of psychosurgery in 1948; editors at the *New England Journal of Medicine* wrote that with psychosurgery, “a new psychiatry may be said to have been born.”¹² Fortunately, medical opinion eventually turned away from this bizarre and aggressive “treatment.” If it hadn’t, I might have found myself in 1995 lying in a hospital bed with an ice pick in my head.

Instead, I found myself lying in a hospital bed unable to move my neck, seeing double as a result of Haldol, an anti-psychotic. Contemporary psychiatry, committed to a “chemical imbalance” theory of mental illness, controls madness with chemistry, but shows little interest in healing madness, where possible, by locating and resolving nonphysical causes of madness. In fact, many psychiatrists deny or minimize causal connections between life events and mental dysfunction. The biomedical party line is that life events may trigger an underlying chemical abnormality that causes madness, but that events themselves cannot drive someone to madness unless a person’s chemicals predispose them to break down under stress. That might be true, but it definitely has not been proven—only repeated so many times that it sounds like fact. Talk therapists, social workers, and skeptical psychiatrists, like Peter Breggins or Judith Herman, tend to be more openminded about causality and less resigned to nonstop drug treatment. Truthfully, we don’t know exactly what causes any specific episode of severe mental distress. Where genetic inheritance may influence distress, we don’t know why the same genetic inheritance produces mental health problems for some family members and not for others. Our uncertainty about etiology should lead to more caution and humility in diagnosis and drug use—both should be guided by an awareness of the highly limited, provisional nature of our present state of knowledge about the mind and brain.

I owe my drug-free mental health today to my decision twenty years ago not to accept a strictly biochemical explanation of my distress as the gospel truth. Biomedical knowledge—doctors, clinical labels, and drugs—helped me manage my crisis in the short term. Poetic understanding enabled me to build mental and physical health in the long term. The study of literature has offered me lifesaving ways to think about the experience of madness. I followed short-term biomedical treatment with long-term effort to *read the story* my symptoms told and to *translate* the metaphors enacted through madness into usable insights. I took responsibility for *naming* and *explaining* my own condition. Reading my madness like a poem or story enabled me to understand and resolve the causes of my breakdown. As I recovered, I used poetic concepts to understand *why* my mind and body collapsed and *what life changes* recovery required. Images and themes from four millennia of literature enabled me to understand what madness had revealed to me about maximizing the creative potential of my own life.

Whereas biomedical thinking asks how we can most quickly get rid of our disturbances, poetic thinking asks us to wonder what our disturbances mean. How and why have our minds stopped functioning effectively? What do our visions, hallucinations, delusions, fantasies, and strange actions mean? Toward what secret or forgotten truths do they lead us? What do they tell us about ourselves that we don't already know? How are they connected to the rest of our lives—to our loves, dreams, hopes, fears, and desires? What do they tell us about our world that we wish we didn't know and wish weren't true? And how can they point us toward changes that will mobilize our creative powers? To adherents of the biomedical model, to approach madness poetically is to romanticize madness inappropriately. My experience convinces me that a poetic approach to madness is more pragmatic than romantic—a potent healing modality.

I used medicine to stabilize my disturbance and literature to comprehend and then resolve my disturbance. I took an anti-psychotic for two months, and an anti-seizure drug, Depakote, for six months. The drugs straightened out my thinking considerably while causing a thirty-pound weight gain, significant hair loss, and sexual dysfunction. Because of the side-effects, and because the diagnosis did not feel like a perfect

fit, I decided to discontinue medication. No one should ever discontinue psychiatric medication without medical supervision and without loved ones being informed of the drug drawdown. With a psychiatrist's supervision, my family's support, an acupuncturist's services, and a lifestyle free of all nonprescription mood-altering substances, I resumed the drug-free lifestyle I had enjoyed before my ordeal began. To everyone's relief, Ophelia did not return. I set myself to understanding what had happened to me.