

INTRODUCTION

Manic Depression in America

If I want to be beyond criticism, loved by everyone,
flawless as a gem and incorruptible as platinum,
having a holy hatred of evil and a desperate love of good—
and if I plunge into suicidal melancholy
when I realize how impossible this is,
is it such a bad thing?

—C. E. Chaffin, “My Testament”

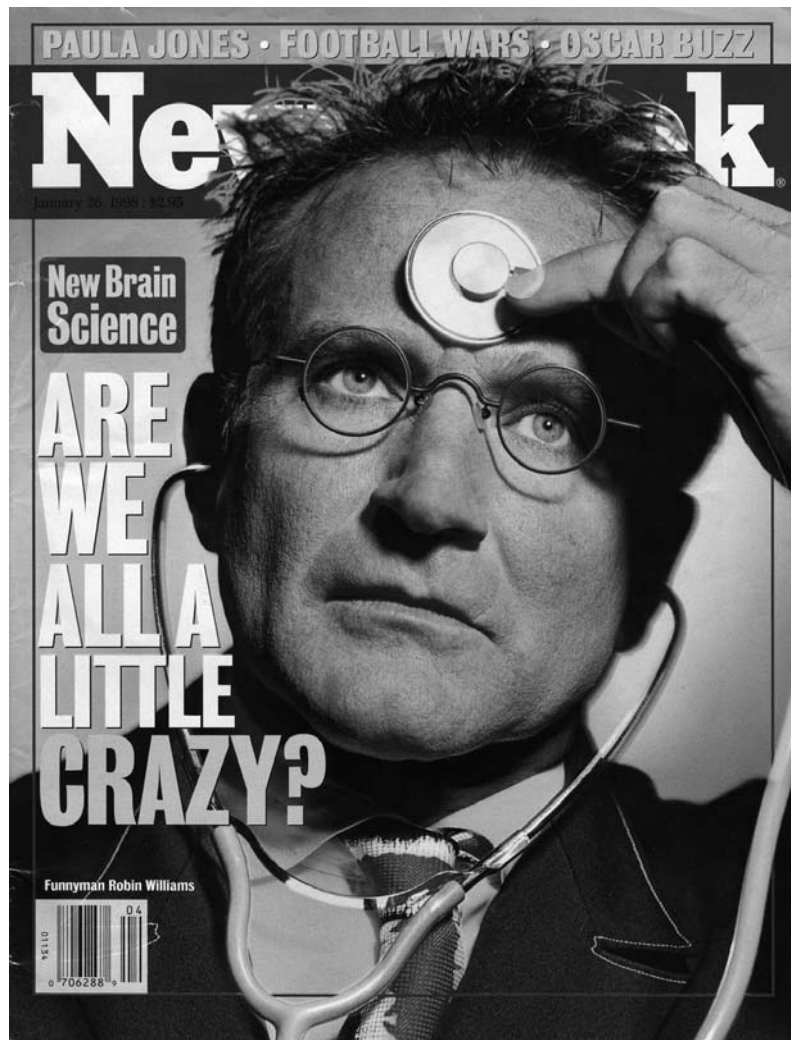
American culture today has a strong affinity with manic behavior. Advertisements use the quality of mania to sell products from Macintosh computers to luxury linens, from perfumes by Armani to shoes by Adidas. Manic energy fuels the plots of detective novels, MTV shows, and television dramas such as *ER*; it rings through the lyrics of songs like Jimi Hendrix’s “Manic Depression.” Serious academic tomes as well as patient advocacy Web sites and professional psychiatry meetings celebrate the creative mania of artists from Vincent van Gogh to Georgia O’Keeffe. During my ethnographic research in the years since 1996, I have found that people in many walks of life in the United States are fascinated by manic behavior and see it as a valuable resource in the ever-accelerating spiral of “productivity.” Members of support groups for people with manic depression look to figures like Robin Williams or Jim Carrey as role models because of their manic performances; television regales the general public with the adventures of larger-than-life figures such as the polar explorer Sir Ernest Shackleton because of his manic and heroic feats. Television programs like Jim Cramer’s *Mad Money* operate at “hurricane-force,” mirroring the manic pace of markets.¹ The high energy associated with manic behavior seems to add to the creative potential of entrepreneurs, business leaders, and entertainers.

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CEOs, Hollywood stars, and MTV *The Real World* youths embrace the diagnosis of manic depression, reveling in the creativity of its mania and regretting the immobility of its depression. Frequently, stories about manic depression involve life-and-death risks. One executive, a “manic CEO,” delivered his company “from the brink of death to complete dominance in an important technology market.” His kinetic energy and frenetic enthusiasm made him “the greatest salesman in the world,” and talking to him was “like being on an acid trip.”² But while manic CEOs are carrying off feats like these in the business world, they are also facing their own brush with death: fearing the public revulsion toward mental illness and reluctant to admit they need treatment because it would be taken as a sign of weakness, they face their inner turmoil privately. Some, like Mark Helmke, first “spend a company into bankruptcy” and then commit suicide.³ Popular media frequently assert the life-threatening nature of the condition. The *Washington Post*, in an article on the rise in diagnosis of bipolar disorder among children, puts it in a nutshell: “The illness, which is usually diagnosed in adolescence or early adulthood, is a serious and disabling mood disorder that, if untreated, carries an elevated risk of suicide. Sufferers typically cycle between manic highs, in which they can go for days without sleep in the grip of grandiose delusions, and depressive lows, marked by a preoccupation with death and feelings of worthlessness.”⁴ Too often, the depressive lows swallow up a person’s life.

Even in the face of life-and-death risk, popular books like *Emotional Contagion* or *Leading Change* report on the importance of high-energy moods.⁵ Since a leader’s mood is “literally contagious,” his primary task, indeed, his *primal task*, is “emotional leadership.” Mood is seen as all important for success: “A leader needs to make sure that not only is he regularly in an optimistic, authentic, high-energy mood, but also that, through his chosen actions, his followers feel and act that way, too.”⁶ A wide variety of publications directed toward business managers claim that the emotional contagion of high moods can directly affect business success.⁷

In this book, I will explore the cultural understandings and practices that surround mania and manic depression in the United States. How have these understandings and practices emerged from the recent past



Intro. 1. Robin Williams, depicted as a crazy comedian on the cover of *Newsweek*. *Newsweek*, January 26, 1998. © 1998 *Newsweek*, Inc. All rights reserved. Reprinted by permission. Photo by MosheBrakha.com.

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and how were they different in the past? With what American cultural assumptions about life, death, power, weakness, capacity and incapacity, the mind, and the body are they infused? How do these assumptions differ for people in diverse life circumstances and at different ages, for men and women, for people with different racial or ethnic identities? Most crucially, how can we understand contemporary psychiatric and neurological claims to knowledge about mental states in a historical and cultural way when they beg to be taken as new forms of scientific truth and when, for some of us (including me), our status as rational people may be deeply dependent on these claims?

The affinity that contemporary American culture has for highly energetic, “manic” behavior is not simple.⁸ On the one hand, in 1998 *GQ* chose Ted Turner as “man of the year.” Because Turner launched several dramatic business successes with the help of his “manic” energy, the magazine described him as “the corporealized spirit of the age.”⁹ On the other hand, just a few years later, Howard Dean’s “manic” behavior wounded him fatally after the 2004 Iowa primary. Some journalists described Dean’s behavior as outrageous: “Face plastered with a manic grin, Dean three times screamed out a litany of states he would win, and capped off his sound bite with a barbaric yawp.”¹⁰ His behavior was even seen as animal-like: “Dean was as manic as a hamster on a wheel as he rambled on and let out a rebel yell.”¹¹ Dean’s fate makes it plain that mania is as much an object of horror as desire. Whatever affinity there is between mania and American culture, it is not harmonious or sympathetic: fear, disgust, and revulsion are the kinds of sentiments that roil the surface when a person flies out of control and “cracks up.” Extreme states like mania may fascinate and attract us, but they disquiet us as well.¹² Why was mania good for Ted Turner but bad for Howard Dean? In this book I will try to answer this question by considering how people in the United States understand manic behavior generally and how scientists, therapists, patients, and pharmaceutical employees understand the kind of mania that is part of the specific condition of manic depression.

Is the mania attributed to Ted Turner or Howard Dean the same thing as the mania that is part of manic depression? This question has no simple answer. In my ethnographic research, moving from setting

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to setting allowed me to observe and listen to patients diagnosed with manic depression, psychiatrists struggling to treat it, pharmaceutical marketers hoping to sell remedies for it, and researchers seeking to understand its causes. None of these different groups would agree on a single answer to the question. Apart from my research proper, my daily life had already shown me that no part of manic depression is seen simply as an asset. Ever since I began to write and speak about bipolar disorder, college students have been telling me how often administrators react with dismay and alarm when they hear a student has been diagnosed with manic depression. At Princeton, where I taught for a number of years, students who are diagnosed with manic depression must often take a lengthy leave and then apply for readmission. Fear—of a student committing suicide, failing academically, socializing excessively—is mixed with the attraction—for writing creatively, studying energetically, socializing exuberantly—that people imagine could come along with the condition. A colleague at a large state university called me for advice about what to do for a graduate student who confided that he had been diagnosed with manic depression. My colleague wondered whether she should inform other faculty, assuming the student gave his permission. Speaking out might cast suspicion on the student's rationality and his academic abilities, but it might also help protect him against undue stress. My colleague felt caught in a vise: the student's manic depression might signal his special creativity but at the same time it would also signal that he suffered from a frightening and dangerous emotional disorder.

Rational and Irrational

Being known as a manic-depressive person throws one's rationality into question. There are high stakes involved in losing one's status as a rational person because everything from one's ability to do one's job, teach one's students, obey the law of the land, or live with one's family can be thrown into doubt.¹³ Exploring how rationality is understood today will be one of my main goals in the chapters to come.¹⁴ From classical times to the nineteenth century, madness was defined as the loss of

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rational, intellectual functions. Plato and Aristotle considered “reason” the defining human characteristic, the means of achieving knowledge, and the prerequisite of ethical freedom. When reason was absent or obliterated, the result was error and evil: the unleashed “passions” would be the source of disorder. However, the passions, as the animal part of humans, served as their source of energy: hence it was important for emotions to be present, albeit reduced and subordinated.¹⁵ The Greeks defined such things as dreams, passion, and poetic intuition, the voices of the insane or of the prophets as irrational. They were not regarded as sources of knowledge of a rational kind, but they were regarded with respect because they came from contact with the supernatural world.¹⁶ There was an interest, in classical Greece, in making a sharp separation between the rational and the irrational: only the rational, male, adult Greek was a full person, a citizen who owned property and cast his vote in the city-state.

Today much of this has changed, but some institutions, like the law, reveal the outline of older dichotomies. Consider a case that appeared in the Florida courts in 1996. Alice Faye Redd was a prominent, well-off citizen who was president of the PTA, the Junior League, and the Garden Club. During Richard Nixon’s presidency she was honored as one of ten outstanding young women of America. Her daughter, however, discovered that for nine years Redd had been running a pyramid scheme, involving 103 people (many of them elderly members of her church), who eventually lost \$3.6 million. The family, assuming she “must have lost touch with reality,” sent her to a mental hospital. There she was diagnosed as “chronic hypomanic personality,” a condition, “known as Bipolar 2, in which she was almost always in an elevated mood, needed little sleep, was full of grandiose ideas and was likely to engage in foolish business investments.” Meanwhile, prosecutors charged her with racketeering and grand theft, charges she did not contest. Psychiatrists retained by both sides in the case agreed she was suffering from “a form of manic depression that made her seem vivacious and charming, while at the same time twisting her thinking.” The psychiatrists selected by the prosecution wrote the judge that she “was

operating on a different reality” and that “her ability to appreciate the nature and quality of the acts was impaired.”¹⁷

But the judge could find her insane only if she could not tell the difference between right and wrong.¹⁸ Finding that she was not insane, the judge sentenced her to fifteen years in prison. He argued that her bipolar disorder merely slightly modified her perceptions, like wearing “rose-colored glasses.” Rather than making her fail to understand that what she did caused harm, her mania merely caused her to underestimate the harm she was doing to others. In the press coverage of the case, reporters said that people who knew her were fooled by appearance and blind to reality. “Appearance” was that “she seemed normal, a ‘super-woman.’ . . . She always had a smile and her hair and makeup were as impeccable as her gracious Southern manners.”¹⁹ The “reality” was that mental illness was common in the last six generations of her family, as shown by a genealogical chart included in the article.

If Redd were a rational person, then she would be held responsible for her actions and be subject to the law. Her actions would flow from the person she seemed to be, and where her actions were illegal, she would have to pay the price. But if Redd were an irrational person, an afflicted person with unmedicated manic depression who seemed rational but actually lived in a different reality, she would need to be hospitalized, not jailed.²⁰

The Alice Faye Redd case shows how oddly in between manic depression is. Like Emil Kraepelin, an early twentieth-century psychiatrist who noted its “peculiar mixture of sense and maniacal activity,” the judge placed her in between having sense and being a maniac.²¹ If he found her to be a wholly sensible person, he would be denying her hereditary manic depression; if he found her to be a wholly maniacal person, he could not sentence her to prison. The assumption that produces this dilemma is that the normal person is wholly rational. I suggest otherwise: in their everyday lives, most people have various degrees of awareness of reality and of the consequences of their actions, various degrees of “reason” in their decisions and opinions. I have an inkling of this from generations of undergraduates and graduate students in my classes who, given the chance to discuss the presence of the irrational

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in their daily lives, have a lot to say about their waking experiences of disassociation, free association, flight of ideas, emotional tempests or voids, and so on. These experiences are often fleeting, they do not usually interfere with daily life, and they would not be grounds for a diagnosis of serious psychological illness. But so frightful is the specter of such a diagnosis that most students say they have never admitted their small flights from the rule of reason before. It takes the strong grip of cultural assumptions to suppress evidence of the myriad ways people experience the “irrational”—awake or asleep. If such evidence did enter the picture, what would we do with Redd? Her case pointedly raises the question of whether the notion of an incompletely rational person—someone, I argue, who is like most of us—is compatible with the operation of one of our central institutions.²²

Although the term “mental illness” implies that Alice Faye Redd could be cured of what is wrong with her, and although new therapies are available that might cure her, the fear of madness still haunts those diagnosed with mental illness. Madness is a strange and horrible thing: who has not felt this? One of the classics of Western literature, *Heart of Darkness*, gave us the image of Colonel Kurtz, a mad soul wandering in a wilderness inhabited by beings he considers barely human, consumed by desire without restraint, operating outside reason.²³ A contemporary anthropological study describes the fear of madness as the terror of looking into the eyes of a mentally ill person and seeing no answering comprehension.²⁴ A contemporary memoir describes the madness of depression as a descent into darkness with a terrifying loss of lucidity.²⁵ In the face of such deep terror, my strategy in this book is to open up the terrain between the comfortable rational and the terrifying irrational, allowing more complex kinds of description to emerge. Most of the tidy dichotomies that float in the wake of the separation between rational and irrational (sane/insane, controlled/uncontrolled, responsible/irresponsible, reasonable/unreasonable) are inadequate to the task of capturing complex experiences like living under the description of manic depression.²⁶

My focus will be on mania for two reasons. First, far less has been written about mania than depression, perhaps because depressive disor-

ders are more common in the United States than manic depression (depressive disorders are commonly estimated to be found in 9.5 percent of the population over a twelve-month period, compared to 1.2 percent for manic depression).²⁷ Second, mania is the part of manic depression that we will see emerges onto the political economic stage as an object of desire. My argument is that we need to understand the meaning of manic behavior by describing what people do with “mania” and why they do it. In the same way we might try to understand the meaning of a word in a foreign language by noticing all the ways native speakers use the word, I have tried to notice all the ways that “mania” and related concepts and practices are used and interpreted in the different contexts of my fieldwork. The task is complicated because people cannot be aware of all aspects of their behavior. A great deal of what people communicate in their words and behavior is inchoate, beyond articulation in words. For this reason I have taken care to notice aspects of behavior—sometimes fleeting ones—that involve performance and style. On the importance of her own performance and style as a dancer, Isadora Duncan said, “[I]f I could tell you what it meant, there would be no point in dancing it.” The anthropologist Gregory Bateson understood Duncan’s remark to mean that communicating her message in words would falsify it: the use of words would imply that her message was fully voluntary and consciously understood when it was not.²⁸

Fully conscious or not, how another person understands one’s actions on a certain occasion may well hinge on such things as the effectiveness of one’s performance or one’s success in carrying off a style. These concepts will be central in my accounts of mania because they allow me to capture nonverbal aspects of meaning and to capture meaning in the moment people are making it.²⁹ Given the importance of language in forming our concepts of mental illness—medical diagnosis and the like—it will be especially important for me to focus on people’s actions as well as their words. Habitual actions, outside discourse, can persist in social life because they are relatively immune from being completely overtaken by the terms of discourse. Habitual practices could be said “to haunt objects and the material world.”³⁰ Hence both observing everyday actions and tracking the movement of ordinary ob-

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jects are ways to glimpse forms of agency that are not entirely captured by the terms of discourse.

These tasks complement the task my students took on: although they were defined as psychologically normal, they were able to produce reams of material about “irrational” experiences in their lives. In this book, I describe the behavior of people living under the description of manic depression, showing that their range of meaning-making, inflected by style, achieved through performance, is easily as complex as it is for those described as psychologically normal. Just what people take manic behavior to be—whether it is rational, irrational, or somewhere in between—is not a given. It is a matter determined by people actively trying to place behavior, words, performance, and style in a field of meanings. To keep this issue foremost, I deliberately use the phrase “living under the description of manic depression (or bipolar disorder)” to refer to people who have received this medical diagnosis. The phrase is meant to reflect the social fact that they have been given a diagnosis. At the same time, it calls attention to another social fact: the diagnosis is only one description of a person among many.

Mania is a concept that is used so differently by people in the same setting that it is almost as if the same word is being used in the sentences of different languages. This makes it a fruitful place to see contemporary changes in the significance that is given to manic behavior. What is happening is not completely new—mania has enduring significance that draws on its early twentieth-century formulation—but the concept is being applied in new domains and used to solve new problems, problems that are specific to the present time and place. While I have just written of “new” problems and domains, I do not pretend that what I will describe in this book is altogether new. It would be more accurate to describe what is happening as a shift of emphasis, a refocusing of the lenses through which we look. Broad notions of self-improvement, cyclic emotion, brain-based mind, and creative insanity have long been abroad in American society. But, as usual, the devil is in the details: my goal is to describe not a completely new set of concepts but rather an intensification of many old concepts that has made it possible for Americans to think about social life and about their psychic lives in new ways.

Brains and Genes

Cultural aspects of knowledge from the brain sciences are not a major focus of this book, largely because this knowledge, though central, did not play a dynamic role in the main settings of my fieldwork. The belief that the brain and its genetic determinants lie behind mental disorders like manic depression was simply assumed by most of the people in my fieldwork, inside and outside medical settings.³¹ In the course I took on neuropsychology during my fieldwork, we students dissected our way, week by week, through a sheep's brain. To understand psychological phenomena like attention or perception, we would have to understand the physical workings of the brain. This meant not only knowing the names and locations of brain structures, but also learning how to see them, and to separate them with a knife from the gray, gelatinous mass of brain tissue. In California, where research on brain imaging is a particular focus of university neuroscientists, many scientists I met were involved in ongoing efforts to correlate specific images of brain activity with specific disorders. More generally, there were increasing numbers of media articles picturing the activity of the brain (through PET scans and MRIs) and claiming to correlate brain states and conditions like emotion, addiction, schizophrenia, or criminality.³² Lately these claims have begun to reach an astonishing degree of specificity. One group reported that Democrats and Republicans had different brain states when they watched campaign commercials.³³ Reflecting an awareness of these news items, people in support groups I attended would quite commonly remark that they had volunteered as subjects in local university or hospital research on brain imaging and bipolar disorder. In group discussions, people often made remarks about having disordered or unbalanced "brain chemistry," which they hoped the drugs they were taking would fix. Since having a physical malady has far more validity in Western culture than having a mental one, people usually greeted new evidence that bipolar disorder is a "brain disease" as welcome news because of the generally accepted belief that physical ailments can be cured and, in the meantime, would be covered by health insurance, disability payments, or compensation claims.

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As for the genes that we may regard as responsible for the shape of our particular brains, people in support groups would often bring in newspaper clippings of scientific researchers' efforts to identify genetic and anatomic locations for manic depression. This was invariably done in the hopeful spirit, identical to the spirit in which most such articles are written, that locating the right gene or genes would lead to a specific treatment for the root cause of the problem. Perhaps because genetic research into the causes of manic depression has not yet reached a plausible conclusion, let alone developed therapeutic interventions, concern with this level of understanding among people in my fieldwork, outside research labs, was at a fairly general, taken-for-granted level. Most people hoped and believed that in time more effective treatments for psychic disorders would come along, and they would act directly, somehow, on genes, the brain, or both.

Although the topic of brains and genes was not often the subject of dispute during the years of my fieldwork, it could still give rise to drama. Some of my interlocutors living under the diagnosis of manic depression told me that given the presumption that the condition has a genetic component, they wondered about having children. The condition might be—whatever its value for creativity and productivity—too painful to risk bringing on one's own. Some knew of the brutal way Kay Jamison (a psychiatrist who has written about her own manic-depressive illness) was advised by her doctor not to have children.³⁴ Others knew of a scene in Stephen Hinshaw's book about his bipolar father, Virgil Hinshaw: Kay Jamison visited Stephen's medical school class and proposed a hypothetical question. If in the future, a prenatal test were available that could detect a gene that was strongly linked to bipolar disorder, how many would elect to abort if their fetus received a positive diagnosis? Almost all of the twenty-odd medical students, interns, and staff in the room raised their hands.³⁵ In these cases, fear of mental illness is enough to make manic depression seem incompatible with life.

Many people in my research believed that neurons and neurotransmitters in the brain affected their mental states.³⁶ In support groups, I frequently heard people discuss their ideas about how low serotonin levels cause depression and how medication can raise the level of sero-

tonin. Although most people treated the brain and its neurotransmitters as stable givens determined by their genetic makeup, they also assumed that drugs could modify the brain and its neurotransmitters.³⁷ In this book I do not deal extensively with the brain or genes, but I do not mean to imply that brain chemistry is unrelated to a scientific understanding of manic depression or to patients' experience of manic depression. I often heard from my psychiatrist that my problems were related to my neurotransmitters, and I always found this comforting. I took this to mean that my problems were not entirely within my control.

The Drug Factor

It is difficult to estimate with certainty whether the prevalence of mood disorders is increasing, but there is widespread public belief that it is.³⁸ For those who have access to information and health care, enhancement and modulation of moods through drugs has become as matter-of-fact as driving a sport-utility vehicle down the highway.

The one glimpse I had of the kinds of databases that the pharmaceutical industry has access to showed me that the rates of prescriptions for antidepressants and antipsychotics (increasingly used for mood disorders) had recently increased about two and a half times, from 51,003,000 in 1991 to 133,782,000 in 1998.³⁹ In 2006, a national survey reported in the *New York Times* found that prescriptions of "potent" antipsychotics for children and adolescents had risen fivefold from 1993 to 2003.⁴⁰ To understand the ways in which drugs become available, we will have to confront some forces that seem driven by the profit motive. For example, the Republican administration made determined efforts in 2004 to prevent the lowering of domestic prices for drugs by blocking European countries from exporting cheaper drugs to the United States and by delaying competition from generic drugs.⁴¹ When I was lecturing in Iceland in 2003, I visited a medical conference that had attracted numerous sales representatives from the major pharmaceutical companies. I asked the representatives at one booth why they had come to Iceland, with its small population and lack of direct-to-consumer (DTC) advertising. The reps explained that they

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Intro. 2. Refrigerator magnet showing antidepressant and anti-anxiety drugs as highway signs. Courtesy of Ephemera-Inc. © Amy Hill.

expected Iceland to be the first European country to permit DTC advertising. They were there to make connections with fledgling patient support organizations for depression and other conditions, and to support them financially as they have done in the United States. Presumably, people suffering from depression, manic depression, anxiety, panic, and other harrowing conditions will benefit from strengthened organizations that work on their behalf, not to mention from greater access to and information about drugs that can lift the spirit, smooth the brow, and ease despair.

A reader might judge these benefits to be sullied by the commercial motives that propelled the development and promotion of psychotropic drugs in the first place, but even the most aggressive commercial campaign can have intriguing multiple effects. Pharmaceutical marketers are no strangers to the kinds of cultural nuances that surround how mental life is imagined. They are studying these nuances, often with the help of ethnographers on staff in their companies. But they have

different aims in mind. For example, there is a sophisticated effort in play to introduce drugs for depression in Japan. This effort began when Solvay Pharmaceuticals and the two Japanese companies that shared rights to sell an antidepressant called Luvox decided it would be necessary to change the language Japanese people used to describe depression. Since the original word, “*utso-byo*,” was associated with severe psychiatric illness, they began to substitute “*kokoro no kaze*,” which loosely means “the soul catching a cold.” This phrase, meant to imply that depression is a simple malady whose symptoms can be treated, contributed to sales of Luvox and to efforts to introduce similar drugs, among them Paxil and Zoloft.⁴² One effect of the companies’ efforts might be to increase the social acceptability of mental disorders, but it is disquieting that the drug comes first and the disorder it is said to cure comes second.

Mania is like a new continent with a distant frontier, whose receding horizon invites exploration and development, promising profits to pioneers. To extend the metaphor, many “developers” have been attracted to the riches of this land, where they have begun to exploit manic behavior as a promising source. Specialized companies actually help corporate work teams learn *how to be* manic. In no case is the development of methods of managing mania a simple matter of exploiting or manipulating people. In order for such management methods to capture public attention and compel action, a cultural proposition about the necessity of continually improving the person must already exist. This proposition builds on the longstanding American tradition of self-help through psychological knowledge,⁴³ but now greatly intensifies it. No person has an option about pursuing his or her development and the task is never done: the horizon of development is ever receding and the landscape that affects *how* one should develop is continuously changing.

The development of a large new array of drugs to alter and enhance psychological states has changed the psychological environment for everyone, inside and outside the categories of mental illness, although not, of course, for everyone in the same way. The familiar debate over whether a person with mental illness is capable of rationality is changed beyond recognition when people in every corner of society are thinking about enhancing their mental processes and when domains like mania

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that were formerly categorized as irrational have become a new continent waiting to be tapped for the sake of greater creativity and innovation, and, ultimately, greater productivity and profit.

A Short History of Manic Depression

Where did the category of “manic depression” come from? Its history goes back to the ancient Greeks, who thought that the health of the body was related to the four body humors: blood, phlegm, choler (yellow bile), and black bile. Because one’s character and health reflected whichever of these fluids was preponderant, a person could be sanguine, phlegmatic, choleric (bilious), or melancholic. Some traits that would look like depression today belonged to the melancholic humor and some that would look like mania today belonged to the choleric humor. The Greeks believed that mental derangement could involve imbalance among the humors, as when melancholy, heated by the fluxes of the blood, became its opposite, mania. Faced with such an organic cause, they might attempt to restore humoral balance by bleeding or purging.⁴⁴

In classical thought, the causes of madness were thought to be much broader than physical imbalance. In Plato’s account in the *Phaedrus*, manias could be caused by inspiration—from God, from poetry, or from love. A much later text greatly influenced by classical thought, Robert Burton’s *Anatomy of Melancholy* (published in 1621 and still in print), listed a wide range of causes for melancholy, including faulty education, stress (he cites too much studying), childhood influences, heredity, supernatural elements, Satan, the stars, God, a bad nurse, poverty, and much else.⁴⁵ Nor were these causes easy to classify as divine or demonic: in Christendom, especially, there was a heated debate about how to tell whether madness in the form of mania was divinely inspired, a form of spiritual rapture, or demonic, a form of frenzied lunacy.⁴⁶ In mania, because the soul had partly or wholly escaped the restraint of the body, the result could be sublime (one could be lifted into a transcendent state) or frightening (one could descend into a bestial, obscene condition).⁴⁷

In later antiquity, some writers began to identify states other than the humors, which contributed to health. Galen wrote about the “non-naturals,” which included the passions, and set them alongside the humors. For Galen and other later medieval scholars, keeping the passions in balance was as important for mental and physical health as keeping the humors balanced.⁴⁸ However, they still believed that the primary cause of insanity lay within the intellect rather than within the passions. Melancholia, for example, involved loss of acuity of an intellectual sort (a mixture of irrationality and impaired behavior) rather than disordered emotions. A specific emotional state such as sadness or fear was neither a necessary nor a sufficient condition for insanity.⁴⁹ The emphasis on the intellect as the domain of sanity—a sound mind as the basis of rationality—reached its apex in the philosophy of Descartes and other seventeenth-century thinkers. In this period, theories of insanity moved away from emphasis on the demons and humors of classical thinking. Enlightenment theorists provided no detailed account of insanity, but left it by default to a defect in the body or to a defective connection between mind and body.⁵⁰

The idea that disorders of the emotions could be responsible for insanity emerged in a halting way. After 1800, adherents of “faculty psychology” began to regard emotions as one of the separate powers of the mind, alongside others such as the will and the intellect.⁵¹ Faculty psychologists acknowledged that there might be disorders of the emotions, or affect, and in line with this, they proposed emotional forms of insanity.⁵² But even those most interested in including the emotions as a cause of insanity failed to develop a systematic account of what different forms of emotion meant to those experiencing them.⁵³ Darwin hindered the chance of developing a more sophisticated understanding of affect because he believed that the emotions were registered so deeply in the organism that no individual experience could account for them. According to Darwin, the emotions were the result of our evolutionary past and revealed our animal origins. Hence, individuals’ subjective experiences would not shed much light on their emotions, a view that left by the wayside doctors who tried to understand patients in terms of their individual lives.⁵⁴

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In spite of Darwin's impact, under the influence of faculty psychology in the second half of the nineteenth century, mania and melancholia were narrowed down and redefined as "primary disorder[s] of affect and action."⁵⁵ These new forms were "combined into the new concept of alternating, periodic, circular or double-form insanity."⁵⁶ This process culminated in Emil Kraepelin's concept of "manic-depressive insanity," which included most forms of affective disorders under the same diagnostic umbrella.⁵⁷ Drawing on thousands of clinical cases in Germany, Kraepelin reclassified all known mental illnesses into two major categories: dementia praecox (later renamed schizophrenia) and manic depression. In this bold reorganization, referred to as Kraepelin's synthesis, one major category (dementia praecox) was a malady of the intellect; the other (manic depression) a malady of the emotions.⁵⁸ He distinguished emotional maladies from intellectual maladies: emotional maladies were periodic, more benign in prognosis, and common in family histories.⁵⁹ Since Kraepelin thought of manic depression as a disease, he assumed that eventually a specific cause would be discovered and the invariant course of the disease would be described, just as the specific natural history and pathophysiology of pellagra (vitamin deficiency) and syphilis, both of which were believed to affect the central nervous system, already had been.⁶⁰ Kraepelin's synthesis continues to operate with force in contemporary psychiatric taxonomies, shaping the division between cognitive and affective disorders.

The other psychiatric school of thought that developed ideas about the etiology of mania and depression in the early twentieth century was psychoanalysis. In his early writings (1917), Sigmund Freud saw melancholia, an "open wound" that drains the ego until it is "utterly depleted," as a loss or disappointment that was turned inward against the ego. He recognized that some patients alternated between melancholia and mania but could not at that time devise an explanation that satisfied him.⁶¹ By 1923, Freud saw that when melancholia takes hold, it is a result of the person's "excessively strong super-ego," which rages sadistically against the ego and can drive the ego into death, if the ego "does not fend off its tyrant in time by the change round into mania."⁶² Mania, therefore, is the ego's defense against the destructive impulses

of the super-ego. More influential in England than in Europe or the United States, Melanie Klein developed the notion of the “depressive position,” something the healthy psyche achieves in the first year of life. The depressive position, in which the person recognizes herself as separate from others and as a result has to contend with feelings of loss, mourning, and sadness, can give rise to the “manic defense.” Out of a wish to avoid the pain of the depressive position, the person uses a sense of omnipotence (manic activity) to master and control the threat. Hence, for Klein, depression and mania could both be part of normal development, though ideally the manic defense would eventually give way to other forms of accommodation to the depressive position.⁶³

Alongside these developments in psychiatry, popular representations of mania and manic depression took many turns from the beginning of the twentieth century to the present. From the start of the century until the 1940s, judging from my reading of popular magazines and newspapers in the United States, neither mania nor manic depression was mentioned with any frequency except in relation to a frightening kind of insanity.⁶⁴ News stories about people with manic depression described uncontrollable impulses that led to violence or self-destruction. These headlines illustrate the tone: “Maniac Kills Man by Push on Elevated [railway]; Says He Acted on Irresistible Impulse in Causing Death at First Attributed to Fall” (1929)⁶⁵; “Mrs. Fosdick Kills 2 Children and Self; Lawyer’s Wife, Deranged for Years, Shoots Daughter, 16, and Son, 10, as They Sleep” (1932).⁶⁶ Closer to the 1940s, articles with sensational headlines about deranged maniacs become hard to find. The appearance of the first reports of chemical means to treat mental illness could have been responsible for a reduction in fear of the out-of-control “mentally ill.” “Chemistry of Insanity” (1938) describes new therapies using insulin and Metrazol shock therapy and new technology, such as the electroencephalograph, that could reveal different brain electric waves in different forms of mental illness.⁶⁷ “New Vistas Opened for Chemical Approach to the Treatment of Mental Illnesses” (1947) and “Chemical’s Cure of Insane Is Seen” (1947) describes continuing technological advances in visualizing brain function and evidence of physical differences between normal and “mentally ill” patients’ brains.⁶⁸

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From the 1940s to the 1960s, the tone in descriptions of manic depression is tinged with sorrow. An episode of the television show *Manhattan* (1960) featured a heroine who was driven to manic depression by her villainous husband.⁶⁹ The victim in this episode was seen as helpless, but in other cases, the manic-depressive person was exhorted to improve. In lectures given in New York to Red Cross home nurses to prepare them to care for returning war veterans, manic-depressive patients were described thus: “They don’t deviate too much from normal people—except they go too far. They are over-elated. They over-talk, over-act. They cannot settle down to things that are part of daily routine.” The cause of this is that these individuals have denied themselves simple pleasures over the years, in favor of working too much. As a result, there is “an accumulation of tension and a final blowing off into a manic-depressive stage.” These people need to be shown “how vitally important it is for them to tone down their excessive energy and to give some of it to the enjoyment of simple human pleasures.”⁷⁰

I have been able to find only a handful of book-length biographies or autobiographies from the turn of the century to the end of the 1960s that mention the subject’s manic depression. By and large, reviews of these books only obliquely, if at all, associate manic depression with talent or virtue. A minor character in a biography of the Robert Pearlsall Smith family suffers from manic depression in old age and becomes an “intolerable old man.”⁷¹ Lawrence Jayson, the author of an autobiography from 1937 titled *Mania* does not spare the reader accounts of his suffering and subsequent suicide attempts. In this book, unusual for its time, the author juxtaposes the states of mania and depression with his experiences at work, for good or ill. On the one hand, his coworkers try to draw on his “high powered salesmanship” to save an account; on the other, he fears that if he fails, this will precipitate another cycle of depression.

It had been the failure of just such business deals as the one I had plunged into last night that had precipitated my melancholia and brought me down. Worry. Worry. Anguish about failing business. Watching the market crash. Then, overwhelmed by a fear of falling seriously ill, of having my brain impaired, I had tried to forget by driving myself more fiercely into work.⁷²

A more positive view surrounded the biography of John Ruskin by R. H. Wilenski (1933), which was hailed in the press for successfully correlating Ruskin's writing with the state of his mind at the time. He was a "mental invalid all his life," "suffering continuously from the malady known in psychiatric circles as 'manic depression.'" ⁷³ Ruskin was regarded as talented: "He learned as the imaginative genius learns, by suddenly piercing to the heart of a thing and understanding it." But his talent stood somewhat to the side of his illness: "In his manic moods he boasted of his power. Even in his depressed moods he very seldom doubted it. And he really had it." ⁷⁴ In a similar vein, the publication of the journals of André Gide in 1947 conveyed to the reviewer his "emotional intensity, his alternate ascent to peaks of joy and physical well-being and descent to an avernus [gateway to Hades] of acute depression, nervousness, insomnia and gloom. Amateur psychiatrists would have no trouble finding plenty of evidence of manic depression in these pages . . . [he] was hardly in normal control of his emotions." As with Ruskin, Gide succeeds in spite of, not because of, his manic depression: "But, there can be no doubt, that [he] has one of the most acute minds and one of the most genuine literary talents of his generation." ⁷⁵ Equally tellingly, when Virginia Woolf's husband, Leonard Woolf, died in 1969, there were some thoughtful articles about his role in her struggles with manic depression, and many references to her "genius." But there was little mention of a link between these two aspects of her life. ⁷⁶

By 1970, an atmospheric change had taken hold. The efficacy of lithium carbonate in animal studies led to its use in humans for the treatment of manic depression, and this discovery received major press attention, even before it had received approval for therapeutic use in the United States. ⁷⁷ As if the existence of a treatment for manic depression in and of itself made the malady seem more approachable or possible to imagine as something more than maniacal insanity, a series of media developments ensued. Lithium as a remedy for manic depression made it into two episodes of a television show, *Maude*, in January 1976. The airing of these shows was controversial because people feared that the public, jumping to the conclusion that all forms of mental illness could be treated by lithium, would ignore lithium's potentially serious side effects. ⁷⁸ Autobiographies began to describe manic depres-

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sion as a stimulus to creativity as well as a hurdle to be overcome. In *Josh: My Up and Down, In and Out Life*, Josh Logan, a theater director and producer who won a Pulitzer Prize for *South Pacific*, describes the triumphs of his career despite the two breakdowns he had as a result of his manic depression. In 1976, Ronald Fieve, who, not coincidentally, was Josh Logan's psychiatrist, wrote the first widely popular book about manic depression, stressing that it could be treated with lithium. This book, *Moodswing*, also laid the groundwork for future elaborations of the links between the manic phase of manic depression and success in the marketplace. In a filmed interview, Fieve expounds on what he called the "Midas effect": the ability of a manic person to take creative risks, work with enormous energy, and sweep others up along the way often leads to his economic success.⁷⁹

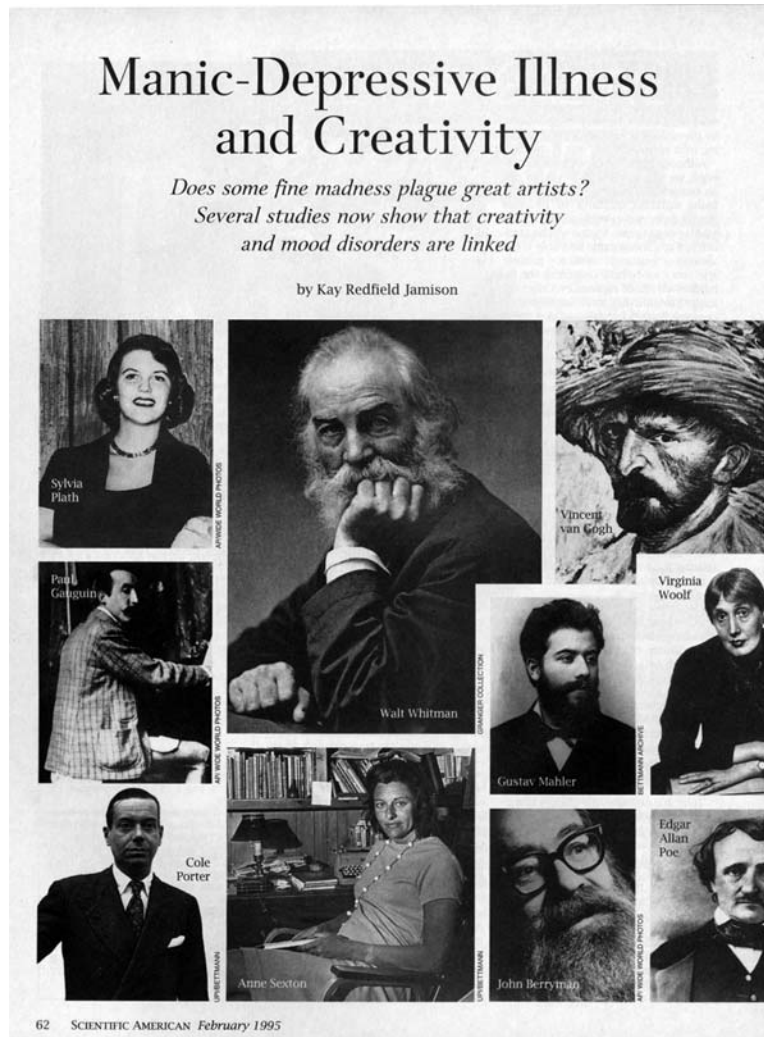
Around this time manic depression came to be used as a general metaphor or framing device for the social conditions of the day. In a 1977 newspaper editorial, "Man's Despair, and Hope," Eric Bentley mused on the "glum" faces of the people he saw across from him on the subway. Their facial expression ranged only from "resignation to rage, from moroseness to aggression." He noted how differently people were depicted on the subway advertisements above their heads: "They picture the same people—ourselves—our fellow Americans, but in an exactly opposite mood. Gone is their manic depression. Come is their fixed elation. Their beautiful teeth proclaim their unmixed happiness. They laugh, they smile, or they show a gravity that is all poise and self-assurance. . . . In short, the ads are populated by optimists, while the seats are occupied by pessimists." Bentley went on to decry both exaggerated optimism and exaggerated depression among U.S. citizens in general, and to call on the moderating effects of an active intelligence to raise mindless (and overly emotional) hopelessness and to lower equally mindless optimism.⁸⁰

By 1980, Kay Jamison had begun to publish her work on creativity and manic depression.⁸¹ In *Touched with Fire*, through careful examination of the content of personal diaries and letters, and patterns of productivity and fallowness, Jamison suggested that the diagnosis of manic depression (she prefers the term "manic-depressive illness") could be retrospectively applied to writers and artists such as Walt

Whitman, Vincent van Gogh, Virginia Woolf, Anne Sexton, and Edgar Allan Poe. Jamison listed over two hundred composers, artists, and writers who arguably had some version of manic depression, from T. S. Eliot and Edna St. Vincent Millay to Georgia O’Keeffe, Edvard Munch, and Jackson Pollock.⁸² Her effect on the public representation of mental illness was dramatic. By 1989, a mental illness advocacy group, Mental Illness Foundation, was soliciting contributions from the public in an advertisement featuring a photograph of Abraham Lincoln.⁸³ The headline read, “You’d be surprised how many people have suffered from mental illness.” The text of the ad read, “It is not commonly known how many well-known figures in history suffered from mental illness. Depression. Manic depression. Schizophrenia. Suicide. Among them were Abraham Lincoln. Vincent van Gogh. Nijinski. To the world at large, they were powerful figures, but in the privacy of their own thoughts and feelings, they were at the mercy of mental illness, and suicidal tendencies.” The ad did assert the link between creative and powerful people and mental illness, but its main message was still that these great people had to overcome a serious handicap in order to succeed.

It would be hard to exaggerate the impact of Jamison’s work, which has been featured in major newspapers, magazines, and documentary films. In 1995 she published an article in *Scientific American*, arguing that the “temperaments and cognitive styles associated with mood disorders can in fact enhance creativity in some individuals.”⁸⁴ The article singles out a number of famous artists, musicians, and writers who could be considered manic depressive by the evidence in their letters and journals, or in descriptions given by physicians, family, and friends. No less than eighteen of these figures were illustrated with dramatic photographs or self-portraits, which surely enhanced the impact of the article for its readers. Among those pictured were poets Walt Whitman and Sylvia Plath, artists Vincent van Gogh and Paul Gauguin, writers Virginia Woolf and Edgar Allan Poe, and musicians Gustav Mahler and Cole Porter. Since Jamison was well known as the coauthor of a technical reference work on manic depression and as a frequent participant in national meetings of advocacy organizations, her publications on

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Intro. 3. Icons of artistic creativity from *Scientific American* article by Kay Jamison.

creativity added an additional layer to the esteem in which she was already held.⁸⁵

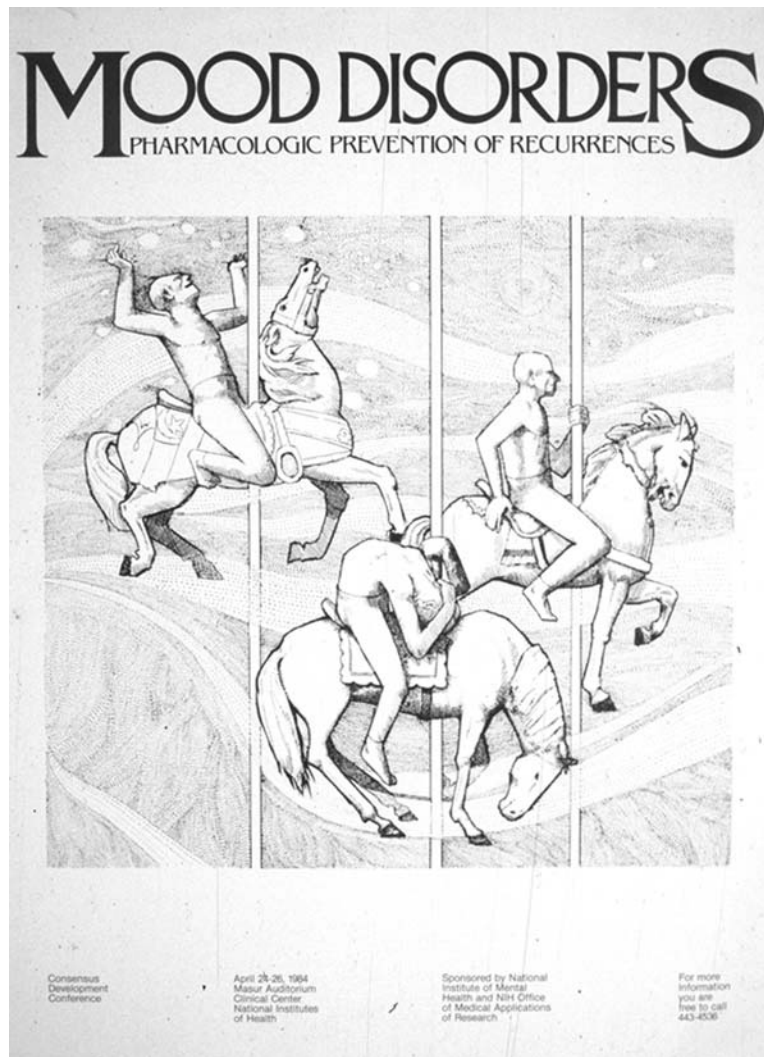
Her revelation in 1995 that she had the diagnosis of manic-depressive illness added further to her popularity. At one meeting of a manic depression support group in Orange County, the facilitator, Sarah, started

off by passing around an issue of the *Saturday Evening Post* containing an article on manic depression by Kay Jamison, together with a program from a concert Jamison organized in southern California to highlight the music of famous manic-depressive composers such as Handel, Schumann, Haydn, and others.⁸⁶ Sarah commented that because these artists from the past did not have the benefit of today's medicine, they were so out of control that they made lots of suicide attempts. She also passed around a photo album that she had kept over the years with photographs she had taken of Kay Jamison giving talks at national meetings. This album was very worn from use and filled with Polaroid photos Sarah had taken herself.

The next developments in the revaluation of mania amount to a sea change in the understanding of mood: scientists began to understand the molecular mechanisms involving receptors in the brain as a system of interacting receptors and neurotransmitters. The pharmaceutical industry began to develop a new generation of drugs that could modify the way receptors worked and therefore the ways people experienced moods. For a brief glimpse of the public representation of these developments, we can look at two public health posters from 1984. The first commemorates Julius Axelrod's discovery of the cycle of interactions involving serotonin, a neurotransmitter: the abstract illustration depicts the space in between neurons, known as the synaptic cleft, and shows the newly understood variety of molecules in that space. The other commemorates a National Institutes of Health (NIH) conference held to develop a consensus about how mood disorders could best be treated. The poster portrays three men on the "merry-go-round" of mood disorder, one in the grip of mania, one in the grip of depression, and one somewhere in between. The title of the conference, "Mood Disorders: The Pharmacologic Prevention of Recurrences," indicated that the components of mood disorders at both ends of the scale from depression to mania seemed amenable to a vastly greater degree of management.

In the 1990s, an important shift in popular terminology occurred, one that probably played a significant role in changing how people regard manic depression. Authors of popular books and articles began using the term "bipolar disorder," following the shift from manic depression to bipolar disorder in the DSM-III in 1980.⁸⁷ From the 1980s

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Intro. 4. Poster from 1984 National Institute of Mental Health Consensus Development Conference showing the ups and downs of mood disorders. Courtesy of National Library of Medicine. Artwork by Robert F. Prien, Ph.D.

to the end of the 1990s, the use of the two terms was equally frequent in U.S. newspapers, but in the years since 1999, “bipolar disorder” has been used nearly three times as often. In August 2002 the major consumer advocacy organization for manic depression and depression, the National Depression and Manic Depression Association (NDMDA), changed its name to Depression and Bipolar Support Alliance (DBSA), specifically to avoid the term “manic depression.” They explained on their Web site:

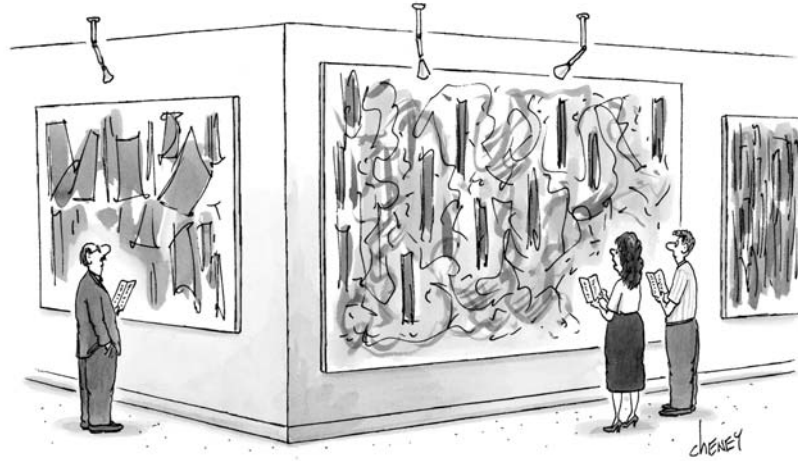
The decision to change our name came only after long and hard thought. There are many reasons the Board of Directors feels this is important. First, and foremost, our name was long and difficult for most people to remember correctly. Perhaps even more difficult was saying our tongue-tying acronym—National DMDA. In addition, bipolar disorder is no longer called manic depression. Many people are frightened by the term “manic depression” and this keeps them from contacting us for help.⁸⁸

Over the last one hundred years or so, fright over the term “manic depression” has transformed into fascination with the term “bipolar.” Sometimes this fascination involves the extraordinary abilities bipolar people apparently have, as demonstrated in the *New Yorker* cartoon that depicts a couple viewing a painting in a museum. One says to the other, “It’s good, but it doesn’t say bipolar.” In other words, if the painter were “crazy,” his painting would have more value.

Sometimes whatever the manic end of bipolar represents has come to seem essential for survival, and certainly for success, as long as it is not overdone. As the novelist Tom Wolfe captures this sentiment in *A Man in Full*, the mayor of Atlanta discusses the city’s midtown high-rise towers and how they demonstrate that Atlanta wasn’t a regional center, but a national one: “He gestured vaguely toward the towers that reached up far above them. ‘They did it! Atlanta favors people who are hypomanic—I think that’s the term—people like Inman Armholster who are so manic they refuse to pay attention to the odds against them, but not so manic that they are irrational.’”⁸⁹

Kay Jamison prefers the term “manic-depressive illness” to bipolar disorder because it “seems to capture both the nature and the seri-

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"It's good, but it doesn't say 'bipolar.'"

Intro. 5. *New Yorker* cartoon associating "bipolar" with outstanding art. Reprinted with permission. *The New Yorker* (2002): 74. © The New Yorker Collection 2002 Tom Cheney from cartoonbank.com. All rights reserved.

ousness of the disease," while "bipolar" seems to her "strangely and powerfully offensive."⁹⁰ "Bipolar" "obscure[s] and minimize[s] the illness it is supposed to represent."⁹¹ Anticipating a theme that will emerge at the end of chapter 8, she also finds that the separation of moods implied by the term "bipolar" "perpetuates the notion that depression exists rather tidily segregated on its own pole, while mania clusters off neatly and discreetly on another."⁹² In this book I prefer the more old-fashioned term "manic depression" because it leaves open the question whether the condition is to be understood only as an illness or also as a psychological style. But when I describe fieldwork contexts, I follow the usage of my interlocutors.

Manic Depression in Culture

This book follows the history I have just sketched, beginning with the experience of manic depression as a psychological state and then trac-

ing its emergence into a broader cultural field. Closely connected to ideas about the market, manic depression morphs into bipolar disorder and comes to serve as a focal point for collective disquiet about why exhilarating highs and frightful lows seem to be inescapably intertwined in contemporary life.

My primary goal is not to take sides in the debate over whether social causes of mood disorders are more important than biological ones. Rather, I am interested in issues that are simply left out of that debate. I want to offer different kinds of descriptions of the experiences and actions of people said to have manic depression, descriptions that allow such people to belong fully to the human condition rather than to an outer sphere of “irrationality.”⁹³ I want to propose that “the human condition” might include both mania and depression within it. I have been guided by this analogy: consider manic depression to be a hand with a pointing finger. We might want to know about the physical properties of the hand, its muscles, tendons, bones, and how they enable the finger to point. Without those physical structures and relationships, no finger could point. But while the structures are necessary for pointing, they are not sufficient to understand what a pointing finger means. The pointing finger is a gesture that takes its cultural meaning from its use in a particular social context. By looking at mania and depression as “gestures,” my aim is to move toward a social theory of irrationality.

Will I be claiming that manic depression is not “real”? Not at all. I will claim that the reality of manic depression lies in more than whatever biological traits may accompany it. The “reality” of manic depression lies in the cultural contexts that give particular meanings to its oscillations and multiplicities. Will I be claiming that people living under the description of manic depression do not need treatment? Not at all. I will claim that whatever suffering attends the condition should be treated by any means possible. But I will also say that manic depression is culturally inflected: its “irrational” heights and depths are entwined in the present-day cultural imagination with economic success and economic failure. This is a central reason, as we will see, why manic depression’s triumphs and failures hold very different kinds of promises and threats for those in powerful social positions compared to those in weak ones.

Research Methods

When I began the research for this project, I had only the sketch of a plan. I began with support groups in southern California and was led to psychiatry, neuroscience, the pharmaceutical industry, and the rest out of my interest in following up on what people living under the description of manic depression were experiencing. I thought of these excursions as “expeditions” into large-scale organizations whose activities I could only sample in the most modest way. The description that follows has the coherence of something written after the fact.

Beginning in 1996, I attended seven support groups for manic depression, some on the East Coast and some on the West Coast, as regularly as I could for the better part of five years. For the most part, I observed and participated in ongoing group meetings and social events, and had informal conversations with people I met. Toward the end of my research I interviewed some of the leaders of the groups’ sponsoring organizations, in their official capacities.

My ethnography primarily focused on a pair of contrasting urban regions on each coast: the Baltimore metropolitan region in the Northeast (this area has been the base of my ethnographic work in the United States for the last twenty years) and Orange County in southern California. Both regions are suffering the effects of deindustrialization, poverty, and faltering town centers.⁹⁴ Baltimore has attempted to recoup its losses by constructing an urban spectacle in a historic harbor to attract tourism and finance capital, but this has arguably increased the concentration of capital in the hands of a few multinational corporations and contributed to poverty in the city.⁹⁵ Psychiatry in the region is located in both public and private institutions, including the University of Maryland, Sheppard Pratt Hospital, and The Johns Hopkins Hospital. Although I attended events at all of these institutions, the psychiatry department in one of them, here given the pseudonym Wellington Hospital, gave me permission to observe over a long term many of the ordinary contexts in which medical students and residents received training in how to treat patients for mood disorders. Since the department chair confined my activity to that of a medical student, I could

attend classes and sit in on rounds (meetings in which doctors and students met with patients whose cases illustrated an important aspect of some psychiatric condition). However, I could not follow patients behind the scenes into the clinic or the community because this would have threatened the patients' confidentiality.

Orange County, in contrast to Baltimore, has become the site for many small and medium-sized firms supporting burgeoning information technologies and the entertainment industry, from Hollywood to Disneyland. Like these industries, psychiatry is also relatively decentralized, diverse, and entrepreneurial, and seeks to create opportunities for feedback from patients.⁹⁶ Though Baltimore County and Orange County are roughly comparable in population and income distribution, and are largely "post-suburban,"⁹⁷ Baltimore County has a concentrated urban settlement (Baltimore City), which it surrounds and which the state requires it to support financially. Whereas in Baltimore I concentrated on the psychiatric treatment of manic depression, in Orange County I worked with the neuroscientists in the region, who were some of the foremost national experts in brain imaging for manic depression and ADHD.

This geographic reach allowed me to pose comparative questions about personhood and mental illness. For example, in Orange County, on the low end of the social scale, I came upon cases of both ADHD and manic depression being used by recent Mexican immigrants as explanations for their own or their children's poor school performance, despite the high intelligence their family and friends perceived. Although people in support groups frequently stressed that each person was unique, they acted as though the group members' common diagnosis could override any social or ethnic differences. The diagnosis apparently provided a neutral way of explaining differences, as well as a path to success in school or work with the help of medication. An ADHD support group in Orange County (all of whom were white) embraced a new member who was Asian American as being "just like us": all were thought to share a particular chemical makeup that made them unable to tolerate conventional nine-to-five desk jobs. In these cases, individuals were brought together across ethnic lines. On the high end of the social scale, my interlocutors in Orange County saw manic depression

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as tantamount to a requirement for a career in Hollywood, so common was it known to be in the entertainment industry and so necessary did its manic qualities seem for success in that field. Throughout the project, I was able to see how psychological categories were used in Orange County, as compared to the harsher, more rigidly divided economic environment of the Baltimore region, even though I did not organize the book along those lines. My research concerned manic depression and ADHD in about equal measure. Since the story that emerged turned out to be very complex, I have, for reasons of space, focused this book primarily on manic depression and its contexts. Because I will be able to mention ADHD here only rarely, the longer account of ADHD in its educational, media, work, and legal settings will have to wait for later publications.⁹⁸

The third project location was central New Jersey (in particular the counties of Somerset, Middlesex, and Mercer), through which the Route 1 high-technology corridor passes. With its high concentration of finance, communications, and pharmaceutical companies (Bristol-Meyers Squibb, Johnson and Johnson, Roche, Merck, American Home Products, Warner Lambert, and Hoechst, among others), its highly educated workforce, and its increasing reliance on temporary workers and outsourcing, the area is an East Coast version of Orange County's business environment.⁹⁹ In New Jersey, I concentrated my research on interviews with pharmaceutical company representatives and marketers, but it was also in New Jersey at Princeton University that I got basic training in the concepts and laboratory practices of contemporary neuroscience.

In addition to these geographically bounded sites, I traveled wherever I could to attend conferences and gatherings for professionals and patients related to manic depression and ADHD: the annual meetings of the American Psychiatric Association (APA); the meetings of the Neuropsychopharmacology Society; the Childhood and Adult Attention Deficit Disorder Association (CHADD); the Attention Deficit Disorder Association (ADDA); the Depression and Related Affective Disorders Association (DRADA); and the Depression and Manic Depression Association (DMDA). Over several years, I also attended a large variety of classes and seminars concerning work and the psychology of daily life: support groups for downsized workers, workshops and

training sessions for management of the workplace, training sessions for workers, support groups for adults with ADHD, seminars in self-esteem, classes for raising children to be productive adults, raising and schooling children with attention deficits, and so on. I collected and analyzed several hundred hours of tape recordings from these events. With people I met in these contexts, I carried out over eighty extensive, semi-structured interviews. To understand the contexts in which psychotropic drugs are produced, marketed, and advertised, I informally interviewed employees in the pharmaceutical industry in sales, marketing, and advertising. I also held a position as “visiting professor” in a major advertising agency.