

COMMENTARY

The intrinsic tension between articulating one's medical condition and explaining it: A commentary on *An Unquiet Mind*

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Abstract

Kay Redfield Jamison, an author, clinical psychologist, and professor at Johns Hopkins University School of Medicine, grapples with bipolar disorder — shaping her professional focus. She dealt with manic-depressive disorder as a professor of psychiatry and a successful medical professional. What was that experience like? In her memoir, An Unquiet Mind: A Memoir of Moods and Madness, she navigates the inherent conflict of explaining her own condition while delving into the discomfort of taking, as well as being on different, "sides". Through a close reading of select chapters, this paper explores the nuanced approach needed to understand the complexity of human experiences and perspectives amidst the challenges of mental illness.

Keywords: bipolar, manic-depressive disorder, mental health, psychiatrist, memoir

Clinical psychologist and author Kay Redfield Jamison is a professor of psychiatry and the Dalio Professor in Mood Disorders at the Johns Hopkins University School of Medicine in the USA. She has had bipolar disorder since she was a young adult, and this has been the focus of her work. Thus, there was an inherent conflict between the presentation and explanation of her own condition — which this paper attempts to delve into through a close reading of the "Prologue" and "Flights of the Mind" chapter of Jamison's *An Unquiet Mind: A Memoir of Moods and Madness* [1].

The book is a personal medical memoir, referring to an account of a person with manic-depressive disorder who is also an authority on the subject. Jamison shares her thoughts and describes her relentless journey across available treatment options, while also addressing perspectives on psychotherapy and lithium treatment. A first-person narrative perspective is used here, and we have access to another real-life character of a doctor — her psychiatrist who has also been her work supervisor in the past. Her tone is straightforward, and one that makes us readers empathise with her. The writing is emotionally charged and engaging, and she describes precisely what she felt.

There is a shift in her sense of self, observed when she goes to consult her doctor for the first time and finds two other patients waiting in the room. She is a doctor who is now a patient — the reversal of roles does not quite sit well with her. It causes her "indignity and embarrassment", which she calls "character-building". However, she is seen trading her ego for

"peace, predictability and a normal life". She has no choice but to be vulnerable — despite all her notions about herself being shattered — and that kind of vulnerability takes courage.

The simile and animal imagery of how she felt "like a large white rat pressing paw to lever for a pellet" are used to describe her pressing a button to inform her to-be psychiatrist of her arrival and secure her chance to speak with him. She finds the system "degrading" yet "practical" — the same system she had never thought much about when she was on the other side of the desk. It points to how looking at something from another person's perspective makes one notice what he/she never did and otherwise would not. Jamison feels she is now on the "wrong side of the desk", which causes her discomfort. She has always been on the doctor's end of the desk. The role reversal causes apprehension.

However, she has no choice but to make peace with it. The complexities of moral reasoning and the intricate fabric of human nature are at the core of the unease surrounding the concepts of "right" and "wrong" sides. Choosing a side frequently suggests a binary opposition, which breeds polarisation and separation and can result in conflict and alienation. Overcoming the discomfort brought on by "sides" calls for a nuanced approach that takes into account the diversity of experiences and viewpoints held by people.

In the subsequent paragraphs, we understand how important the reassurance and patience offered by a doctor are for the frame of mind of the patient. And how their manner of saying something is probably more important than what they are saying. It is interesting how Jamison describes her mind as "dark and frightened" and how the doctor's words and kindness gave it a "tiny bit of light".

He asks her several questions about her symptoms and lifestyle, to understand what is happening to her and to diagnose her condition. The inquiry ranges from how many hours of sleep she had been getting, to her sexual activity, to if anyone in her family had similar issues. While her examination is being described, there is a repetition of the word "unnerving". Having to answer the psychiatrist's questions and realising the confusion faced by a patient makes her lose some courage and confidence. It could also be a reference to her nerves and neural pathways in the brain — and how they were being affected.

Having been on the other side of the desk as a psychologist, she knew why the doctor was asking what he was asking, and what he would do next. Yet, she was now placed in the shoes of a patient and could understand how exposed they felt. This new perspective from the other side gives her a new “respect for psychiatry and professionalism”. Perhaps it could also help her be more empathetic and sensitive towards the mental state and needs of her future patients.

Her doctor’s experience and self-confidence have a “gradual” effect on her, and she compares that to the gradual calming effect of medication for mania. This points to how most treatments and procedures in mental illness take a “little-by-little” and progressive approach, rather than a sudden and abrupt one. As he made her diagnosis “unambivalently clear” to her and was not ambiguous in his delivery, the certainty of her having manic-depressive disorder both frightened and relieved her. Her relief shows the human tendency to constantly look for meaning, want to make sense of things, and find peace in absolute certainty.

Her sentences here tend to sound longer, and it is seen that she is both emphasising and connecting her ideas. The complicated “alternative explanations” of stressors for her breakdowns that she gives her doctor, is a very human reaction to the diagnosis of a mental health condition. It points to how we as humans tend to psycho-analyse our emotional states and behaviours. However, the reaction is even more weighted due to the fact that she is a mental health professional herself.

She describes her doctor as someone who kept her “alive a thousand times over”. A spectrum of events and emotions are revealed in that particular paragraph — giving us a glimpse of what manic-depressive illness looks and feels like — with all its highs and lows. The inner world she conjures up is intensely vibrant. This is complemented by praise and appreciation for her doctor’s nature, qualities, and abilities — and also his belief in her ability to get better. It is also worth noting how she mentions that she was losing “...energy, vivacity and originality...” due to the medication, but was advised to take it for her “...costly, damaging and life-threatening illness...”.

Through her treatment, she becomes more aware of the “beholdenness” between the brain and the mind, and how the chaos in her mind may have been leading to the chaos in her life — externalising what is happening internally. Her treatment makes her understand how her temperament and moods directly affect her relationships and her work — and vice-versa. She notices the roles played by “lithium, will, and insight” in getting well. She gains clarity into the complexities of her condition through psychotherapy. She then moves on to talk about the many ways in which both lithium and psychotherapy help her lead a normal life.

While pills are able to cure her and keep her “out of the hospital, alive...”, she mentions that it is psychotherapy that “heals” her and brings her back to reality. She calls psychotherapy a “battleground” due to the range of emotions

it makes her feel — but it also gives her hope. However, this is not the first time she uses a war metaphor to describe her illness and treatment. “The war I waged against myself is not an uncommon one...”, she writes in the prologue.

Despite having treated many patients, and now owing her life to pills, her own “lack of judgment” and reluctance to take lithium earlier had had severe consequences for her. She mentions how the medication or the psychotherapy alone does not suffice to deal with her condition and treat it, and talks about the benefits of both taken together. She advocates for a healthy combination of both pills and psychotherapy — as she says, “I need both” — no matter how odd that feels.

These paragraphs indicate that Jamison is someone who realised she was ill and was no longer able to deny it. She understood that she needed to make some adjustments if she wanted to stay alive, and she decided to get treated for her illness. It is fascinating to see her explain how her extensive understanding of mental symptoms and her own condition was ineffective in opposing her mind’s belief that she is well, symptom-free, and does not require medication. Her writing is intellectual yet approachable. It is hard to explicate how mania and depression can coexist simultaneously — but she manages to find the right words to do it.

It is illustrated here how severe mental illness can, and does, affect intelligent and high-functioning individuals. It also shows how one’s own knowledge and intelligence may not always be helpful when it comes to acknowledging and accepting one’s mental illness. Having said that, it is important to acknowledge and respect Jamison for her bravery and vulnerability in writing this account as a practising clinical psychologist. She not only acknowledges having the illness but also chronicles her experiences with it and its treatment.

She does not hesitate to admit that she experienced moments of “madness”, and that she was initially reluctant to avail of the treatment for it. She openly and accurately describes her treatment procedures. This contributes to reducing the stigma associated with mental illness and provides clarity on mental health challenges — while also altering the perception of medical advice that is typically prescribed in textbooks.

Jamison dealt with manic-depressive disorder as a professor of psychiatry and a successful medical professional — and these paragraphs demonstrate how she eventually came to terms with it. Her illness gave her states of highs and lows, and the middle ground between mania and depression was considered “healthy” and “normal”. However, she does not confine her descriptions to the tidy oppositional boxes of mania and depression. Her writing style reveals the complexity of the disorder while also drawing the reader in — because of its strength, vibrancy and brutal honesty. She has also woven in one of the major medical controversies of

the century — surrounding lithium and psychotherapy — into her own story. These paragraphs have effortlessly combined the seemingly contradictory domains of doctor and patient. As a doctor-patient, her narrative holds up a mirror to difficult particularities and dogmatic beliefs, and exposes their errors and inconsistencies.

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Conflict of Interest: None declared

Funding: None

To cite: Shetty S. The intrinsic tension between articulating one's medical condition and explaining it: A commentary on *An Unquiet Mind*. *Indian J Med Ethics*. 2025 Jul-Sep; 10(3) NS: 231-233. DOI: 10.20529/IJME.2025.021

Submission received: April 8, 2024

Submission accepted: March 5, 2025

Published online first: March 11, 2025

Manuscript Editor: Sanjay A Pai

Peer Reviewer: Anupama Iyer

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COMMENTARY

Applying the non-maleficence principle to basic research in Alzheimer's disease

BOR LUEN TANG

Abstract

Despite the urgency for new leads towards Alzheimer's disease (AD) interventions, the impact of such basic research on patient welfare and potential socioeconomic repercussions are considered remote. Nonetheless, basic science research in AD must adhere to the highest level of ethical stringency. Even preliminary advances in AD basic research offer hope that percolates along the line from researchers to patients. A promising basic research result that is subsequently proven unreliable due to irreproducibility or research misconduct would not only dash hopes but might also misdirect downstream efforts. Furthermore, such misadventures could quash promising research directions that, if otherwise carefully and meticulously interrogated, could yield useful leads. Stringency and reproducibility in biomedical research should thus be framed in accordance with the principle of non-maleficence, which I posit should take priority over loose attempts at beneficence that offer more hype than hope.

Keywords: Alzheimer's disease, beneficence, hype, non-maleficence, research ethics

Introduction

Alzheimer's disease (AD), the manifestations of which range from progressive mild cognitive impairment to severe cognitive decline [1], underlies 60-70% of age-associated dementia [2]. In the United States (US) alone, an estimated 6.5 million Americans aged 65 or older suffer from AD, and this number is projected to grow to 13.8 million by 2060 [3]. A 2017 meta-analysis estimates the prevalence of AD in Europe at staggering 5.05% [4]. The total cost for healthcare, long-

term care and hospice services for people aged 65 and older with dementia in the US is estimated to be \$321 billion in 2022, while unpaid caregiving was valued at \$271.6 billion in 2021 [3, 6]. The hugely debilitating disease symptoms and heavy socioeconomic burden of AD have prompted extensive research efforts in finding and testing preventive measures and interventions against disease progression.

However, AD has proven to be a complex and difficult disease to tackle [6], and for many years therapeutics have been limited to drugs that provide only temporary relief of cognitive symptoms. These include those that sustain cholinergic activity (the acetylcholinesterase inhibitors donepezil, galantamine and rivastigmine) and a N-methyl-D-aspartate (NMDA) receptor antagonist memantine, none of which alter disease progression. More recently, an oligosaccharide from marine algae, sodium oligomannate (marketed as GV-971, Green Valley Pharmaceuticals), was approved for mild to moderate AD in China [7]. The US Food and Drug Administration (FDA) has granted accelerated approval to two human monoclonal antibodies (mAbs) targeting amyloid- β (or A β , which is a key pathological feature in AD), Aducanumab [8] and Lecanemab [9]. The latter mAbs are purported to be disease modifying through the reduction of amyloid load in the brain. At least for Lecanemab, a moderate suppression in measures of cognitive decline was also demonstrated in clinical trials [10-11], and the mAb (marketed as Leqembi) has recently been given full approval.

Most controversies in AD research have focused on the latter part of the research pipeline, namely clinical trials and the