

BREAKING THE SILENCE



Mental Health Professionals Disclose Their Personal
and Family Experiences of Mental Illness

Edited by Stephen P. Hinshaw

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OXFORD
UNIVERSITY PRESS
2008

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Oxford University Press, Inc., publishes works that further
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Oxford New York
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Kuala Lumpur Madrid Melbourne Mexico City Nairobi
New Delhi Shanghai Taipei Toronto

With offices in
Argentina Austria Brazil Chile Czech Republic France Greece
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Published by Oxford University Press, Inc.
198 Madison Avenue, New York, New York 10016
www.oup.com

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Library of Congress Cataloging-in-Publication Data
Breaking the silence : mental health professionals disclose their personal and family
experiences of mental illness / edited by Stephen P. Hinshaw.
p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-19-532026-8

1. Mental health personnel—Mental health. 2. Mental health personnel—Family
relationships. 3. Mental health personnel—Biography. 4. Mentally ill—Family
relationships.

[DNLM: 1. Mental Disorders—Personal Narratives. 2. Family Relations—Personal
Narratives. WM 40 B828 2008] I. Hinshaw, Stephen P.

RC451.4.P79B74 2008

616.890092—dc22 2007012827

9 8 7 6 5 4 3 2 1

Printed in the United States of America
on acid-free paper

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Contributors

Jarralynne Agee, PsyD

Organizational Psychologist, Lecturer,
Department of Psychology and African
American Studies, 615 C University Hall,
University of California, Berkeley,
CA 94720

Marc S. Atkins, PhD

Professor of Psychology and Psychiatry,
Director of Psychology Training, Department
of Psychiatry, University of Illinois at Chicago,
Institute for Juvenile Research (M/C 747)
1747 W. Roosevelt Rd., Room 155, Chicago,
IL 60608

Theodore P. Beauchaine, PhD

Robert Bolles and Yasuko Endo Endowed
Associate Professor, Department of
Psychology, University of Washington, Seattle,
WA 98195–1525

Jessica L. Borelli, MS

Clinical Psychology Graduate Student,
Department of Psychology, Yale University,
Box 208205, New Haven, CT 06520

Kay S. Browne, MD

Behavioral Pediatrician, Diagnostic Center
of Northern California, 39100 Gallaudet
Drive, Fremont, CA 94538

- Stephen P. Hinshaw** Professor and Chair, Department of Psychology, Tolman Hall #1650, University of California, Berkeley, CA 94720-1650
- Esme A. Londahl-Shaller, PhD** Staff Psychologist, The Children's Center, Langley Porter Psychiatric Hospital and Clinics, University of California, 401 Parnassus Avenue, San Francisco, CA 94143
- Jeffrey Liew, PhD** Assistant Professor, College of Education and Human Development, Department of Educational Psychology, Texas A&M University, 4225 TAMU, College Station, TX 77843-4225
- Janet Lucas, PhD** Deceased
- Laura B. Mason, PhD** Associate Clinical Professor and Coordinator, Psychology Clinic, Department of Psychology, University of California, Berkeley, Tolman Hall #1650, University of California, Berkeley, CA 94720-1650
- Peter E. Nathan, PhD** University of Iowa Foundation Distinguished Professor of Psychology and Public Health, Department of Psychology, E119 Seashore Hall, University of Iowa, Iowa City, IA 52242
- Elizabeth B. Owens, PhD** Research Psychologist, Institute of Human Development, University of California, Berkeley, Tolman Hall #1690, University of California, Berkeley, CA 94720-1690
- Tara S. Peris, PhD** Postdoctoral Fellow, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles, 300 Medical Plaza, Suite 1315, Los Angeles, CA 90095
- Ruth C. White, PhD, MPH, MSW** Assistant Professor, Social Work, Department of Anthropology, Sociology, and Social Work, Seattle University, 901 12th Avenue, PO Box 222000, Seattle, WA 98122-1090
- Carolyn Zahn-Waxler, PhD** Senior Scientist, Department of Psychology, University of Wisconsin, 1202 West Johnson St., Madison, WI 53706-1611

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Introduction

Stephen P. Hinshaw

In the chapters that follow, you will find 14 narrative journeys, written by students, clinicians, teachers, and scientists from the mental health professions, broadly construed. The subject matter of each chapter is the author's family or personal experience of mental illness.

You must, of course, judge for yourself, but my guess is that you will have a wide range of emotional responses when reading these contributions. You will hear, for example, about the suicide of a psychologist's mother when he was still an infant, along with the reverberations of that act over the ensuing decades. Other chapters also bear witness to the lasting effects of parental mental illness—schizophrenia, depression, bipolar disorder—on several contributors' identities and career choices, with pointed discussion of their own perceived vulnerability to mental disturbance. You will read, too, about the effects of severe abuse on personal development, as well as the major consequences of serious emotional disturbance in the brothers or sisters of several authors. You will share a medical doctor's experience of having her young adult son begin a long journey of psychotic and withdrawn behavior, followed by his gradual recovery. Still other material involves the accounts of contributors who have worked through the process of self-recognition of mental illness in their own lives.

The range of experiences described in these chapters is wide, and each narrative displays an astonishing degree of openness. My own responses include shock and outrage at the still-taboo nature of mental illness in today's world, deep sadness over many of the devastating experiences portrayed, tenderness and admiration for the responses often displayed by the authors and their family members, and hope regarding the future potential for mental illness to evoke a different set of reactions and outcomes. I have found all of these accounts to be riveting, and I believe that you will, too.

As editor of this volume, I have had the unique opportunity to read and edit these contributions, often being one of the first individuals to see the initial drafts. I must tell you at the outset that this has been one of the most gratifying challenges of my entire professional life. What a rare gift, to have become a part of the creative process in the formation of this volume!

At certain points in each contribution, there are passages that knife through everyday perceptions and mundane concerns, taking aim straight at the heart

of the effects of mental illness on individuals and families. Some of these passages include the stark, sudden realization that mental illness is present, as when 8-year-old Jeff Liew finds his mother in the basement of their San Francisco apartment, moments before nearly hanging herself...or Ruth White comes to the clear understanding that she can no longer contemplate hurting, even killing, herself and her young daughter...or Marc Atkins realizes that the voice he hears across the college courtyard emanates not from someone else but from his own mind...or Laura Mason understands that her oldest sister will never be the same again and, subsequently, that her other sisters have major forms of mental disorder, shattering the family.

In other instances the recognition and realization are more gradual. Note, for instance, the process whereby Liz Owens experiences the seemingly endless series of drug-induced, self-destructive episodes of her beloved sister, interspersed with rare moments of deep contact, which quickly vanish when mental illness takes its toll once again. For Jessie Borelli, it is the repeated discovery that there are no rules for consistently engaging with her seriously emotionally disturbed brother, as unpredictability and potential violence lie just underneath the surface.

In the case of several other authors—Jarralynne Agee, Ted Beauchaine, Esme Londahl-Shaller, and Carolyn Zahn-Waxler—poignant moments surround the recognition that a parent is suffering from a mental illness too severe to conquer through love and support alone. For these authors, continued instances of irrational and unpredictable behavior throughout childhood have served to shape views of their families, themselves, and the world at large.

Janet Lucas's discovery was that, in the face of almost unspeakable abuse and neglect from her seriously disturbed parents, she had to feign competence and normality to survive in the world. These devastating words are not easy to hear, especially given that, several months after completing her contribution, Lucas took her own life. With hindsight, it is chilling to read her words that convey the hopelessness she felt with respect to ever feeling truly connected with the rest of the world.

In the case of Kay Browne, it is the realization that her beloved, athletic son, inexplicably home from college, was not experiencing the same reality as the rest of the world—and that her prior medical training had not even begun to prepare her for what lay ahead. And pointedly, Peter Nathan conveys the moment when, as an early adolescent, he could no longer believe that his mother passed away from “natural causes,” as his father had alleged, but had instead killed herself barely a year after his own birth.

All of these moments, and all of these portrayals of emotional awareness, penetrate the fog of denial and misunderstanding that so often enshrouds mental illness. Painful as many of these words and images are, they signal the realities encountered each and every day by individuals and family members

contending with mental disorder. Reading the contributions in this volume has, in fact, brought me back into close touch with my own personal and family experiences—of my father’s lifelong bipolar disorder, misdiagnosed for 40 years as schizophrenia; of the professionally dictated silence about it that pervaded my childhood; of my mother’s heroism in dealing with the situation, largely alone—rekindling a deep empathy for all individuals and family members who suffer from mental illness. Each contributor’s articulateness, perseverance, and sheer determination to put intensely personal words on paper deserve the accolades of us all.

In its many forms and with its many consequences, mental illness covers a vast territory. Every chance that we get to experience the reality rather than the stereotypes of mental disorder is an opportunity not to be missed. Such portrayals are, after all, the sum and substance of the mental health professions, serving as the raw material for clinical intervention and research investigation. Sometimes mystifying and terrifying, sometimes tragic and inexplicable, sometimes uplifting and triumphant—but always fascinating, poignant, and human—each chapter tells a unique story.

WHY THIS BOOK?

It is a truism that many individuals who enter the mental health professions do so at least in part because of a desire to examine their own (or their family’s) psychological issues, vulnerability, and pain. If this is, in fact, the case—that there are often deep personal and family roots that underlie the decision to engage in these disciplines—wouldn’t there be a host of volumes like this one, in which people in mental health professions eagerly convey their stories?

Sadly, the actual situation is far different. Indeed, there is a strong current in medicine and mental health that pushes those in the field away from even mentioning such issues, much less exploring them in depth. It is as though such topics and experiences are completely out of bounds; silence remains the order of the day.¹

Why would personal disclosure of the kinds of harrowing, moving, sometimes tragic, and deeply human events that motivate interest in the mental health field be viewed as almost unthinkable, even forbidden? In my view, there are two main roots of this situation. First, people with mental illness still undergo a huge amount of stigma, so that having a mental disorder in oneself or one’s family is among the last things that most individuals would ever want to disclose, regardless of their line of work. Second, the mental health professions themselves convey stigmatizing attitudes, so those who work in the field are subject to a particularly strong code of silence. Let me elaborate on both of these interlinked themes.

At a general level, punitive responses toward mentally disturbed behavior have been strongly present throughout history, evidenced by rejection, overt discrimination, and distressingly poor access to treatment (if any intervention indeed existed). Although there are many roots of such prejudice and rejection, they are likely to have been influenced by ignorance, reductionistic views of causation (ranging from demonic possession to hereditary flaw), and biased accounts in popular lore and public media. Even today, despite our apparently more open and progressive era, serious forms of mental illness are akin to the leprosy of earlier eras, eliciting extremely high levels of shame and disgrace.²

Such stigma has deep roots. All societies have in-groups and out-groups, and strong motivation exists to identify with in-group members and to castigate those outside the mainstream. In its various forms, mentally disturbed behavior signals nonconformity, unpredictability, irrationality, and loss of control, qualities that threaten social perceivers both directly and symbolically. There may well be naturally selected origins of the tendency to stigmatize persons displaying mentally disturbed behavior, related to deep human propensities to avoid contagion and exploitation.³ The history of social responses to mental illness is replete with rejection, punishment, and isolation, with periodic instances of compassion and enlightenment overshadowed by the long legacy of harsh stigmatization.

I hasten to point out that real signs of progress have occurred in recent years. Mental illness is now much more openly discussed than was the norm in the past, scientific knowledge of mental disorders is skyrocketing, and evidence-based treatments for many forms of mental illness now exist. Even if cures are not yet a reality, the potential for intervention strategies to yield symptomatic improvement, enhancement of life functioning, and significant rehabilitation is real.⁴

At the same time, however, distressing evidence exists that the stigmatization of serious forms of mental disorder has actually *grown* across the past 50 years.⁵ In other words, our enhanced knowledge base regarding causes and treatments has failed to overcome pervasive practices of distancing from and openly rejecting people with major forms of mental illness. Furthermore, as social norms change in the future and it becomes less acceptable to show open rejection of mental illness, covertly expressed and implicit forms of bias and prejudice will be likely to escalate, similar to the ways that hidden stigma dominates with respect to racial bias in today's world.

On top of this discouraging state of affairs, it is upsetting and perhaps even shocking to realize that an important source of stigma comes from mental health professionals themselves. After all, shouldn't those entrusted with the care and treatment, as well as the scientific investigation, of people with mental illness be expected to show acceptance and compassion? Certainly, there are many professionals in the various disciplines related to mental health who display just

these qualities, whether they are performing treatment, effecting prevention, delivering services, or conducting research.

Yet several factors make the reality of the situation more ominous. For one thing, the mental health professions are low on the status hierarchy of those who work in health care. In the words of Goffman—one of the twentieth century’s seminal thinkers about stigma—those who perform such work receive “courtesy stigma,” in that they are denigrated simply for their association with mental illness.⁶ In addition, pay scales are relatively low, work can be quite stressful (with a clientele that can pose real challenges), and prestige is lacking. It would not be surprising if tensions and frustration got displaced onto the very individuals who require service and research investigation.

In addition, the tradition in medicine, psychiatry, and clinical psychology is that the healer is healthy, correct, and knowledgeable, whereas the patient is sick, flawed, and ignorant. That is, there is a huge status differential between those who give and those who receive care, with a resultant tendency for those in professional and scientific roles to hold to an “us versus them” attitude. Given the general degradation of mental illness in the wider culture, professionals may well seek to avoid being tainted by those believed to be inferior, either directly or by association.

In addition, psychological and psychiatric models of mental illness throughout the majority of the twentieth century held that the core cause of mental illness was faulty parenting, as well as personal weakness and deep character flaws within the afflicted person. In other words the field’s basic causal models were inherently stigmatizing toward recipients of care—and particularly toward their relatives. In recent years, etiological models have shifted to genetic and biochemical perspectives. But even here, espousal of explicitly biogenetic theories of mental illness can be quite stigmatizing, fostering a view of individuals (and their relatives) as deviant at their very core. Indeed, if genetic perspectives on causation are promoted in reductionistic fashion, punitive attitudes and stigma may actually *increase*, fueled by a view of the subhuman status of those with mental illness.⁷

For all of these reasons, the mental health professions have a checkered history in terms of attitudes toward clinical clientele and research participants. Indeed, in systematic surveys, people with mental illness and their family members report that many of the messages they receive from mental health professionals are unhelpful, pejorative, and even ridiculing, with the frequent communication of low expectations for positive change.⁸

If negative views toward mental illness are present in the mental health professions, think of the bind for those people who work in the field and whose lives are touched by mental illness. In the first place, disclosing personal and family struggles is likely to be perceived as failing to keep appropriate boundaries, potentially tainting the dispassionate stance needed for effective treatment

or potentially biasing an objective attitude toward research. At a deeper level, such disclosure is akin to admitting a terrible personal weakness, incompatible with serious, careful work. Furthermore, admission of mental illness in oneself or one's family is clearly a signal of lowered status. The premium is therefore placed on keeping distance from any signs of mental disorder—and on suppressing any disclosure of the deep personal and family issues that may well have been central in promoting initial interest in such work.

In this discussion, I am not contending that mental illness is uniformly uplifting and inspiring or that relevant disclosures should take place in cavalier fashion. Indeed, despite the sometimes-held view that mental disorders are linked with creativity and even genius, mental illness is far more likely to be seriously handicapping.⁹ Individuals in the throes of psychosis would be hard pressed, for example, to provide adequate clinical services or perform rational research, much less take adequate care of themselves. In short, mental illness is not inherently adaptive or noble.

But is it the case that healers and investigators must be free of any sign of mental illness and show no history of mentally disordered functioning in order to be effective? For one thing, such a requirement would greatly limit the potential population of professionals, given the high lifetime prevalence rates of mental disorders in the population.¹⁰ In addition, and crucially, personal or family experiences may well provide a unique kind of empathy, sensitivity, and even resilience. Those who know the pain of mental disorders may be uniquely motivated to help clients, work with families, or perform important research on basic mechanisms of pathology or on the effects of clinical services.

With respect to treatment, many sources of empathy and identification may facilitate good clinical contact, but a key wellspring may be the ability to recognize the pain that individuals and families experience when mental illness strikes—so long as overidentification can be avoided. As for research, most often emphasized is the “confirmation” phase of the scientific enterprise, which mandates objective testing of hypotheses and which doubtless requires dispassionate inquiry and rational control. Yet the “discovery” phases of research, linked to the creative process of generating ideas and hypotheses worthy of study, may well receive inspiration from rich personal and family experiences. Scientists with deep motivation to pursue questions of genuine clinical interest are bound to be those who can carry the spark and drive to persevere through the lengthy process of investigation.

In short, the stance of silence and shame for clinicians, teachers, and scientists serves to cut off much of the lifeblood of the field, short-circuiting needed discussion and insight. It may also act to maintain stigma: if we can't even admit to the sources of our own interest and inspiration, how can we accept parallel experiences in those we aim to help or investigate? A vicious cycle is likely to ensue, as crucial issues seldom get discussed or studied, mental illness is further

silenced and stigmatized, distance between health-care providers and recipients of treatment grows, ignorance and fear escalate, media images remain derogatory, and discrimination continues. At the same time, funding levels for mental health research and care continue to remain low, and the lack of parity of health insurance coverage makes obtaining adequate treatment difficult, if not impossible.

It is time to stop this cycle. Multiple strategies are needed to overcome stigma, ranging from the elimination of discriminatory laws and the fostering of equitable health care policies to the alteration of pervasive media stereotypes.¹¹ A particularly helpful avenue for promoting change entails disclosure of the truth—that is, allowing the actual stories of those with mental illness, including those who work in the field, to emerge. Openness on the part of professionals and scientists may well usher in a new era, fostering appreciation of the realities of mental disorder and real concern for those with mental illness. As barriers are surmounted, mutual respect can grow, from professionals to patients/participants and vice versa; all can rise with the tide.

Several pioneers deserve accolades for paving the way. In the early 1960s Kaplan edited a remarkable volume, *The Inner World of Mental Illness*, which provided a compendium of first-person accounts of severely disturbed behavior that has served as an inspiration for numerous professionals in the field. Although several of the excerpts in the volume emanated from medical and mental health professionals, its focus was on portrayals of severe mental illness from a variety of sources. Next, in 1985, Rippere and Williams edited a daring compilation of personal accounts of depression from mental health workers in the United Kingdom, but this work did not readily spread to the United States. Gottesman's *Schizophrenia Genesis* contains lucid, compelling first-person accounts from individuals with this devastating disorder, but once again, the emphasis is not on providers or scientists.¹²

Norman Endler's *Holiday of Darkness*, a gripping account of serious depression, was written from the perspective of an eminent research psychologist. In the mid-1990s, Kay Redfield Jamison published her groundbreaking autobiography, *An Unquiet Mind*, an open and at times devastating account of her lifelong bipolar disorder, which began at age 16 and as a result of which she very nearly took her own life. As a practicing clinical psychologist (as well as author and scholar), she undertook particular risks in making such disclosure, given that it presented challenges to her ability to continue practice. Still, it heralded an atmosphere of openness rather than silence and shame.¹³

My own disclosure of serious family mental illness, *The Years of Silence Are Past: My Father's Life With Bipolar Disorder*, chronicled my father's 40-year struggle with misdiagnosed bipolar disorder and his major psychiatric hospitalizations. In it, I emphasized the silence I experienced as a child (his doctors told him never to discuss mental illness with me or my sister), as well as his

gradual disclosures of his life story to me as I attained young adulthood and the effects of both on my professional and personal development. As I discuss in the concluding chapter to the present volume, the act of writing this book forever changed my entire professional identity.¹⁴

The field of neurology is, in some ways, a step ahead. I recommend a remarkable volume that appeared in the late 1990s: *Injured Brains of Medical Minds*, edited by Narinder Kapur. In this book, a large number of medical and health professionals courageously describe their own experiences with amnesia; memory, language, and perceptual disorders; Parkinson's disease; head injuries and brain tumors; stroke; and epilepsy.¹⁵ This welcome book is accompanied by a growing tradition of case studies and clinical reports far more humanly portrayed than the dry and depersonalized accounts that previously dominated the field. Oliver Sacks is a noteworthy provider of such intriguing depictions of a range of neurological and psychiatric conditions.¹⁶ A key consequence has been the humanizing of individuals formerly viewed as patients, labels, or mere "cases."

Finally, there are now a host of personal stories and narratives of mental illness in the media, ranging from books to magazine pieces and television programs.¹⁷ But disclosures from mental health professionals and scientists per se have been slower to emerge. Even when such narratives have appeared, responses from people in the field have been far from universally positive.¹⁸

Overall, in regard to the question that constitutes the heading for this section of the Introduction—why this book?—the answer is that there remains a great need for those who work in the mental health fields to tell their own stories, to demystify the entire topic of mental illness, to shed light where darkness has for too long reigned, and to humanize the experiences of mental disorder. There is a parallel need for students, trainees, coworkers, patients, and the public at large to learn of the personal and family realities that have inspired many in the mental health professions to take on the clinical and scientific roles they have embraced. The hope is that this volume's contributions will portend a set of broad and deep discussions within the mental health professions—and across the culture at large—about the presence of mental illness throughout the health care and scientific professions and society as a whole.

HOW DID THIS BOOK GET STARTED?

Rather than emanating from a grand master plan, this book had its origins in personal contacts, individual-level communication, and in some instances quite fortuitous circumstances. Let me give you a brief sense of this process.

This volume got its real start through my writing of the previously noted account of my father, *The Years of Silence Are Past*. The act of disclosing my

family's—and my own—experiences opened me up to the power of narrative in starting to comprehend difficult, even tragic life circumstances and in beginning to understand that mental illness can be associated with compassion, strength, and courage. It also alerted me to the harsh reality of stigma in relation to mental illness, prompting my subsequent writing of *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*. These experiences illuminated, for me, the particular burdens carried by family members of those who are afflicted. My mother, for example, suffered through years of almost impossible behavior patterns on the part of my father while receiving virtually no support from mental health professionals; how she kept our family together is difficult to comprehend. Yet the countless parallel stories of caregivers and relatives that exist are seldom heard.

During book readings, public talks, academic lectures, and course offerings related to my family narrative and the impact of mental illness and its stigmatization on families and society, I have encountered, with regularity, individuals who desperately want to talk about their own experiences. As a clinical psychologist, academic investigator, and professor, I have “known,” through clinical experience and the research literature, of the high prevalence of mental illness and its substantial impairments. Yet on hearing countless people ask (almost beg) for contact, on reading the numerous letters and e-mails I received in conjunction with the book on my father, and on investigating just how pervasive the stigmatization of mental illness really is, I became aware at a deeper level of the need to reach out to the mental health professions.

That is, I began to contemplate a book of personal and family disclosures, written by those whose work relates to mental health in one way or another. At first slowly, I began talking with such talented individuals as former Berkeley undergraduates Jessie Borelli, Esme Londahl-Shaller, Jeff Liew, and Tara Peris, learning of their incredible family stories. I subsequently began to ask if each would contemplate writing a chapter for a still-unformed volume dedicated to such narrative disclosures. All contributed compelling narratives, and these were among the first completed entries for this book. All are wonderful, revealing deep sensitivities through intensive, often painful disclosures. Each of these contributors is destined for a stellar career, which should become apparent on reading their pointed and stirring words.

Picking up steam, I made more contacts. Over lunch or during discussions with friends and colleagues, I probed when I heard that someone I knew (or someone they knew) might have a story to tell. Gradually, after several promising leads and a few false starts, additional contributions came together.

For example, I work regularly with UC Berkeley Psychology Clinic Coordinator Laura Mason, and I had spoken with her on several occasions about the pain of mental illness in families. Given her role as a deeply compassionate therapist and educator of our Berkeley graduate students, I was not surprised at

her interest in my emerging work in this area. Still, after she read *The Years of Silence Are Past*, I was floored when she revealed to me the stories of her three older sisters, each of whom suffers from devastating mental illness. Her decision to write about her family and about her own personal trajectory is a gift to the entire field.

Around the same time, my colleague Ted Beauchaine and I discussed the “genetic legacy” (a term I had used in *The Years of Silence Are Past*) of having parents with schizophrenia and bipolar disorder, respectively. After a period of reflection, he decided to produce a contribution; as with all of the others in this volume, it is searing in its honesty. Another colleague, Marc Atkins, began to talk to me about college experiences that he had never quite come to terms with. Following considerable thought, he realized that he would like to explore those experiences on paper. The integration of his late-adolescent symptoms of mental illness with his growing interest in children and in positive mental health serves as the subject matter for this deeply personal chapter.

More recent contacts began to mount, some by chance but also because I was increasingly ready to move ahead with the project. Jarralynne Agee, who teaches a course a cross-listed course in Psychology and African-American Studies at Berkeley, began to speak with me about her mother and her family’s extremely difficult early years. After she was interviewed for inclusion in another book, she realized that a narrative she could herself create might be of real value. Her contribution is sobering, poignant, and inspirational.

Liz Owens, a skilled developmental psychopathologist with whom I work on my own research team, wondered whether telling the tragic story of her beloved sister’s early demise from mental illness and drug abuse would be important to others—and to herself. Its power is a testament to Liz’s love and courage.

Kay Browne, a behavioral pediatrician with whom I had collaborated over a decade ago and with whom I had several discussions at the onset of her college-age son’s descent into psychosis during the 1990s, realized that she had many themes to cover in writing about her experiences as a parent, advocate, and professional. Her harrowing, moving, and informative contribution adds an incisive perspective to the assembled narratives. Although it is, of course, impossible to compare pain across people, the recognition that a son or daughter is battling a serious mental disorder must be near the top of any list of wrenching experiences.

Still other contacts were the result, it seems, of pure luck, but luck sometimes benefits from preparation and readiness. Ruth White, a UC Berkeley School of Social Welfare PhD who is now a faculty member at Seattle University, happened one day to read a nationwide alumni mailer from the Berkeley Development Office. One of the “Five Big Ideas at Berkeley” in this publication, selected from hundreds that had been proposed, was a piece that I had written on

psychology's role in combating both mental illness and the stigma that surrounds it. On seeing this article, Ruth—whom I have never met in person—contacted me; we instantly began an e-mail discussion of our own personal experiences. Within a short time, given my instincts about her integrity, energy, and honesty, I invited her contribute to the book. Her jumpy, poignant chapter, interlaced with journal entries from much of her adult life, was completed within a few weeks; it discloses her awareness of and ambivalence about the need to obtain treatment for her increasingly severe bipolar disorder.

Janet Lucas, a gifted scholar and teacher of English and Lacanian theory, happened to have seen my image on the Berkeley Psychology Department homepage and then found links to my work on narrative and stigma. Contemplating a sabbatical summer in Berkeley (which unfortunately did not materialize), she sent me a dense, rich treatise on child abuse and the creation of false and true selves, with significant autobiographical component. I encouraged her to edit it for the present volume's specifications, and the result of our joint editorial work is found in these grueling yet enlightening pages.

However, I learned several months later that Lucas had died suddenly late in the summer of 2006. My almost-certain hypothesis is that the many burdens she had carried throughout her life led her to end it. The tragedy of recurrent mood disturbance, compounded in her case by a legacy of horrifying abuse, is inescapable.

Peter Nathan, a professor of psychology at the University of Iowa and a member of the Psychology Board at Oxford University Press, had the opportunity to read the book proposal for this very volume after I had submitted it to Oxford. Following the proposal's acceptance, he humbly contacted me, explained the situation, stated that he was intrigued by the idea, and respectfully asked if he could write a chapter about the lasting effects of his mother's suicide, which occurred when he was a year old. I was astounded, having had no idea of this history, and readily agreed. His wonderful contribution followed over the next months. Its title, "Reverberations," would have been an apt name for the entire volume.

Another senior investigator with a distinguished research record, Carolyn Zahn-Waxler, heard of my book on stigma, *The Mark of Shame*, and we subsequently communicated about it. Our e-discussions advanced to consideration of her own family experiences, and she ended up writing a stirring chapter about her mother, her father, herself, and her daughter—illustrating vividly the intergenerational patterns involved with mood disturbance within a family system—with the hope that it will itself expand into a book-length narrative in the near future.

I feel a deep connection with each contributor, in some cases supplemented by a rich friendship and in others solely through correspondence about the writing that now appears in this volume. I hope that you begin to feel such

connection yourself as you read these contributions, given that one of the core aims of this book is to promote close linkages to the realities of mental disturbance in individuals and families. With material like this, there is no doubting the honesty, the reality, and the deep humanity of the material presented in each and every case.

Indeed, fostering a sense of the underlying *humanity* of individuals with mental illness is perhaps the key goal for the entire volume. Through presenting these narratives, the contributors and I hope to push beyond stereotypes, distortions, and silence to foster comprehension of mental illness in all its pain, reality, strength, and hope. I hope that you gain from joining in this process.

CORE THEMES

A number of issues and themes emerge from the chapters that follow; I cannot claim to have a handle on all (or even most) of them. But I present several of what I believe to be the main currents underlying these personal and family stories, toward the end of providing at least a preliminary framework for this rich material.

Confusion

The symptoms of mental illness are confusing for sufferers and family members alike. For individuals who become afflicted, problems can include diffusion of identity, exaggerations and distortions of preexisting characteristics, intense and inappropriate emotional responses, and a profound disorganization of mental life and behavior. Those who experience such conditions may not know that mental illness is descending on them; instead, they may incorporate the symptoms into their own paranoid, depressive, or grandiose worldviews. Even when self-recognition occurs, admitting to a mental disorder is extremely difficult, given the levels of stigma that still exist. As a result, seeking treatment may often be delayed. In short, the process is inherently confusing.

On the other hand, close contacts and relatives usually experience a different type of confusion, as they typically have far quicker awareness that things are different. For children, siblings, and parents alike, a clear sense emerges that stable family patterns are disintegrating and that they themselves may have to play extraordinary roles of caretaking for years to come. Mental illness is disorienting and befuddling for family members, and it can take lengthy periods of adjustment to incorporate a changed view of the loved one into a newfound sense of family. Getting a handle on the processes related to such altered perceptions is a prevalent theme throughout many chapters in this volume.

As just one example, Tara Peris had to deal with the disappearance of her mother—already displaying signs of an increasingly severe, yet still subtle, psychotic disorder—when she was a 12 years old, subsequently needing to figure out how to relate to the world (and to herself) in the face of this absence. Years later, the potential for a reunion appeared for an instant but then vanished. Not surprisingly, heartbreak, shock, anger, and a host of confusing emotions reemerged. Almost every other contribution in this volume expresses the confusion and bewilderment that so frequently accompany mental illness.

Searing Pain

There is no escaping the pain and devastation that pertain to mental disorders. Mental illness robs individuals of life opportunities and, in some cases, the will to live. Despair, hopelessness, and a sense of ultimate futility are frequent accompaniments to serious mental disturbance, bringing on severe levels of pain for the afflicted individual. Janet Lucas's narrative is telling in this regard: that she could ultimately not bear the pain related to the overwhelming legacy of her abuse and depression is a sobering reminder of the lethal power of mental disorder.

The pain of mental illness spreads quickly to those who are close to the afflicted individual. Family members, in particular, often experience emotions that are nearly unbearable. Witness the opening sentence of the chapter by Laura Mason, regarding the severe mental disturbances faced by all three of her sisters: "My experience of mental illness in my family of origin is a story of loss and what has been, for me, an unspeakable grief."

There is something about the identity diffusion, untapped potential, extreme disorganization, and lack of hope often present in those with mental disorder that taps a profound sense of loss in family members and close contacts. Responses include shame, survivor guilt (why my relative and not me?), sympathy, pity, frustration, and despair. Although the promise of recovery—or some degree of acceptance of the individual in his or her changed state—can provide an antidote, the pain linked to a family member's mental illness can be unrelenting. Overall, no contribution in this volume is without disclosure of levels of pain that may be among the most intense each writer has ever experienced.

Aloneness and Isolation

One of the most debilitating aspects of mental illness, both in those who experience it and in those close to the individual, is the isolation that often ensues. The strangeness and poignancy of many symptoms, along with decreased

motivation for social contact, are among the most pernicious features of many mental disorders. Indeed, some forms of mental illness lead to intense self-absorption and preoccupation, resulting in evaporation of social connectedness. Frequently apparent in the narratives in this book is the sense that no one can understand and no one can help, that mental illness takes away the possibility of true communication and contact.

The sense of isolation and aloneness readily spreads to family members. Indeed, it is relatives who must often deal with not only the person's condition but also their own stigmatization, social shunning, embarrassment, guilt, and blame, incurred at the hands of relatives, contacts, and even the mental health profession. When family members are left to cope as best they can without adequate resources, either financial or psychological, the entire family system becomes further isolated. Think of Kay Browne, who was without adequate support in her fight to find the right services for her son's psychosis, struggling to find professionals and contacts who might really understand the situation.

We can only hope that the tide is turning and that the kinds of experiences depicted in these contributions—which range in time from early in the twentieth century to the past few years—will be different in the future. That is, recognition of mental illness may be quicker, with shame minimized, communication enhanced, and treatments instituted with faster turnaround.¹⁹ The battle remains a long and hard one, however, given the isolation and stigma that are still attached to mental illness.

Vulnerability

Mental disorders promote intense feelings of vulnerability. Ruth White, Marc Atkins, and Jeff Liew give vivid portrayals of the personal vulnerability they have each experienced as they have wondered whether psychiatric symptomatology would recur. Ruth's vulnerability lay in her reluctance to come to terms with a diagnosis of bipolar disorder; Marc's took the form of the question of whether his college-age experiences were signs of an inevitable, lifelong mental disorder, a view promoted by his psychiatrist at the time; Jeff's reluctance to obtain treatment was exacerbated by the shame and stigma he experienced firsthand as a child when friends and neighbors derided his mother for her depression and suicide attempt.

Some of the sense of vulnerability is quite basic, as relatives wonder about their own risk for becoming mentally ill. This fear has been a main theme in my own life, particularly when I was in college and attempted to synthesize my father's disclosures to me about his own severe mental disorder.²⁰ In addition to wondering about one's own vulnerability to mental illness, knowing that a loved one is suffering (or causing others to suffer)—and at the same

time not being able to really help—can lead to frustration, discouragement, and another kind of vulnerability. That is, relatives actively wonder when the next episode will ensue and what on earth might be done to prevent or stop it. Jessie Borelli has dealt with vulnerable feelings regarding her brother Daniel for many years, still wondering what the ultimate prognosis will be and how her next set of interactions with him will transpire. Carolyn Zahn-Waxler explores in depth her own vulnerability, emanating from the ripple effects of her mother's mood disturbance (and her father's anxiety and alcoholism), with implications for her own relationship with her adopted daughter. And the sense of vulnerability is extreme in Janet Lucas's devastating portrayal of the abuse and neglect she received as a child, leading to a lifelong sense that she had to compensate (indeed, overcompensate) to maintain a semblance of normality and humanity.

Everyday Lives and Experiences

Sometimes mental illness leads to extreme, nearly unthinkable actions and emotions. Far more often, it is enacted through the experiences of everyday life, as individuals struggle with difficult symptoms and attempt to cope, work, stay connected to their families, and simply live their lives. These routine actions can certainly be put to a severe test by manifestations of psychopathology, but the struggles encountered are on the same continuum as those of everyone else.

In other words, despite prevalent stereotypes of superhuman or subhuman qualities, mental illness is deeply embedded in the kinds of life experiences that we all share. Telling the truth about mental disorder involves bringing to life realities of struggling, coping, caregiving, and navigating the world, without promoting the false view that mental illness is somehow lived on a different plane. If we can understand that life goes on despite the pain and struggle often engendered by mental illness, we will have gone a long way to demystify it.

Esme Londahl-Shaller's tender, humorous, yet concerned portrayal of her father, with his foibles and his positive qualities, is a clear example of a depiction that emphasizes the day-to-day existence of a father and daughter. In addition, after a series of short-lived jobs following his psychotic-level mental illness that began during his second year of college, Kay Browne's son, Nathan, must now cope with work and with navigating his environment as everyday challenges. His struggle is compounded by medication side effects (including weight gain), which add to the burden of his residual symptoms. Jeff Liew's mother, after years of depression and then bipolar episodes, had to deal with the cancer of her husband, allowing the rest of the family to care for him. It may be instructive to look for additional daily challenges and coping strategies in the lives of each individual and each family represented in this volume.

Strength and Courage

Mental illness is often portrayed as unrelenting, hopeless, and utterly crushing of the spirit. There is no doubting the extreme impairments that mental illness can produce, but often left out of many depictions are the following facts: the symptoms of mental disorders wax and wane over time; periods of normality are often interspersed with those laden with problematic functioning; behaviors and emotions do change with situation and context; and individuals and family members may well show unexpected courage, strength, and even resilience in the face of mental illness.

Clear examples of this crucial point can be found in the narratives herein. For example, the early, tragic suicide of Peter Nathan's mother did not stop him from becoming an eminent psychologist—and, in fact, reverberations of that act may well have spurred his deep interest in the entire topic of psychology (as noted in the following section, "Shaping of Identity and Career"). In addition, whether as siblings, parents, or offspring, many of the contributors have benefited from the experience of mental illness through developing enhanced empathy, interest, or sensitivity in themselves. As a young teen, Laura Mason spent hours on end with her severely disturbed sister; these experiences served as a model for her ability to stay with and facilitate contact with noncommunicative, troubled patients years later. Jeff Liew's ability to manage both positive and negative images of his mother served him well as he fought for his own identity as a young adult. Jaralynne Agee's struggle to understand her mother's serious depression (coupled with serious poverty) enabled her to empathize with the most disturbed of the patients she saw as a trainee. Ruth White and Marc Atkins have used their own experiences related to mental illness as a major impetus to assist others.

In all, these examples highlight the ways in which encountering serious mental disorder can often fuel intense empathy, commitment, and passion. Mental illness is so often portrayed as inevitably frustrating, demoralizing, and chronic that we may forget—or never hear at all—that working through its symptoms and impairments can be inspirational to individuals and family members alike.

Shaping of Identity and Career

Personal and family experiences of mental illness are often related to an underlying desire to deal with conflict and pain, to give something back in the form of service and teaching, and/or to understand mental disorders or their treatments from a scientific perspective. In my brief "instructions" to the contributors of this volume, I asked each to address, in some way or another, the influence of personal and family experiences on identity formation and choice of profession.

In some contributions, this linkage is unmistakable—Laura Mason’s dedication to training budding clinicians and to providing therapy for a wide range of clients is undoubtedly linked to her experience of the plight of her sisters. Carolyn Zahn-Waxler’s long-standing interest in the development of empathy and the transmission of pathology and coping within families must have direct origins in her experience of her mother’s depression. Still, career paths are likely to be multiply determined. What was it precisely about Liz Owens’s witnessing, both close at hand and at a distance, her sister’s deep emotional troubles that provided motivation for Liz to pursue the study of children at risk and the characteristics that shape resilient functioning? Or consider Ted Beauchaine, whose mother’s progressive schizophrenia undoubtedly molded his interest in pursuing study of the origins and nature of mental illness. But how did this family experience translate into his sophisticated quantitative and developmental approaches to doing so?

In other cases, the path was more circuitous. Marc Atkins went from his vulnerable college days to the study of child development, poverty, and educational settings as a way of promoting positive mental health from a different angle, without directly confronting serious disturbance in adults. Janet Lucas became an expert in highly esoteric fields of postmodern scholarship through the need to prove herself as a competent, supremely intelligent individual rather than a tainted victim of rampant abuse. Peter Nathan became interested in psychology and the study of alcoholism largely through courses and research experiences he obtained as a student—yet at a deeper level, there must have been a profound interest in human behavior, both normal and atypical, prompted by the early loss of his mother.

Stigma and Treatment

Evidence of the continuing degradation and stigmatization of mental illness is apparent in all of the chapters. Although not the major theme of any particular narrative, levels of stigma depicted herein range from subtle to blatant.

One ramification of stigma is that mental illness may not even be recognized as such in many individuals and families—and they may have no access to care even if recognition is present. Thus some individuals in the following narratives never got help at all—for example, the mothers of Jarralynne Agee (because of poverty) and Tara Peris (because of lack of recognition of her often-hidden symptoms). As a boy, Peter Nathan was never seen in treatment, despite the early loss of his mother and his depressive temperament. His father’s ways of dealing with his own loss of his wife and the era in which the family lived prevented any preventive care from occurring. Laura Mason’s middle sister, whose behavior became increasingly bizarre, never really recognized a mental disturbance in herself.

Other individuals initially resisted and then relented to treatment, in part because of the stigma associated with labeling and diagnosis. Like so many individuals with bipolar disorder, Ruth White did not want to admit that she had this condition or that she needed mood-stabilizing medications. Finally, however, she has reached a degree of stability with treatment that she had not experienced for years. Jeff Liew's mother met with a counselor who had little cultural competence in reaching out to Chinese-speaking individuals and families. Liz Owens's sister was in and out of treatment, including residential facilities, for years. Yet even when intervention was good, aftercare in the community rarely occurred, prompting severe relapse. And despite helpful care, some contributors experienced stigma from providers (e.g., Marc Atkins's psychiatrist predicted a lifetime of schizophrenia; Janet Lucas's pharmacists looked askance at her prescriptions for multiple antidepressants).

Parents are particularly likely to feel blamed by the community and even by mental health professionals; Kay Browne's contribution provides particularly pointed evidence along these lines. Siblings have felt potentially cursed or betrayed by the serious problems of their brothers or sisters, with little available in the way of direct avenues for communication or understanding. The accounts of Jessie Borelli, Liz Owens, and Laura Mason are particularly gripping in depicting such isolation. Offspring have experienced a combination of anxiety, confusion, and mystification, largely related to the role of stigma and shame in stifling needed interchange about what was wrong with their parents (see, for example, the chapters by Ted Beauchaine and Carolyn Zahn-Waxler).

For many contributors, the decision to write about their experiences was marked by conflict over what their families, employers, or friends might think—in other words, by the rampant stigma that still exists. Indeed, a number of potential contributors I was in touch with ultimately chose not to write for this volume. And for many of those who did contribute, the decision was not easy. In all, mental illness is still the subject of ridicule, banishment, and degradation, revealing the long road ahead in the fight against stigma.

Stigmatization transcends culture. In his contribution, Jeff Liew directly tackles the shame and stigma of admitting mental illness in Chinese-American culture. Indeed, for him the stigma had become so internalized that he fought against getting any help for himself for long periods, despite the presence of panic attacks and a suffocating sense of inadequacy. He now takes an activist stance, contending that active efforts must be undertaken to overcome stigma.

In all, at both implicit and explicit levels, the present narratives add to the evidence for continuing stigmatization of mental illness into the twenty-first century. One of my hopes for this volume is that it will provide a beacon of clear communication, which is essential in the battle against silence and stigma.

CHAPTER ORGANIZATION AND SUMMARY

With these themes in mind, I invite you to become immersed in the personal and family narratives that follow. My hope is that you will be intrigued, sensitized, and energized at the same time that you gain education about the realities, rather than the stereotypes, of mental illness. Perhaps reading these accounts will motivate you to learn more and even to contribute in some way to the fight against mental illness and the stigma that pulls down all aspects of mental health care, both here and around the world.

Some compendia of personal accounts include lengthy annotations for each contribution. I have chosen not to write such accompaniments to each chapter, as I believe that each account is sufficiently strong and self-explanatory that it does not need a specific road map. Indeed, the goal of this work is not to provide diagnostic tips or “teaching points” about symptoms, treatments, and the like. This volume is not a textbook but rather serves as compilation of intensely personal narratives, with the hope that story talks for itself. (Note: In order not to interrupt the flow of each chapter, I asked those authors who wished to include references to scholarly literature to do so in endnote style and to keep these to a minimum.)

Deciding on the ordering of the chapters has been a puzzle. At one level, it might have been logical to include a set of chapters on the experience of having a parent with mental illness, then another related to having an afflicted sibling, still another of being a parent, and finally a set of those dealing with personal experiences of mental disorder. Yet the contributions herein resist such simple categorization: some that begin with portrayals of parents or of offspring also contain a considerable amount of material on personal experiences; the chapters most connected with sibling issues have clear implications for personal adjustment and identity; and those narratives that deal most directly with personal experiences of mental illness convey great understanding of family dynamics.

What I have chosen instead is an impressionistic ordering, with longer contributions intermixed with those that are somewhat shorter and with younger authors interspersed with those having more life experience. First, Laura Mason’s wrenching narrative about her three sisters and her own life’s journey in the wake of this decades-long family tragedy starts the volume. It is followed by Ruth White’s edgy and chilling contribution on her own bipolar disorder, which incorporates her views on the positive aspects of mania, her initial resistance to receiving treatment, and her gradual acceptance of intervention. Next is the harrowing, self-deprecating, yet devastatingly lucid chapter of Tara Peris on her mother’s slow demise and disappearance, followed by the narrative of Liz Owens, which vividly and poignantly conveys her sister’s chronic eating pathology and substance abuse, which led to her untimely death.

Jeff Liew's story about his mother's near-suicide and his own resistance to treatment during early adulthood provides a harrowing life-span narrative. It is followed by Kay Browne's agonizing account of her son's psychotic illness and her lack of preparation for this event, despite years of medical training. At this point, Marc Atkins tells the pointed story of his college-age activism, confusion, and mental disorder, as well as his newfound calling in work with children in community settings. This chapter is followed by Ted Beauchaine's deeply honest account of his mother's progressive schizophrenic illness.

Jarralynne Agee's pointed chapter on her mother's dual experience of depression and severe poverty is next, preceding Jessie Borelli's thorough and wrenching story of her brother's severe emotional disturbance, with its ripple effects on her entire family. Peter Nathan then describes, with eloquence, what he has learned about his mother's suicide when he was an infant and the continuing effects of this event throughout his and his family's life. Esme Londahl-Shaller then writes endearingly and honestly about her father's lifelong bipolar disorder, conveying both humor and wisdom.

The searing account of Janet Lucas follows, dealing with her severe abuse as a child and her isolation and depression as an adult. Finally, Carolyn Zahn-Waxler describes, with lucidity, her mother's depression, her own development, and implications for her own parenting. I conclude with a final chapter in which I respond briefly to these narratives, raise several cross-cutting themes, and provide my own personal view of the value of narrative works that deal with personal and family experiences.

So, I invite you to read, admire, identify, and empathize. I also invite you to become angry, to wonder at what might have been, and to deepen your appreciation of mental illness in the lives of individuals and families. Throughout, I ask that you consider the essential humanity depicted in each contribution.

Indeed, when we confront the realities of mental illness rather than stereotypical, media-portrayed images of inevitable violence and despair, all of us will gain. We may then begin to comprehend, more than ever, the deep variability in our species and the need to provide compassionate and science-driven treatments to those who need them. We are all human—none more so than those of us in the mental health professions—and it is through the telling of life stories that our humanity comes to the fore, deepening appreciation of our own contributions to the field and presaging a new spirit of openness and acceptance.

Welcome.

NOTES

1. In medicine, for example, there are strong proscriptions against disclosing personal weakness. Partly as a result, rates of suicide and substance abuse are

alarmingly high in the medical professions. See Myers, M., & Fine, C. (2003). Suicide in physicians: Toward prevention. *Medscape General Medicine*, 5. Retrieved from <http://www.medscape.com/viewarticle1462619>. Note that in the United Kingdom, two decades ago, Rippere and Williams compiled an edited book of the experiences of depression from those in the mental health fields: see Rippere, V., & Williams, B. (Eds.) (1985). *Wounded healers: Mental health workers' experiences of depression*. Chichester, UK: Wiley.

2. For extensive discussion of the stigmatization of mental illness, see my recent book: Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change*. New York: Oxford University Press. In this work, I cover historical, sociological, social psychological, evolutionary, and empirical evidence for the long-standing stigmatization of people with mental disorders. A key point is that despite deeply seated human tendencies to stigmatize those with mental illness, it is equally clear that such biases can be overcome, meaning that stigma is not inevitable.

3. Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin*, 127, 187–208.

4. Nathan, P. E., & Gorman, J. (Eds.). (2007). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.

5. Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in the 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behavior*, 41, 188–207. For a review, see Hinshaw (2007).

6. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

7. Mehta, S., & Farina, A. (1997). Is being “sick” really better? Effect of the disease view of mental disorder on stigma. *Journal of Social and Clinical Psychology*, 16, 405–419. Helping the public to understand that mental disorder entails both biological/genetic predisposition and life stress/psychosocial risk—and that even extremely heritable conditions can be amenable to nongenetic/nonbiological forms of treatment—is a major task ahead.

8. See, for example, the systematic national survey of Wahl, O. F. (1999). *Telling is risky business: Mental health consumers confront stigma*. New Brunswick, NJ: Rutgers University Press.

9. Kramer, P. (2005). *Against depression*. New York: Viking.

10. See Kessler, R. C., Berglund, P., Demler, O., Jin, R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, 62, 593–602; and Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, 62, 617–627.

11. Hinshaw (2007).

12. See Kaplan, B. (Ed.) (1964). *The inner world of mental illness: A series of first-person accounts of what it was like*. New York: Harper & Row. See also Rippere & Williams (1985) and Gottesman, I. I. (1991). *Schizophrenia genesis: The origins of madness*. New York: W. H. Freeman.

13. First, see Endler, N. S. (1990). *Holiday of darkness: A psychologist's personal journey in and out of his depression*. Toronto: Wall & Thompson. Second, see Jamison, K. R. (1995). *An unquiet mind: A memoir of moods and madness*. New York: Free Press.

Also, for a compilation of historical, literary, and personal perspectives on suicide, see Alvarez, A. (1972). *The savage god: A study of suicide*. New York: Random House.

14. Hinshaw, S. P. (2002). *The years of silence are past: My father's life with bipolar disorder*. New York: Cambridge University Press.

15. Kapur, N. (Ed.) (1997). *Injured brains of medical minds: Views from within*. Oxford, UK: Oxford University Press.

16. See, for example, Sacks, O. (1996). *An anthropologist on Mars: Seven paradoxical tales*. New York: Vintage. For a review of the trend toward greater humanization of neurological patients and conditions in case reports and write-ups, see Harrington, A. (2005). The inner lives of disordered brains. *Cerebrum: The Dana Forum on Brain Sciences*, 7(2), 23–36.

17. Even media celebrities have begun to disclose experiences of mental illness. Consider, for example, Shields, B. (2005). *Down came the rain*. New York: Hyperion, in which actress Brooke Shields disclosed her severe postpartum depression. In Pauley, J. (2004). *Skywriting: A life out of the blue*. New York: Random House, television personality Jane Pauley discusses her own bipolar disorder. In addition, Kitty Dukakis openly discusses her depression and substance abuse and the electroconvulsive therapy that greatly helped her in Dukakis, K., & Tye, L. (2006). *Shock: The healing power of electroconvulsive therapy*. New York: Penguin.

18. For an example of negative responses to professional disclosure, see Jamison, K. R. (1998). Stigma of manic depression: A psychologist's experience. *Lancet*, 352, 1053. Here, she reports that, following the publication of *An Unquiet Mind*, the most vehement reactions to her self-disclosures emanated from colleagues in the psychiatric and psychological professions.

19. In the national survey of Kessler and colleagues, it was found that, on average, the delay in the United States from recognition of symptoms of mental illness to first receipt of treatment was measurable in years and even, for some conditions, decades. See Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact in the National Comorbidity Survey replication. *Archives of General Psychiatry*, 62, 603–613.

20. See Hinshaw (2002).

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My Story Is One of Loss

Laura B. Mason

My experience of mental illness in my family of origin is a story of loss, and what has been, for me, an unspeakable grief. When any loss or trauma cannot be spoken—either shared with another person or felt and “spoken” within oneself—there is a kind of loneliness that is hopeless and despairing. The facts of mental illness in my family, including the diagnostic information, the appointments with psychiatrists, the bizarre behavior that broke through periodically, and the rushed hospitalizations, were all out in the open. But we never found a way to talk about what was happening, to create what William Beardslee would call a “shared narrative” that could help us stay connected through these devastating illnesses.¹ My sisters’ conditions have shaped my life, my choice of profession, and my sense of what it means to be human, yet these influences have operated in some private inner space. This narrative is an effort to open that private space, to share these experiences more fully with myself and with others.

I am the youngest of four daughters and the only one of us whose adult life has not been laid waste by severe mental illness. All of us now are middle-aged, our lives having taken whatever shape they will. The acute breakdowns, hospitalizations, and suicide attempts happened long ago. It has been well over 20 years since all of us were together with our parents, although amazingly all of us are still alive. I am now a practicing clinician and clinical professor, guiding young graduate students through their first clinical experiences. More profound an achievement is that I am married (for the third time) and the mother of two children. My sisters’ stories are, of course, theirs to narrate, but here is mine.

When Steve Hinshaw first mentioned this book to me and asked if I might contribute, I had to ask myself, “Why is this aspect of my history and my identity NOT something I am open and public about?” I think of myself as an emotionally open and expressive person. I am quite willing to share all kinds of stories about my past; I am very self-disclosing when I teach; and even as a clinician I disclose many aspects of who I am. But this, this family story, is really private, I think. Or, I reason that it wouldn’t be fair of me to write about members of my family. It’s one thing to share my history, but not theirs. Or I think of “recovery” therapists, clinicians whose professional identities include being a “survivor” of some group or experience. I don’t want to be thought of as an “adult sibling

of mentally ill sisters.” And I think of the people I work with: “I don’t want to burden my clients with all this information about me.”

One day at lunch with Steve, he asked me point blank, “So why is it, do you think, that you haven’t talked about your sisters’ mental illness, let’s say, in a discussion with students or colleagues about personal experiences that influenced your choice of clinical psychology as a profession?” For me, the answer always begins with how overwhelmed and burdened my listeners might feel; my narrative is just too much. “But do you actually believe that would be the response?” Steve probed further. At that point in the conversation, fear took over, and thinking became difficult for me. My family did not respond to mental illness with silence and euphemisms; in our case, chaotic and disorienting behavior swept through the household like wildfire. Using another metaphor, torrents of emotion—shrill and fierce and tearful—were like destructive flood waters that spilled over the riverbanks. As Steve and I talked, it became clear to me that *I* am the person who is overwhelmed and burdened when I consider telling my story.

In working on this narrative, I have unpacked and explored many of these contradictory, confusing thoughts, feelings, and objections. My internal relationship to my sisters and our parents has become more textured and softer. The “simple” truth is that my story is hard to share because it’s hard for me to bear. My much-loved big sister shattered into bits and pieces. She turned into someone frightening and unrecognizable, and she never came back to being the big sister I had grown up loving so much. It was as if she had died, although still physically alive. In some kind of internal collapse of emotion, I felt that any grieving was destructive, as if acknowledging the loss meant that I was trying to get rid of the person who was still there. Years later, my next-oldest sister disintegrated. Her breakdown was slow, steady, and bizarre, a creeping undertow that has never let her go. I had never been that close to her, and by the time of her decompensation, I was living far away from our parents and grateful to be so far away. And finally, in my early 30s, my third sister’s depression erupted with a violent suicide attempt, which seemed to come out of nowhere, leaving her and me shaken. Twenty years and several hospitalizations later, her life is still dominated by despair.

So how can I tell my story? Let me try to do my best.

EARLY YEARS

When I was a very little girl, maybe around 4, I felt so lucky to be one of the Mason girls. There were four of us. Most families had three kids at the most, and we were ALL girls, which seemed so unlikely. My father—who was raised on a ranch on the sparsely populated high desert of Montana—took us camp-

ing in the summer, and my mother, noisy and busy and big like her hometown of Brooklyn, took us to New York City for spring vacation. When my parents first married, they lived outside of New York City, where my three sisters were born in the mid-1940s. In the early 1950s, my father's work took the family to Chicago, where I was born. My sisters, who were many years older than I and clustered closely together in age, were often the smartest pupils in their classes. We ate dinner at a round oak table with a lazy Susan, and there was lots of lively conversation. We fought loudly, and laughed loudly, and did lots of interesting things.

My sisters, then, had each experienced a big rupture in their elementary school years, when the family was uprooted. My own childhood, by contrast, has a seamless sense of place. The rambling old house on the South Side of Chicago was the only home I knew in my growing-up years, and although the neighborhood changed dramatically, it was always, to me, my familiar turf. My favorite sister, the oldest, Adelaine, took me special places and hugged me too tight. She was 9 years older than I, and I remember very early feeling that she was different. She had bright red hair, and whenever I saw another person with red hair, I would run home and tell her. I think I wanted to reassure both of us that there were other people like her in the world. When I was very little, she had been a baseball fan, but by the time I was 6, she was enormously fat and didn't go out in the street to bat a ball around anymore. She didn't have any friends of her own, although she was often included in things with my other sisters and their friends. She had lots and lots of interests—language and music and art and math. She was *so* smart, and she would play the piano sometimes and sing, but somehow it seemed that she was different and sad and not right.

I remember one winter night, in her senior year of high school, when Addie didn't come home for dinner. It was alarming to me: she never went anywhere, or with anyone, so where could she be? Finally when she came home, she was laughing, and her eyes were so bright. She was giddy and giggly. She'd been visiting a new friend, and they'd talked and talked and lost track of the time. Something about this didn't feel right to me. Addie didn't have friends, and her lively chatter was rushed. She laughed too loudly, and I couldn't tell what was funny. But I was relieved that she was back home and safe, and I recall feeling with shame that maybe she was even normal after all. I was embarrassed by her; she always seemed lonely and huge, though I would never have articulated that. I just knew that I felt anxious about her, even when I was a little girl. Clearly, I was watching her, noting the signs and shapes and textures of her life.

My second oldest sister, Anne, was an exceptional student. She had skipped a grade, so that she and Addie were graduating at the same time from high school. Anne was the class valedictorian, a sharp and witty girl, very sophisticated. When I think about her now, the most striking thing to me is how empty and disconnected I feel. I always felt, as the littlest sister, that there was no way I could

capture her interest. My most vivid recollection of her comes from around the time I was 8, and she would have been 16. Walking by her bedroom one afternoon, I saw her sitting still on her bed, with a sketch pad and fancy mechanical pencil. She looked very serious, which to me meant that she was doing something very important. “What are you doing?” I bounded into her room. “I’m drawing snowflakes,” was the reply. “Can I see?” I was eager to be close to such a sophisticated and impressive person. Anne showed me the page, full of intricate, lacy designs. How could she see those patterns in the simple dots of snow? She seemed so far beyond me, so advanced. I always thought of her as the refined, polished sister, the only one of us who was small boned and elegant. She had style, she understood art, she was so responsible that, when she was 18 and I was 10 (and after Addie’s first psychotic break), my parents named her my guardian. Anne went to college on the East Coast, whereas Addie went to a small liberal arts college in the Midwest.

Around Christmas of their freshman year, my parents got a phone call that Addie needed to return home. I would have been 9 at this time, just about to turn 10, and I remember how rushed and sudden everything seemed. I recall that my mother’s face looked dark and closed. Something too terrible to talk about had happened. “What is it?” I had to ask. “Adelaine’s sick, she’s had something called a nervous breakdown.” My mother explained to me that this was something that happened when people study too hard and they can’t sleep.

This answer must not have satisfied me. Addie was admitted to a nearby hospital, but I was told that I couldn’t visit her—my favorite sister!—because it might upset me. I stole into my parents’ bedroom and found the cache of letters Adelaine had written to our parents during her first semester away from home. Here I read about Addie’s belief that people were talking about her, that other students spied on her when she went to the bathroom, that when she passed gas she was sending messages to professors and to our father. I never told my parents about reading these letters. I knew that something was terribly wrong with Adelaine, that whatever was wrong with her was kind of exciting and definitely gross, and that whatever it was, I was not supposed to know.

It’s hard to write about this. I’m confused about who I am writing this for—myself? An unknown audience? Writing about my sister and my family is very upsetting, and unsettling, and I question my motives and everything about myself. I wish that I came from another family; I wish that I hadn’t had to raise myself so completely on my own.

I don’t remember too much about Adelaine’s first breakdown or her return home from the hospital. When she was better, Addie transferred to a state college. “She needs to be at a school where there’s not so much pressure,” my parents said. Something about this was a loss of face, but I wasn’t sure why.

When she came home for spring vacation that year, everyone was very happy because Addie had made friends. My mother said, "There are such nice people at this school, they seem to have taken Addie under their wings, and encouraged her to lose weight and curl her hair." I guessed they were transforming my strange sister into somebody normal, somebody who went on dates and wore pastel skirts.

The next years swirl together and apart in my mind. I know that for 18 months or so we all thought that Addie was fine. I'm sure that I wanted this to be true, but there are so many troubled memories. What I can say, without regard to accuracy in the time line, is that Addie did well for some time at the state college and even fell in love. She might be engaged! Then, I thought, maybe we could relax at last. But once again, Addie fell apart, my parents rushed to the school to bring her home, and—that was it. Her decompensation never let up afterward.

Once I asked my mother what could have happened to make Addie so fragile and sick. My mother told me then that Addie's psychiatrist thought that maybe when our family moved from New York to the Midwest when Addie was 8, Addie never recovered, like a plant with weak roots that couldn't be transplanted.

I remember, too, that once again Addie was sent to a hospital and that I was not allowed to visit. When she came home, her speech seemed strange, as if she spoke with an accent. I have a vivid memory of sitting at our big, round dining room table, looking at Addie, with her coppery hair curled carefully in the style her state-college friends had taught her. She was wearing a pinkish blouse with a little Peter Pan collar, again so stylish, but in my mind's eye, I see all of this with some kind of edge or fracture. Addie doesn't look right, the collar is too loose around her neck, and her hair is curled in some freakish, uneven way. I didn't know it at that time, of course, but things would not ever settle down again. Ever.

Anne stayed at college on the East Coast, and when my third sister, Teresa, finished high school, she joined Anne at the same college. Neither of them came home very often; we couldn't afford the air fare except in summertime. Each time Addie had a breakdown, the expectations and hopes we had for her diminished. Although she had been a wonderful student, it seemed that going to school was "too much."

Some time later, Addie is back at home. She has been diagnosed as schizophrenic by this time. My mother blames herself, and so does Addie's psychiatrist, it seems. I hear my mother's anguished cries to my father, "What could I have done so wrong? Why does [her psychiatrist] accuse me of being cold? I just loved her, I did the best I could." She retreats from Addie and me in a way that frightens me. My mother is now out of my reach, and I am acutely aware that she can't sleep and that I must be quiet at all hours of the day and night in case