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# Suicide in the Middle Ages

ALEXANDER MURRAY

"Suicide in the Middle Ages" sounds strange. Did anyone really commit suicide then? Didn't they all believe suicides would go to Hell if they did it? And how can we know, anyway?

Let me start with the last question. Treating the "Middle Ages" as running from 500 to 1500, it is almost true to say that records on this topic are non-existent until around the year 1000. But only "almost"; and from the year 1000 records gradually multiply, with upward step-changes around 1100 and 1300. The records divide into three categories, each with its own perspective. One is chronicles, and other supposedly factual narratives. These do begin before 1000, and say just enough to show that suicide was not wholly unknown even in those obscure centuries. The second category is that of legal records. These grow steadily in England and France after around 1200, and in Germany slightly later. (Italy is an exception, to be explained later.) The third category consists of religious narratives like saints' Lives and miracle stories, which run fairly steadily throughout the Middle Ages. Because their aim is "PR" for a saint, they are particularly informative about suicide attempts, where a saint steps in to save a suicide – though a few go the other way with a "Judas-type" suicide, when stubborn opposition to the saint earns this grim reward.

All three types of source need careful interpretation. Suicide is notoriously elusive to records even in modern times, and more so for the Middle Ages. Once due allowances have been made for each genre, however, it is some reassurance that they agree on certain basics, and that these, in turn, agree with estimates from better-recorded centuries – suggesting that from this particular angle, at least, the very notion of a "Middle Ages" may be partly a myth. One basic is the male-female ratio for completed suicide. This comes out at roughly 2.5: 1. The ratio is all but reversed for attempted suicide, to the extent that we can overcome the inveterate difficulty of distinguishing the attempt as a different kind of act. Both ratios tally broadly with those from post-medieval estimates. Again unsurprisingly, female suicides tend to happen in or near home, male out in the fields or in the woods. Methods, too, confirm the same broad medieval-modern continuity. A graph based on a fourfold distinction of methods – as between hanging, drowning, a hand-held weapon, and "other" – will be almost identical for the Middle Ages and for the late nineteenth century. Hanging is nearly twice as common as the next method down, drowning (slightly commoner in the Middle Ages). Blades come in the medieval third place, most of their role taken in modern times by firearms. "Other methods" come fourth in each survey, if by a smaller margin in the modern one, perhaps because there are now more high buildings and pharmaceuticals.

*"Hanging is nearly twice as common as the next method down, drowning. Blades come in the medieval third place, most of their role taken in modern times by firearms."*

Where we can divine the circumstances and motives of suicide, these again hold nothing surprising. The age of a suicide is seldom indicated. But where it is, ages suggest a

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INSIDE

# Welcome to the Fall/Winter 2012 edition of Synergy.

This edition's theme is *History and Psychiatry*. A psychiatrist's clinic days are spent peering – or sometimes, unfortunately, rifling – through the past events and motives of an individual life. In this issue, we examine aspects of the history of our profession itself.

Our cover essay is by one of the world's foremost medieval historians who has written two volumes so far in a trilogy on suicide in the Middle Ages. An emeritus fellow of University College, Oxford, Alexander Murray here condenses the vast research of his work thus far into an extended essay – no mean feat. We have not included footnotes, as further reading and references can be easily found in his volumes themselves.

Our second essay focuses on Canada, but on a topic not unique to Canada. A Canada Research Chair in Medical History, Erika Dyck discusses the legacy of our imposing – physically and culturally – government asylums, a topic still very relevant for mental health policy despite the demolition of some of the hospitals themselves.

Our third essay examines the contributions of a 19th-century psychiatric pioneer whose legacy has been largely misunderstood or forgotten. Ian Dowbiggin, an historian and Fellow of the Royal Society of Canada, explains the contributions of Benedict-Augustin Morel.

Finally, our back pages go to a book review, which discusses a topic (a question, really) relevant to history and psychiatry: Can psychohistory be accurate, and should psychiatrists analyze or diagnose the well-known dead?

We hope you enjoy the prose and, as always, welcome your comments.



## *SYNERGY* SUBMISSION GUIDELINES

*Synergy* invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.



Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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"bell-curve," with middle age the most dangerous time, but also with extremes, such as a "mad" Frenchman of "a hundred," or – this is among attempts for she was saved by a miracle – one of a child. As to days and dates, Monday seems to have been a bad day, and April the cruelest month, as for T. S. Eliot (at least for women; July was worse for men). All socio-economic classes are represented – poor, middle-class, and rich – though their proportions are especially hard to gauge because courts had an eye on confiscations. They took little or no interest in the destitute, and an absorbing interest in a super-rich man, if his unexplained death could be construed as suicide. (The under-representation of nobles, as such, is almost certainly due to their regular participation in war, which gave abundant opportunities for death to anyone who wished for it.)

In the matter of motives for suicide we have to include attempts, since the religious sources that tell of them are conspicuously strong on the lead-up. The motives are again comprehensible from a modern point-of-view. Bereavement, poverty, and sudden disgrace or dismissal from a high post – this last one conspicuous in the chronicles – all play a part. One somewhat modern-looking case, from a religious source, is that of a girl whose body some German monks came across one day: she had been seduced by a young man, then abandoned, and had apparently drowned herself.

A smaller number of suicides have no obvious external motive. They seem to reflect mere "sickness of the soul," to use William James' expression. They appear to have been a specialism of monks and nuns, and this invites a word of comment, especially since clerics and the religious have a noticeably high profile in the data as a whole. Most of this high profile is almost certainly due to "over-determination" in the sources. "Cleric" was a broad term, claimed by anyone who thought he could gain legal advantage from it without his otherwise keeping the rules (look at all the "Clarks," etc. in modern surnames). Clerical status would also infallibly be recorded, unlike that of peasants or merchants. One category of source, furthermore, the saints' Lives and miracles, was written in religious convents with disproportionate knowledge of tragedies in their own milieu.

After all these allowances have been made, however, suicides without obvious external motive do seem to have presented a special danger for the cloistered religious. Monastic teachers became expert on it and on the moods that might lead to it. St John Cassian (d. 435), one of the most widely influential teachers, had spoken of *acedia*, a depressive mood which he thought endangered his monks, especially after their early lunch. He identified it as the psalmist's "demon that stalketh at noon-day" (Psalm 91: 6). I think of it as an equivalent to the mood to which Durkheim gave the name *anomie*, the motiveless misery of a loner in a "bed-sit," with no moral compass; and I relate it to one of the big changes brought about by the medieval-modern transition, a dispersion of the small monastic society into a big non-monastic one. The dispersion appears to have brought the demon of noon-day with it, but without the advantage, for sufferers, that most medieval novice-masters knew about it and kept it well in check – some having gone through it themselves, and knowing they had come out all the better for the experience. (The autobiography of John Busch (d. 1479/80), of the Dutch *Devotio Moderna*, has good remarks on the subject, but he was far from the only one.)

The starkest difference between medieval and modern suicide is in the rate per 100,000 of population. Modern rates are usually judged this way, and run between approximately 3 and, say, 25 (the latter figure is from Paris in the 1870s). I can wrangle no medieval source into suggesting a higher rate than around one, and of course even that involves much speculation. Subjective impressions by contemporaries are more informative and a few suggest trends. Dante wrote his *Divine Comedy* soon after 1300 and had a canto specially for suicides. Commentators soon after then say he did so because there were a lot of suicides in his time and region, in and around his native Florence. (Giotto's picture of *Disperatio* as a self-hanged woman, in Padua's Arena chapel, reflects Giotto's similar Tuscan background.) This place and time just happens to be when the city was becoming Europe's great financial powerhouse, and there may be a lesson here. It is as if Adam Smith's otherwise salutary doctrines had this dark underside: the capitalist free market may make us collectively richer (and did for the Florentines), but at dreadful cost for some individuals. This theory would fit with another, later, circumstance. Post-medieval England had a continental reputation for being the promised land of suicide (the French thought English people might do it between lunch and tea, so to speak). But I find no trace whatever of that reputation in the Middle Ages, even the opposite (the English drank too much and boasted, but there is never any word of melancholy). The first trace I know of was in 1562, when a Venetian visiting London's "Square Mile," in its first mighty stirrings, remarked on the number of people who seemed to throw themselves down wells.

As to rates just before and after 1500, business-centres apart, a lot suggests they were edging steadily upwards anyway. Some sixteenth-century suicides were in palpable response to the religious upheavals ("apostates," and double "apostates," throwing themselves off towers, etc). Although legal records are one sign of this general rise in the suicide rate, they are difficult to read because we can never be sure

whether it is a case of more suicides or more active courts. The answer is probably a bit of both. The interest in suicide shown by Renaissance writers Spenser, Burton, and Shakespeare has this background.

I have said nothing about public attitudes to suicide, or of the reasons why it was condemned. Over history – of which the European Middle Ages are just one phase – there have been three main "rationales" for the condemnation of suicide. They touch at their corners like sides of a triangle. One rationale dominant in the Middle Ages was the idea of lordship. Everyone "belonged" to someone else. To kill yourself was to rob your lord of your service, so the lord could "punish" you. The growth in legal records after *c.*1200 reflects the growth of monarchies, when the monarch established himself as "lord of lords" and treated suicide as an offence against the Crown – whence those revealing court records. I said earlier that Italy was an exception in not "punishing" suicide. One reason for this was almost certainly that the Italian communes had deliberately rejected lordship as an idea, and preferred to take their cue from Roman law, whose main drift was against treating suicide as an offence.

A second rationale, distinct from lordship, draws from the community, arguing that a suicide offends his fellow human beings. The socially-minded Aristotle said this was why the feet of suicides were cut off before burial in his contemporary Athens as a sign of public disapproval. Aristotle was here probably rationalizing a more instinctive taboo, present all over early Mediterranean society and certainly widespread in the European Middle Ages. The taboo element is clear from some medieval "punishments" for suicide, like the pulling-down of a suicide's house, or the extraction of a suicide's body from a house otherwise than over the threshold. These have clear anthropological reference and resemble rites traceable in Africa and other non-European societies. If a modern rationalization were required for the taboo, we might point to the evidence, well-known to sociologists since Durkheim, that suicide is contagious. If I do it, you are more likely to (though I hope you have wholesome enough defences to resist the idea). On this argument, sheer biological necessity would dictate that a species must discourage suicide or damage its chances of survival.

This brings us thirdly to religion. Its link-up with the social argument is clear in the case of that passage in Aristotle. When Aristotle's *Ethics,* where it appears, became available in Latin translation around 1250, theologians leapt on it like hungry men on a sandwich. Earlier theologians had not had much to appeal to. Until then, they had usually treated suicide as so unmentionable that they rarely mentioned it. To kill oneself was just a very bad sin indeed (some said the worst), but when it came to explaining why, they could only quote snippets from a very long passage on the subject by St Augustine (d. 430), provoked by the suicides of some Roman women who had thrown themselves into the Tiber rather than be raped by Goths during the sack of Rome in 410. Augustine had based his case mainly on the commandment "thou shalt not kill," and the example of Judas. This latter was especially important because pagan Romans had their own "saint" in Lucretia, who according to legend had killed herself after being raped, declaring that she preferred death to "dishonour". Augustine said that being raped was *not* dishonourable. It was just a case of extreme suffering, and there was a difference between pollution and guilt. Because Lucretia's rapist had been the son of King Tarquin, it had triggered off the rising against the monarchy (all this allegedly in 509 BC), which established the Roman republic, of which Lucretia had thus become a kind of patron saint.

Putting Judas in her place therefore made Augustine's point, though on historical grounds hardly less shaky. According to St Matthew, Judas had hanged himself. The Acts of the Apostles gave a different version, saying Judas had died when his guts burst out. But the vulgate translation of St Jerome (d. 420) had given the operative word as *suspensus.* So medieval readers had no reason to doubt Judas' suicide. Nor did they. Artists portrayed Judas as *both* self-hanged *and* with his guts hanging out, and this image, added to accounts of Judas' tortures in Hell, different each day (with Sundays off), exercised medieval imaginations to their exotic limits. The reasons for this did not have much to do with history, or even theology, but with the fact that medieval society was largely held together by the idea of lordship. Judas was the arch-traitor. It was only when the lordship idea declined in importance that anyone could try to understand his motives or even sympathize with him. Meanwhile, it was dangerous to do so: St Vincent Ferrer (d. 1419) once narrowly escaped a charge of heresy for trying to excuse him. Judas thus remained a potent symbol and proof of just how bad suicide was.

Christianity, as such, had in fact only strengthened ancient religious misgivings about suicide. Before Aristotle, the more religiously-minded Plato had given a different rationalization to the suicide taboo, approving a doctrine he ascribed to Pythagoras, which said that we mortals are soldiers on sentry-duty, and must not abandon our posts without divine permission. The Roman Empire had tried to concrete-over these ideas by decriminalizing most suicide. The Empire, after all, had been created by outstanding soldiers, and was counseled by outstanding philosophers; and both categories have their own "take" on suicide. Soldiers have generally had above-average suicide rates, for reasons not too difficult to suggest – honour, and the proximity of weapons and death. Philosophers for their part follow reason, as distinct, that is, from instinct, custom, or public opinion;

and reason may well recommend that if life becomes intolerable we should end it. A favourite Epicurean way of putting that point was that if a room gets too smoky you should leave it. Seneca, who was his own kind of Stoic, went so far as to say that to stop a man committing suicide was worse than to kill him, because it deprived him of the ultimate human freedom. The philosophers' exculpation of suicide became a principle of Roman law, which took pains to remove any sanctions specific to the act, assiduously distinguishing it from any breaches of social obligation some suicides might entail. The main obligation they thought about – because it affected the Emperor's wealth – was that of a criminal sentenced to death, who might try to save his estates from confiscation by committing suicide before execution. Careful study of successive stages of the law reveals how these obligations kept pushing through, so that by the late Empire, when the tide of public opinion was changing anyway, the law had given up trying to excuse suicide *per se* and was condemning it.

There is no sign that the change in public opinion was a result specifically of Christian influence, though the Empire was by then officially Christian. Even before Augustine's utterances on the subject, Neoplatonist philosophers like Porphyry (d. 303) were condemning suicide as an act of "passion," conceivably in reaction, partly, to currents associated with Indian religion – currents which actually recommended a kind of suicide, teaching that if you had conquered all bodily passion it was positively virtuous to complete your escape from passion by (for instance) starving yourself to death. Porphyry objected that to kill yourself was *itself* an act of passion, so was wrong, and this (he said) was why suicides could not "get away," but instead became ghosts, lingering round their homes or places where they had done the act. Semitic religions, including Islam when it came, only strengthened all these misgivings. To the Semitic God, all-powerful and all-knowing, but simultaneously knowing intimately and loving every individual, suicide could only be an act of defiance, as if one were saying to God: "You may have created me, but I don't care, and I'm going". This argument was peculiarly strong in the case of Christianity, whose man-god had suffered extremes of loss and pain without disobedience.

But Christianity was also meant to be kind and understanding. As in so many other respects, Christianity had to pull both ways, and the Middle Ages inherited this apparent contradiction. Thus we often find parish priests trying to hide or excuse suicide, helping families conceal it, and themselves getting into trouble for doing so – all this despite the Church's official condemnation of the act. We find the same contradiction in religious literature. Some saints' Lives record "miracles" which implicitly negate the official doctrine. A touching example is that of St Hugh, abbot of Cluny (d. 1109), who happens anyway to have been one of the most conspicuously humane and eirenic of medieval saints. (He once told an attempted suicide not to be such a silly boy, but to go home and look after his ageing mother.) The miracle in question concerns a monk called "Stephan" who had hanged himself in a wood. Soon afterwards, one of the monks in choir said he had received a supernatural message that Brother Stephan could not be admitted among the Cluniacs in Heaven, because of the way he had died. St Hugh prayed, and prayed, and prayed, and prayed. Several nights later, the "wireless-operator" monk got another message. As a result of the saint's prayers, Brother Stephan had been admitted into Heaven after all.

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# Assessing the Asylum

ERIKA DYCK

Recently I was approached by a provincial government agency to provide information about the historic value of mental hospitals. Saskatchewan was looking to close its last asylum-styled but active mental health facility and members from the local community had convinced the government to do a historical assessment before demolishing the building altogether. Assigning a particular cultural value to the legacy of the long-stay, custodial mental hospital proved to be a difficult and challenging task.

Historically, Saskatchewan had been home to two large-scale mental health facilities or asylums, alongside a series of smaller or adjoining clinics. The first, and remaining, one had been built in the 1910s in North Battleford, while the second hospital opened in 1921 in Weyburn and has been hailed as the last and largest asylum built in the British Commonwealth. The Weyburn facility closed in 2007 after retreating from providing mental health services over the latter half of the twentieth century under a wave of deinstitutionalization and decentralization of mental health services. The once grand, even palatial, asylum was eventually closed entirely and boarded up – and then literally began crumbling apart. It finally reached a point where the bulldozers finished the job and leveled the building, its outposts, and any remaining signs that thousands of people had ever lived and worked there. This story has repeated itself across the continent as long-stay asylums have disappeared from the landscape or been repurposed and erased from public memory. How could one begin assigning heritage value to this relic of psychiatry's past?

In an effort to undertake this challenge, I started by considering some of the historical conditions surrounding the rise and fall of the asylum. Asylum-styled mental health accommodations arose in the late 19th century in Canada as elsewhere as a logical, progressive solution to the perceived growing problem of mental disease. The rise of the asylum occurred amid state building campaigns, rapid industrialization, and urbanization.[1] Some historians have argued that the asylum provided a progressive alternative to family-based care, while at the same time created space for the emerging psychiatric discipline to observe, study, classify, and ultimately treat individuals suffering from problems that were increasingly understood as medical in nature. The grand facilities also reminded visitors, staff, and patients that the nation-state had the capacity and financial strength to provide large-scale facilities for its citizens. Put more cynically, the towering and sprawling buildings dwarfed the flow of individuals moving in and out of the asylum and reinforced a sense of state power over individual autonomy, particularly for the institutionalized residents.

The dismantling of asylum-based care was similarly shaped by concerns for national development. After the Second World War, Canadians entered a period of reconstruction and the development of what some have called the "welfare state".[2] Mental health care expanded as the welfare state blossomed at mid-century and acquired additional social services and associated elements of care in the community. By the latter half of the century, and certainly by the 1970s, national goals had shifted once again, and an era of Reaganomics took over in the United States, while Britain faced Thatcher-style reforms, and Canada, though a few years later, succumbed to a similar economic mantra as Brian Mulroney opened the Canadian border to freer trade and weakened the social services infrastructure that previous governments had established. The changing economic frameworks that supported or reduced support for mental health care had corresponding implications in public policy on areas of child welfare, disability supports, and provincial programs for social services, health care, housing, and education more broadly.[3]

The asylum had also emerged in the 19th century as a bi-product of industrialization, which introduced new valuations on labour and output. A growing but persistent emphasis on one's contributions in the workforce has continued to frame discourses on ability and disability. The asylum, in some ways, functioned as an integral part of the labour economy, not only by providing employment for medical, nursing, administrative, and social work staff, but also for capturing individuals who fell within the framework of disability, or an inability to work in a new industrialized economy. Within the institution, rehabilitative treatments often focused on work therapy as a path for reintegration into the community with a newly acquired set of useful skills. Patient labour simultaneously contributed to the functioning of the large institution as residents contributed to the laundry, cleaning, gardening, sewing, and other areas of the institution's maintenance. Some scholars have critiqued this situation by pointing to the folly of assigning value to work but not providing remuneration for work conducted by institutionalized individuals, when it could be written off as therapeutic. Geoffrey Reaume's pioneering work in this field not only reminds us that the labels of ability and disability were often too simplistic, but he shows how the social and economic context of the asylum influenced ideas about meaningful versus rehabilitative work.[4]

Over the course of the first half of the twentieth century psychiatric approaches also changed. Moral and occupational therapy gave way to more aggressive attempts to curb the incidence of serious mental illnesses. Institutions began showing their age as residents grew increasingly accustomed to the rhythms of asylum life but showed few signs of progress towards rehabilitation or reintegration into mainstream society. Stories of overcrowded asylums repeated across the continent and mental hygiene surveys routinely reported on the unsavoury conditions faced by patients and staff alike in an under-funded and overcrowded mental health system where the asylum appeared to warehouse the detritus of society. This period bore the stigma of a languishing discipline that had failed to support a struggling segment of the population.

During and immediately after the Second World War, psychiatrists began experimenting with asylum populations in a manner that appeared both desperate and humane. Somatic or bodily therapies, including lobotomies, promised to restore health to psychiatric patients and to the profession. Although perhaps these seem barbaric in hindsight, the gross overcrowding and problematic conditions experienced in asylums required drastic measures, and even lobotomies offered some positive testimonials. In the United States, lobotomies attracted sufficient praise to encourage the Kennedys to arrange for a lobotomy for Rosemary, sister to both Bobby and John Fitzgerald who had been diagnosed with intellectual disabilities. Rosemary's lobotomy ended badly, leaving her permanently incapacitated, and the public attention cast the therapy in a negative light. The temporary embrace of such interventions, nonetheless, indicated that the asylum had played an important part in producing conditions that led to an experimental phase within psychiatry as it continued to wrestle with its professional and scientific orientation.

After the Second World War, the widespread development of psychotropic medications helped to launch what some scholars have called a psychopharmacological revolution.[5] The same year that the first anti-psychotic medication became commercially available in Europe and in Canada, 1952, the American Psychiatric Association released its first version of the *Diagnostic and Statistical Manual of Mental Disorders*. These professional and structural developments in psychiatry coincided with new research directions within the discipline which, as historian Edward Shorter has argued, resurrected biological psychiatry



Photographs of The Weyburn Mental Hospital, Weyburn, Saskatchewan. Used by permission.

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and forged a renewed connection with neuroscience after the distractions of the Second World War and a fascination with psychoanalytic, psychodynamic, and Freudian-based theories of behaviour.[6] The asylum functioned as an important testing ground for psychopharmaceuticals, and some advocates even claimed that the pharmacological revolution would transform mental health care and alleviate the reliance on long-stay custodial institutions by controlling psychiatric symptoms and allowing patients to live in regular communities.

The nature of mental illness, however, was also undergoing changes. Asylums had been home to a wide variety of individuals with different diagnostic pictures, but as drug therapy gained traction, some diagnostic categories seemed fixed in the asylum. Psychotic disorders, and typically schizophrenia, responded inconsistently to the much-celebrated anti-psychotic medication chlorpromazine. Patients exhibited side effects and returning to a somewhat inhospitable community no longer seemed feasible for many patients. Pharmaceutical companies also recognized that the drug market extended well beyond asylum populations.

North American communities were also undergoing dramatic changes during this period. Urbanization by the second half of the twentieth century included suburbanization and led to the creation of new, often gendered, discourses on mental health, behaviour, and illness, including that which Betty Freidan called "the problem that has no name,"[7] while psychiatrists now armed with newly approved medico-scientific labels from the American Psychiatric Association offered medical explanations and pharmaceutical remedies.[8] Some of these pharmacotherapies replaced institutional care in an asylum setting, but did not fundamentally replace the need for care and attention to disordered, undesirable, or unwanted behaviours – whether from the individual's or the physician's perspective. The gendering of mental disorders, for example, has a long history. Asylum wards had reflected a structural division of genders, but in the post-asylum era many of the gendered distinctions remained in place, even as the walls of the institutions dissolved from the picture.[9] Acceptable displays of masculinity and femininity, often characteristics infused with ideals of sexuality, continued to shape the way that mental disorders were understood and addressed.[10] In that way, at least, the presence of the asylum made very little impact on the gendered experience of mental illness.

Drugs, however, did not cause deinstitutionalization. The process of closing asylums was multi-faceted and had a combination of economic, political, cultural, and medical triggers. American historian Gerald Grob, one of the leading scholars on the history of mental health care policy in the United States, argued that there were several distinct factors that culminated in what became a transnational phenomenon called 'deinstitutionalization'.[11] He suggested that psychotropic medications and changes within the professional landscape of psychiatry, including a shift towards more private practice and an increased reliance on general practitioners; more federal funding for intensive research programs into mental disorders; a changing politico-economic climate that coincided with the dismantling of the welfare state; and the rise of human rights and humanitarian campaigns, including those leveling critiques at the plight of institutionalized individuals, were critical ingredients in the history of deinstitutionalization.

On the social horizon, for example, amid the momentum of civil rights, feminism, and gay and lesbian rights movements, patients' rights began campaigning for their place in the human rights discourse. Disability rights activists engaged in aggressive campaigns for better access to services,[12] while psychiatric patients and their families began lobbying for anti-stigma campaigns, alongside demands for adequate housing, basic health services, voting rights, and access to safe employment. Some of these campaigns were both fuelled by, and gave inspiration to, a set of intellectual critiques that questioned the way that mental disorders were understood and treated, many of which leveled their criticisms at the asylum itself.

Some critics, including Thomas Szasz, pronounced that "mental illness was a myth," which had no basis in scientific or medical reasoning.[13] Michel Foucault went well beyond blaming the psychiatric profession, but began his career with a trenchant critique of a modern world where psychiatrists wielded significant and illegitimate power to determine what was and what was not acceptable behaviour.[14] In a world where free will was leached away by modern aspirations of productivity, capital accumulation, and moral authority, Foucault lamented the opportunities that the modern world created for individuals to police normalcy and to discipline members of society, including through the use of institutions. The evolution of an "anti-psychiatry" perspective, which sometimes cross-fertilized with post-modernism, provided fodder for critiques of asylums. One contemporary scholar of Foucault and Szasz, Erving Goffman, focused his doctoral work specifically on the way in which the institution itself produced abnormal behaviours, due to the disciplined existence within its walls, the rhythms of institutional life, and the reinforced labels that one was forced to adopt while "playing a role" in the institution. Goffman introduced the term "total institution" to describe the damaging effects that life in an asylum had, not only for the patients, for whom this fate was the worst, but also for the staff at all levels, whose versions of the outside world became perverted over time as they became more and more accustomed to the routines of the asylum.[15]

Deinstitutionalization, with its myriad beginnings and endings, nonetheless signaled the end of the age of the asylum and the dawn of a new kind of mental health accommodation. The new face of mental health included a precipitous decline in

long-stay patient populations, the gradual closure of separate mental hospitals as psychiatric wards were folded into general hospitals, and the rise of an entirely new system for mental health, one that increasingly relied on emergency wards and family physicians to sift through psychiatric cases before they might ever reach a psychiatrist. Where the asylum had ostensibly provided a set of services under one roof, problematic though they may have been, the post-asylum world involved a complicated matrix of services that did not even belong to a single governmental or medical department, nor did it necessarily fit neatly into a constitutional federalist framework. Medical services alongside housing and employment needs in combination with financial and family support services often involved a delicate degree of bureaucratic coordination in a Kafkaesque world of red tape.

For many people, deinstitutionalization was not an event, but instead a process. In 2004, psychiatrists Sealy and Whitehead published a report in the *Canadian Journal of Psychiatry*, suggesting not only that deinstitutionalization was still underway, but that its greatest variability came in a province by province comparison. Moreover, they concluded that the term deinstitutionalization was misleading; "transinstitutionalization" better suited the reality faced by patients who left long-stay hospitals only to be later admitted, albeit in shorter stints, to a variety of hospital-based facilities, including nursing homes, emergency rooms, and for some, penitentiaries.[16] According to their study, centralized mental health services in the form of an asylum had merely become decentralized in the latter part of the twentieth century. The asylum then had not disappeared, but had transformed into a new era of service delivery that relied on a more individualized and client-oriented series of services. The onus had shifted from the state and medical authorities to consumers, patients, and families who needed to navigate the contours of a patchwork of services, supports, and gaps in a modern mental health system.

Deinstitutionalization represented a culmination of ideological and cultural changes in the latter half of the last century. As that process hollowed out the old asylums, and forced communities across the country to respond either by demolishing or refurbishing these antiquated mausoleums of a by-gone era, I am left wondering whether destroying asylums has a positive effect on our mental health systems, or whether it serves simply to help us forget the indelible mark that mental illness has left on our communities. Exchanging institutions for golf courses will not fix our mental health system, while perhaps maintaining a few buildings will serve as a reminder of the intransigence of mental illness in our society.

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1 For a thorough historical examination, see: David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*. Boston: Little Brown; 1971; Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*. New York: St. Martin's Press; 1979; James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario*. Montreal: McGill-Queen's University Press; 2000.

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# The Art of Medicine:

## Clinic and Compassion in 19th-Century Psychiatry

IAN DOWBIGGIN

Like a scene from *La Bohème*, two medical students huddle in a cold, rundown Paris garret. They are so poor they have only one suit between the two of them. When one dons the suit, the other curls up in bed shivering under threadbare blankets in a desperate effort to keep warm.

One of the medical students is Claude Bernard, who will achieve fame as perhaps the greatest physiologist of all time.

The other student is Bénédict-Augustin Morel (1809-1873). Today, unlike Claude Bernard, Morel is hardly remembered. Yet few individuals better embodied the adventuresome nature of nineteenth-century medicine. Morel's day was a time of brilliant, larger-than-life characters who often sacrificed their own health in the quest to expand the frontiers of medical science and improve the fortunes of humanity. People like Morel and Bernard believed that clinical and experimental science could solve the mysteries that had plagued human health for centuries. If from our vantage point one hundred and fifty years later we find it difficult to share fully their optimism, we still must admire the courage of their convictions and their soaring intellectual bravado.

Morel, a pioneer in psychiatry and public health, also possessed a rare clinical brilliance and a deep learning. Combining these traits with true compassion for his patients, he devised a sweeping theory about humankind's place in the natural and social order – a combination akin to melding William Osler with Charles Darwin.

If Morel has never received his due recognition, it is mainly due to his 700-page *Treatise on Degeneracy*, in which he argued that the families of many people plagued by mental and physical disabilities were doomed to extinction because of their bad heredity. Morel described how the poor in Europe's burgeoning cities were exposed to a variety of poisonous agents, including tobacco, lead, ergot, and alcohol, all of which caused fearsome health effects. These factors, Morel argued, afflicted countless families whose members passed on their diseases to offspring through inheritance.

Morel's theory of degeneration rapidly passed from the realm of biology and medicine into popular language. By the end of the century, there arose countless opinion-makers, ranging from *Dracula* author Bram Stoker to sociologist Emile Durkheim and sexologist Havelock Ellis, who used the term "degeneracy". Meanwhile, Morel's original definition of the word was forgotten. Instead, degeneration had become a pejorative term referring to people with disabilities as a whole. When in the twentieth century psychiatrists ceased using "degenerate" to describe patients, Morel's great contributions to clinical psychiatry largely vanished from memory. Only recently have historians begun to restore Morel to his rightful place in the history of medicine.

Morel's fluctuating reputation began the day of his birth on November 22, 1809, in war-torn Vienna. Aside from Morel's father, a supplier of military equipment to Napoleon's armies, little is known about his parents or his upbringing. In 1831 Morel arrived in Paris where he dabbled in journalism before entering medical school. There he met Bernard and his medical career accelerated.

Three key nineteenth-century currents shaped Morel's approach to medicine in general and psychiatry in particular. The first was a movement, led by Henri Saint-Simon and Auguste Comte (who coined the term "sociology"), which held that the progress of science had reached a point in history when researchers could talk realistically about a science of humanity. Comte's own theory of positivism best captured this sentiment and bolstered the view that scientists were on the verge of discovering the natural laws governing society. Such knowledge, it was felt, would enable scientists to

end the illnesses, disabilities, injustice, and conflict which had afflicted human history.

The second trend that influenced Morel was the growth of psychiatry as one of the first specialties to carve out a separate professional identity in medicine. Largely led by French physicians trained in the hospitals of revolutionary Paris, psychiatry began as an institutional specialty headquartered in the asylums that western governments started to build in the nineteenth century to house the countless poor with mental disabilities at public expense. Psychiatrists – or "alienists" as they called themselves then – argued that people with mental disabilities were all too often jailed, whipped, neglected, or drugged. The mentally ill, so went the argument, were best off in modern hospitals headed by licensed physicians whose benevolent care provided inmates the opportunity to recover their senses and rejoin society. Alongside their self-avowed compassion, psychiatrists were motivated by the belief that mental diseases were real organic illnesses whose causes anatomists and physiologists would soon discover. Studying people with mental disabilities in asylums enabled psychiatrists to begin the time-consuming task of classifying diseases of the mind on a scientific basis, each with its own symptoms and outcome.

The third influence on Morel was the turmoil within early nineteenth-century Roman Catholicism. Faced with the appalling costs to human health and dignity inflicted on the poor by industrialization and urbanization, more and more Catholic thinkers called on the Church to take an active role in social reform. Catholic intellectuals with a social conscience advocated trade unions under Church auspices and legislation to improve work conditions in factories. The views of these Catholics have often been described as "Christian socialism" and were designed to counter-act what was perceived to be the rampant individualism of the day. Between the fall of Napoleon I in 1815 and the failed European revolutions of 1848, in the words of one historian, "virtually everyone who considered himself a socialist claimed to be inspired by Christianity or even by Catholicism itself. The Gospels were everywhere, and Jesus, it seemed, was the founding father of revolutionary change."[1] Reared as a devout Catholic, Morel viewed psychiatry as a means of the putting the social gospel into practice.

Meanwhile, Morel had begun his own medical career. Jean-Paul Falret, a leading French psychiatrist of the day, took Morel on as a resident at the well-known Salpêtrière hospital, and soon Morel was engaged in efforts to establish a professional identity for the fledgling specialty. Morel traveled extensively across Europe in the 1840s to see how people with mental disabilities were treated in other countries. After a stint at the Maréville asylum, Morel became head psychiatrist at the St. Yon asylum near Rouen.

Morel's travels and clinical experience taught him that Europe's masses endured a host of crippling diseases, including cretinism and ergotism. Shocked by the incidence of these and other diseases among the poor, Morel turned the theory of progress on its head. His theory of degeneration said that the very growth of civilization could impede the progress of human history if the necessary public health measures were not taken.

With his emphasis on heredity, Morel has been accused of helping to launch the theory of eugenics, which in the twentieth century culminated in the enactment in numerous industrialized countries of involuntary sterilization laws targeting the mentally handicapped. However, those who blame Morel for eugenics ignore the fact that he rejected the idea, popular among later eugenicists, that people with mental disabilities were highly fertile. On the contrary, he wrote that such people and their families tended to have few offspring. Far from the

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infamous Jukes and Kallikak families of eugenic lore, which supposedly kept breeding profusely, patients who suffered from degeneracy were mostly infertile.

If Morel's only contribution to medicine had been his theory of degeneration, his lack of notoriety might be understandable. But Morel deeply cared for his patients, removing restraints, encouraging early discharge, and boarding out patients in the community. He worked assiduously to prevent the warehousing of his patients.

Next to his compassion for his patients, perhaps Morel's most striking talent was his keen clinical eye, which empowered him to make one of the outstanding discoveries in the history of medicine. Typically asylum physicians of his day first encountered patients when they were admitted to hospital, well after the onset of sickness. It was difficult to discern at that point the full course of the illness; so nineteenth-century psychiatrists normally based their diagnosis on the state of the patient when he or she was admitted. A psychiatric diagnosis was often just a "snapshot" of the underlying illness, and thus incomplete.

In some respects, Morel was susceptible to the fashions of his time, but like the other greats of the history of medicine he also had a talent for "thinking outside the box." During the 1850s he devoted more and more attention to disease outcome, notably dementia, what he called the "terminal state" for most asylum inmates. Then one day a distraught father brought his fourteen-year-old son to see Morel. Once a bright student, this teenager had lost all his earlier intelligence and was rapidly becoming dull and lethargic. When Morel saw the boy later in adolescence, he wrote that it was obvious that the patient suffered from a kind of "démence précoce," a premature dementia. "This desperate diagnosis is ordinarily far from the minds of parents and even of the physicians who care for these children," Morel added.[2] Families living with schizophrenia today can poignantly relate to these words.

With this case history Morel became the first psychiatrist to use the term "dementia praecox," later popularized by German psychiatrist Emil Kraepelin. In 1911, Swiss psychiatrist Eugen Bleuler renamed dementia praecox "schizophrenia". By then, Morel had been written out of the history of schizophrenia as a disease concept, an undeserving casualty of the widespread celebration of all things German in medicine.

Morel's discovery of a form of schizophrenia with early onset and poor prognosis was not the only breakthrough that made the period a revolutionary time in the history of psychiatry. In 1851 his former patron Jean-Paul Falret had discovered bipolar disorder, the concept that mania and melancholy were not two separate disorders but just distinct phases of the same disease. Considering the many obstacles Morel and Falret faced due to the conditions of asylum psychiatry in their day, their discoveries stand out as stunning achievements in the art of medicine.

Morel died of diabetes in 1873. By then over-crowding and rising rates of chronic disease were steadily transforming mental hospitals into the "snake pits" muckrakers of later generations would denounce. In the coming years, the profession Morel had done so much to establish would begin splintering into recondite conflicts between biologically-oriented and psychodynamically-oriented psychiatrists.

But for a brief time in the mid-nineteenth century the field of mental health care had pulsed with the energy and vision of physicians such as Morel who brought a compassionate and unwavering commitment to their challenging clinical tasks. Later generations might match their dedication, but they would have trouble equaling their selfless resolve to help those less fortunate. We may never see the likes of Morel and his generation again.

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# On the Use and Abuse of Psychohistory

ERIC PROST

Ghaemi, Nassir. *A First-Rate Madness: Uncovering the Links Between Leadership and Mental Illness* (Penguin, 2011); 340 pages; CAD$17.00 paperback.

If a psychiatrist is wise – possesses knowledge and discernment beyond his narrow field – it is neither because of his profession nor in spite of it. Rather, it probably has little to do with his day job at all and much more to do with upbringing, interests pre-dating psychiatric training, or the influence of friends and lovers. The practice of psychiatry itself, while honourable and full of satisfactions for the intellectually curious, equips no one to venture beyond its boundaries and to tread with confidence in other fields. And yet, as Paul McHugh, the former and long-time psychiatrist-in-chief at Johns Hopkins, writes, "a belief persists that psychiatrists are entitled to special privileges – that they know the secret of human nature – and thus can venture beyond their clinic-based competencies to instruct on non-medical matters: interpreting literature, counseling the electorate, prescribing for the millennium."[1] If a psychiatrist "counsels the electorate" as other than a psychiatrist, that is one thing – as Charles Krauthammer (MD, Harvard, 1975) does daily on PBS and Fox News as a political pundit – but if a psychiatrist feels qualified to lecture on various topics of interest *because* he is a psychiatrist, then the whole profession looks bad.

Many disciplines ostracize the member who escapes the academy and publishes in the popular press, often making a name and money in the process – the professional historian who writes for the Sunday papers and debates on TV for example, or the amateur historian who writes bestselling works of history for the general public. And yet the public deserves to be presented with knowledge that is well-packaged and neither dry nor pedantic; no one can expect the non-specialist to digest academic journals on the one hand, or to be simply satisfied with sound-bites devoid of content on the other.

To explain psychiatry (how does it differ from psychology, anyway?), or to present the fascinating but confusing symptoms of mental illness in good prose (what is "psychosis"?), or to outline the various theories of child development (why is my child so obsessed with rules and fairness right now?) is a useful task for any psychiatrist wishing to leap the confines of routine clinical work or randomized controlled trials and go public. But to diagnose the dead with psychiatric disorders in an attempt to prove a tenuous thesis based on incomplete and sometimes shoddy sources is this tendency at its worst.

Nassir Ghaemi is a well-respected and published academic psychiatrist at Tufts University in Boston, and an expert in mood disorders. In his book, *A First-Rate Madness*, he argues the following thesis: "*The best crisis leaders are either mentally ill or mentally abnormal; the worst crisis leaders are mentally healthy*" (italics, unfortunately, are ubiquitous in the original).[2] His text is divided into four main parts, each a supposed attribute more common in the mentally ill than the majority of people: creativity, realism, empathy, and resilience. He admirably takes some time to discuss definitions of each and then attempts to prove how these qualities were present in our great leaders and, indeed, made them great, and that all this was simply and only because they were "mentally abnormal". General Sherman, Ted Turner, Winston Churchill, Abraham Lincoln, Gandhi, Martin Luther King, Franklin Roosevelt, and John F. Kennedy are presented as the main examples of the Mentally Abnormal Leader who successfully handles crises because he is ill. Mentally Normal Leaders are fine during good times, even preferable as they place a steady hand on the peaceful nation and its flourishing economy, but in a crisis it is the mentally abnormal who are necessary. In such circumstances the calm, the measured, and the bland will always fail.

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Dr. Ghaemi follows all readable historians by having a point-of-view and marshaling his evidence to support it while mostly ignoring contradictory information. After all, Edward Gibbon and A.J.P. Taylor were great because of their novel and opinionated ideas on the Roman Empire and the origins of the Second World War, not because they wrote eminently balanced history textbooks. Unfortunately, Ghaemi's work does not deserve to rest on the shelf beside Gibbon's *Decline and Fall* (although alphabetically it may do just that). While it has a clear thesis, it has many faults.

First, the thesis is so bald and the evidence displayed so one-sided that the historian's craft is ultimately abused. There are few armchair neurosurgeons in the world, some armchair psychiatrists, but many armchair historians. Pontificating about the past seems open to all, regardless of qualifications; many do not understand that more than one's personal common sense is needed to write history, and that training, as in any profession, might add something. Without this, Ghaemi presents history as simplistic with all the depth of a cardboard prop. For example, he reduces the 20th century to a paragraph that would fit well if delivered in jest and spoken rapidly from a drawing room in a George Bernard Shaw play: "Soon he [Hitler] began to abuse those treatments [amphetamines] by receiving daily intravenous injections – a practice that continued every day throughout the Second World War, worsening his bipolar disorder, with more and more severe manic and depressive episodes, while he literally destroyed the world".[3] In a sentence, Ghaemi has reduced the world's bloodiest century to one man's abnormal mental state. Not only is this the simplistic "Great Man" theory of history where key individual actors make all the difference, but it is the "Abnormal Great Man" theory where the course of history is changed by an individual mood swing or an injection.

Ghaemi makes a good point when he writes that historians must not ignore true mental illness when it exists in historical figures: if mental illness affects the life courses of our individual patients, it likely also has affected the course of the lives of prominent figures of the past. Historians, he writes, already engage in psychological history when they attempt to understand why past leaders behaved in certain ways. Why then not label one's historical research for what it is – a psychological assessment of past figures and their motives – and then attempt to judge accurately by incorporating real evidence from the sciences of psychiatry and psychology? Where Ghaemi errs even in this argument, however, is that his criticism of how history is practiced does not apply to most current historical writing, but rather just to biography – only a sub-genre of historical writing.

But Ghaemi has more to say on writing history. "History," he writes, "involves the interpretation of people's motives and intentions. Psychiatry also entails interpreting people's motives and intentions. The only difference between history and psychiatry, in this sense, is mortality – psychiatrists examine the living, historians the dead, but both in the same manner".[4] When this is coupled with a comment earlier in the book that "Psychiatrically speaking, living people are more difficult to examine than the dead",[5] we have a portrait of the author as fully equipped, nay better equipped, than the historian to illuminate the personalities of the past. Compare this stance to the position taken by another practitioner of psychological biography, the psychiatrist Anthony Storr (1920-2001). Right at the beginning of his essay "Churchill: The Man," before a lengthy psychoanalytic treatment of the British prime minister, Storr writes this:

> The psychiatrist who takes it upon himself to attempt a character study of an individual whom he has never met is engaged upon a project which is full of risk. In the exercise of his profession, the psychiatrist has an unrivaled opportunity for the appraisal of character, and may justly claim that he knows more persons deeply and intimately than most of his fellows. But, when considering someone who has died, he is deprived of those special insights which can only be attained in the consulting room, and is, like the historian, obliged to rely upon what written evidence happens to be available.[6]

Hubris is missing. Just the necessary reverence for the awesome task of presuming to understand the dead remains, a task best approached with humility by the historian, and certainly by the psychiatrist.

When Dr. Ghaemi presents a positive argument – one that attempts to prove the existence of something, in this case mental illness in certain leaders – he makes some questionable points. He argues that General Sherman had Bipolar Disorder and President Lincoln depression, and he is probably right. However, his case for depression in Martin Luther King is more tenuous. Less convincing yet is his treatment of Presidents Franklin Roosevelt and Kennedy, for in these last two cases the label of mental illness is downgraded to "mentally abnormal," a nebulous label if there ever was one. Ghaemi thinks that both men had "hyperthymia," a collection of personality traits for which Ghaemi seems to claim reliability and validity as a diagnosis. These include being "high in energy, extremely talkative, outgoing, extraverted – in short, very good company"[7] (this last statement of preference alone seems highly questionable to this introverted reader). Hyperthymia also explains Kennedy's sexual peccadilloes (the trait is dubbed "libidinous" in Ghaemi's words). The collection of traits is less extreme for Kennedy than for Roosevelt, Ghaemi admits, but he nevertheless surges forward with his thesis that Kennedy's leadership abilities were because of mental abnormality. He concludes this section with the supposedly novel insight that there is a Kennedy gene for "hyperthymia" and that the presence of certain personality traits in successive Kennedy generations is somehow surprising.[8]

With both Roosevelt and Kennedy, Ghaemi stresses the influence of each man's physical illness on his mental resilience. Again, this is no doubt true: surely FDR's sudden polio and lasting paralysis from his 30s onward, and JFK's Addison's Disease and chronic pain shaped their personalities and likely contributed to resilience and drive. But this hardly proves Ghaemi's central thesis about the best crisis leaders being mentally ill or abnormal. The only possible (and non-original) conclusion to this section is this: FDR and JFK were extraverted high-energy aristocrats who suffered physical illnesses which, in turn, reshaped them to be resilient and manage their respective crises when in power. This I learned in textbooks years ago.

Where *A First-Rate Madness* really falters though is when Dr. Ghaemi attempts to prove a negative – the absence of something, in this case that all unsuccessful crisis leaders were "mentally normal". Even to attempt this shows a sensibility at odds with the writing of serious history. It is difficult not to suspect that evidence of unsuccessful leadership during a crisis came first and then evidence for the normality of the leader was sought at all costs.

All unsuccessful crisis leaders are, for Ghaemi, "homoclites". Again, this term is presented as a robust diagnosis. It comes from a 1962 study in the *Archives of General Psychiatry* where young men from the American Midwest, students at a YMCA-run college, were administered a battery of psychological tests; a group who scored in the middle "healthy range" were then selected to be interviewed over two years. The resulting cohort does indeed sound bland and was described in the study as having "practically no trouble with those in authority" and men who would "abide by rules". Whether these "homoclites" can then be assumed to comprise the bulk of humanity, or the vast denizens of the mentally normal, across time and cultures, is a big leap. Young men from 1960s Chicago might be more different than similar to most members of the officer class in the Union Army or most of the 20th-century U.S. presidents or Prime Minister Neville Chamberlain, even if they all would score middling results on psychological tests. All these people, however, are just homoclites to Dr. Ghaemi, men too mentally healthy to possess the attributes to lead in a crisis, men who couldn't hack it like their insane counterparts General Sherman, John F. Kennedy, and Winston Churchill.

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The historical record is stretched almost beyond belief in the chapters attempting to dismiss as normal successive world leaders. Tony Blair is "curious but not a risk-taker" and, therefore, a homoclite. "Even his earnest attitude to religion is consistent with homoclite psychology," writes Ghaemi.[9] This intriguing statement is not explained further. George W. Bush, too, is the quintessential homoclite who got Cs at Yale and married a librarian. Ghaemi sketches Bush's pre-presidential life in a few pages, highlighting the evidence for homoclite status while sprinkling the paragraphs with stand-alone sentence-paragraphs suitable for quoting, such as "A homoclite makes a good friend, but a risky leader". Bush's alcoholism is simply explained away. It is odd for a 21st-century psychiatrist to treat a substance use problem so lightly and categorically refuse to call it a mental illness. It is true, if Bush is an alcoholic in sustained remission, this would spoil a perfectly good thesis. Better to use Bush's success at abstinence to say patronizingly that his alcohol problem "was mild and easily solved," thus rendering him again mentally normal, as all who do not meet crises satisfactorily must be.[10] President Eisenhower is dubbed a homoclite even though he was "relatively successful," because his presidency did not entail "handling major crises"; in fact, although he "briefly intervened in Little Rock" regarding civil rights, he "otherwise avoided conflict".[11] Planning and commanding the invasion of Normandy – deemed a conflict by some – while Supreme Allied Commander in Europe has never before earned this personality description.

If 20 percent of the population will experience a mental illness over their lifespan, then 80 percent will not. They are the homoclites. 80 percent of the population, therefore, is described by Dr. Ghaemi's universal statement: "The homoclite does not fail often, and when he does, he learns little".[12] Is it not possible that some men and women who will never suffer from mental illnesses may yet learn from mistakes? Is it not possible that introverts, rule-followers, middle westerners, the calm and the measured, might gain insight when they suffer? A psychiatrist with a clinical practice sees many patterns in a day's work: he sees patients whose symptoms fall into common clusters again and again, across generations and cultures; he sees childhood insults presenting in similar ways in patients later in life. But he also sees infinite variety. Ghaemi is right in saying that Lincoln's melancholy enhanced his leadership performance, as did Churchill's moods. But Roosevelt's paralysis likely accomplished this too, for it made him become more than a lightweight aristocrat from New York State with a jaunty manner. We do not have to prove he was also mentally ill or abnormally "hyperthymic" to understand this. There are routes to insight that do not pass through mental illness. Hemingway's sentiment in *A Farewell To Arms* potentially applies to 100 percent of humanity: "The world breaks every one and afterward many are strong at the broken places".

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