A FIRST-RATE MADNESS

UNCOVERING THE LINKS BETWEEN LEADERSHIP AND MENTAL ILLNESS

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INTRODUCTION

THE INVERSE LAW OF SANITY

"Genl Wm T Sherman Insane" ran the headline of the November 1861 *Cincinnati Chronicle*. General William Tecumseh Sherman had gone "stark mad" and been removed from Union command in Kentucky; his peers, family, and staff all agreed that he suffered from paranoid delusions. On his way home to Ohio, Sherman said with a shrug, "In these times it is hard to say who are sane and who are insane."

He would reclaim his commission and go on to become a symbol of the Civil War's horror and a spokesman for psychological terror—the man history remembers for decimating Atlanta and scorching a trail through Georgia on his devastating "March to the Sea." He is an iconic figure in American history, yet few Americans know about an essential aspect of the man whose "scorched earth" strategy informed modern warfare from London, Dresden, and the Battle of the Bulge to Vietnam, Bosnia, and Iraq.

Historical evidence suggests that Sherman suffered from manic-depressive illness, or bipolar disorder—extreme shifts in a person's mood, energy, and ability to function. Someone need have only one manic episode to be diagnosed as manic-depressive; in fact, most

people with the illness suffer mostly from depression. In addition to the Kentucky breakdown, Sherman apparently had at least four other major depressive episodes, the first at age twenty-seven, with symptoms of hopelessness, inertia, insomnia, and loss of appetite. He'd been having trouble settling into a military career and feeling excessively controlled by his father-in-law. The second episode occurred around age thirty-seven, when Sherman was a struggling banker. Another followed a few years later, again involving financial hardship. Another, at age fifty-eight, thirteen years after the war, came after his oldest son, Tom, a deeply depressed and sometimes homeless man who ultimately died in an institution, refused to study law, as Sherman desired, and decided instead to become a Jesuit priest. (A paternal uncle of Sherman's also likely suffered from recurrent depression, a genetic link that supports this diagnosis.)

Sherman never admitted to a mental illness. In his *Memoirs*, published in 1875, he famously blamed others for his mistakes and finessed all questions about his mental health. Historians indulged his charitable self-image for more than a century. Only in 1995, with the work of historian Michael Fellman, were Sherman's moods more thoroughly documented. Retrospective psychiatric diagnosis is fraught with risk and never definitive. Yet this doesn't mean we shouldn't follow the documentary trail and, in Sherman's case, consider the likelihood that a man who caused so much suffering, suffered much himself.

MOST OF US make a basic and reasonable assumption about sanity: we think it produces good results, and we believe insanity is a problem. This book argues that in at least one vitally important circumstance *insanity* produces good results and *sanity* is a problem. In times of crisis, we are better off being led by mentally ill leaders than by mentally normal ones.

There are different kinds of leadership for different contexts. The *non-crisis leader* succeeds in ordinary times, but in times of crisis should

be kept far away from the scepter of rule. As we'll see, the typical non-crisis leader is idealistic, a bit too optimistic about the world and himself; he is insensitive to suffering, having not suffered much himself. Often he comes from a privileged background and has not been tested by adversity; he thinks himself better than others and fails to see what he has in common with them. His past has served him well, and he seeks to preserve it; he doesn't acclimate well to novelty. We see the non-crisis leader all around us—the CEO, the department chief, your neighbor's boss, the bank president, the president. One more fact: he is quite mentally healthy. He has never suffered from depression or mania or psychosis. He has never seen a psychiatrist.

ARISTOTLE FIRST SPECULATED about the link between genius and madness twenty-five hundred years ago, and at the height of the Romantic era the nineteenth-century Italian psychiatrist Cesare Lombroso defined that link forcefully, which we might translate as a simple equation: insanity = genius. He believed you can't have one without the other. In contrast, the statistician and founder of behavioral genetics, Francis Galton, took the opposing view, which we can summarize as: sanity = genius. Galton argued that intelligence—the strongest indicator of a healthy brain—produced genius. Both men saw genius as biological in origin, but one believed it arose from illness, the other from health.

These two views have seeped into Western culture, with most of us reflexively preferring Galton over Lombroso. In this book, I take Lombroso's side, with some qualifications. Throughout I trace a basic law that emerges from studying the relation of mental illness to leadership. One might call it the *Inverse Law of Sanity:* when times are good, when peace reigns, and the ship of state only needs to sail straight, mentally healthy people function well as our leaders. When our world is in tumult, mentally ill leaders function best.

Four key elements of some mental illnesses—mania and depression—appear to promote crisis leadership: *realism*, *resilience*, *empathy*,

and *creativity*. These aren't just loosely defined character traits; they have specific psychiatric meanings, and have been extensively studied scientifically. I use these terms in their scientific, not their commonsense, meanings. Among these qualities, psychologists have studied creativity and empathy most, but resilience and realism are just as important for leadership and have also been examined in some detail by recent researchers. Of these four elements, all accompany depression, and two (creativity and resilience) can be found in manic illness. Except for resilience, none are specific for other mental illnesses (like schizophrenia and anxiety disorders). Depression makes leaders more realistic and empathic, and mania makes them more creative and resilient. Depression can occur by itself, and can provide some of these benefits. When it occurs along with mania—bipolar disorder—even more leadership skills can ensue. In this book, I'll examine eight great political, military, and business leaders whose lives and work show various aspects of the link between leadership and madness: William Tecumseh Sherman, Ted Turner, Winston Churchill, Abraham Lincoln, Mahatma Gandhi, Martin Luther King Jr., Franklin D. Roosevelt, and John F. Kennedy. I also provide counterexamples of five mentally healthy "normal" leaders who failed in moments of crisis: Richard Nixon, George McClellan, Neville Chamberlain, and possibly George W. Bush and Tony Blair. These counterexamples are important: I am not just diagnosing illness everywhere; I see mental health in most of our leaders, and I see it as a potential impediment in times of crisis.

In the course of my research, it became clear to me that mental illness was even more influential in historical terms than I had first imagined. Several major Civil War leaders were mentally ill or abnormal: Lincoln and Sherman, as will be shown later, but also Ulysses S. Grant, the alcoholic; possibly Stonewall Jackson; even, according to some evidence of depression and a family history of mental illness, Robert E. Lee. All the major leaders of World War II can be shown, with reasonable evidence, to have been mentally ill or abnormal: Churchill,

FDR, and Hitler, as we will see; as well as Stalin and Mussolini, each of whom had severe depressive episodes and probable manic episodes. Two key figures in the American civil rights movement, John Kennedy and Martin Luther King, were also mentally abnormal.

I believe these examples are more than coincidence, and more than a historical oddity. They suggest a relatively consistent pattern that, if true, has been largely ignored by historians and the public, but that may have in fact shaped the second half of the twentieth century more than any other single force. Once we start to see history through this lens, the reach and import of madness and leadership become hard to deny.

THIS IS A BOOK of psychology and of history; it sits at the long-disputed intersection of two different disciplines. But this book is not psychohistory. Psychohistory is a discredited discipline, and with reason. One need only read the book that started it all, written by the founder himself, Sigmund Freud's *Woodrow Wilson*, cowritten with the American politician (and one of Freud's patients) William Bullitt. There one finds passages like this:

> [Wilson] carried great burdens during the war for a man whose arteries were in precarious condition; and, although he continued to be troubled as usual by nervous indigestion and sick headaches, he suffered no "breakdown." His Super-Ego, his Narcissism, his activity toward his father, his passivity to his father, and his reaction-formation against his passivity to his father were all provided with supremely satisfactory outlets by the war.

No wonder historians are allergic to psychological interpretation. The book was so weak psychologically that Freud's daughter and his closest disciples suppressed its publication, and when it finally appeared in 1967, they tried to argue that Freud wrote very little of it. For many

historians, psychiatry and psychology are synonymous with psychoanalysis, and any psychological interpretation seems bound to end up in fruitless speculation about the early childhood traumas of historical figures. Indeed, until recently historians were correct. Psychiatry and psychology, in the United States, have long been infatuated with psychoanalysis. Only in the last two decades has psychoanalysis been put in its proper place—not simply discarded, but no longer seen as necessary and sufficient in itself. (Imagine if all of economics was thought to be contained in Marxism; psychiatry was that dependent on psychoanalysis until recently.)

This psychoanalytic obsession has been replaced by a perspective on mental illness that is scientifically and medically sound. This psychiatry, stripped of its psychoanalytic faith, can be an extremely useful tool for historians.

THE NEW PSYCHIATRY begins where modern medicine began, with the search for objective ways to diagnose illness. In internal medicine, doctors get a "case history"—a story of signs and symptoms and their course over time. Psychiatrists and historians do the same. Yet the internist has one resource that that historians and psychiatrists do not: pathology. Physicians have long disagreed with each other; one could diagnose a patient with a certain illness, and another could offer a quite different diagnosis, even given the same case history. But medicine changed dramatically when the pathologist could take a piece of tissue and determine which doctor's diagnosis was right. The doctors would discuss the case in an auditorium, with students watching, each providing a rationale for a diagnosis. At the end of an hour's debate, the pathologist would stand up, put a slide under a microscope, and reveal the right answer.

Sometimes other tests are done: an analysis of blood chemistry, or an MRI scan of an organ. Yet sometimes these tests don't give a definitive answer; sometimes tests can even be wrong. And good doctors know

that tests help us get to the right answer by adding to the evidence gathered in the case history; alone they are hardly foolproof ways to diagnose illness. Of course, tests for physical conditions are often conclusive, but the problem with psychiatry—and with history—is that there's no conclusive test. One can't prove that a patient has schizophrenia with a blood test or a brain scan; and if this is true with a living patient sitting in front of me, it is obviously so with a dead historical figure.

Yet medicine has long faced and solved this problem. Many illnesses outside of psychiatry can only be examined based on the case history—migraine, for example, and rheumatoid arthritis, and many forms of epilepsy. In these cases, doctors are in the same boat as are those who study mental illness—there's no definitive test. The solution comes from the field of clinical epidemiology, the same discipline that teased out the link between cigarette smoking and lung cancer. When there's no single proof, the solution is to obtain several independent sources of evidence. No single source is enough to prove a diagnosis, but all of them can converge to make a diagnosis likely.

Four specific lines of evidence have become standard in psychiatry: symptoms, genetics, course of illness, and treatment.

Symptoms are the most obvious source of evidence: most of us focus only on this evidence. Was Lincoln sad? That symptom could suggest depression, but of course one could be sad for other reasons. Symptoms are often nonspecific and thus not definitive by themselves.

Genetics are key to diagnosing mental illness, because the more severe conditions—manic-depressive illness in particular—run in families. Studies of identical twins show that bipolar disorder is about 85 percent genetic, and depression is about half genetic (The other half, in the case of depression, is environmental, which is why this source of evidence is also not enough on its own.)

Perhaps the least appreciated, and most useful, source of evidence is the *course of illness*. These ailments have characteristic patterns. Manic-depressive illness starts in young adulthood or earlier, the symptoms come and go (they're episodic, not constant), and they generally follow

a specific pattern (for example, a depressive phase often immediately follows a manic episode). Depression tends to start somewhat later in life (in the thirties or after), and involves longer and fewer episodes over a lifetime. If someone has one of these conditions, the course of the symptoms over time is often the key to determining which one he has. An old psychiatric aphorism advises that "diagnosis is prognosis": time gives the right answer.

The fourth source of evidence is *treatment*. This evidence is less definitive than the rest for many reasons. Sometimes people never seek or get treatment, and until the last few decades, few effective treatments were available. Even now, drugs used for mental illnesses often are nonspecific; they can work for several different illnesses, and they can even affect behavior in people who aren't mentally ill. Sometimes, though, an unusual response can strongly indicate a particular diagnosis. For instance, antidepressants can cause mania in people with bipolar disorder, while they rarely do so in people without that illness.

IT'S IMPORTANT TO NOTE that the psychiatrist's method is exactly the same as the historian's. In other words, what the psychiatrist does when evaluating a living patient is no different from what a historian can do when evaluating the psychological makeup of a dead historical figure. The case history approach is the same: one assesses the person's past, based on his or her own report and that of third parties (families and friends and colleagues). The only difference is that the living patient can speak to the psychiatrist, while the dead historical figure speaks only through documents like personal letters. This difference is not as much of a drawback to the historian as it might seem. Living patients are often inaccurate or reticent about their symptoms during interviews with psychiatrists. In fact, some mental illnesses are characterized by how difficult they are to diagnose through interviews: for instance, about half the time, people with bipolar disorder deny having manic symptoms that they've actually experienced. In medical

parlance, a patient's "self-report" is often inadequate and insufficient; psychiatrists should get information from family and friends as well. Historians faced with a dead figure are only at a partial disadvantage; even if that figure were alive, much of what he or she might say about potential psychiatric symptoms would be wrong.

Whether dealing with the living or the dead, third parties are often better sources than subjects themselves. In that sense, historians and psychiatrists are working with the same material: the case history of a living person being evaluated by a psychiatrist isn't fundamentally different from the history of a dead person being studied by a historian.

THIS BOOK DESCRIBES conditions that have applied to many leaders throughout history, and no doubt the reader can think of contemporary leaders to whom they apply as well. I'll focus primarily on a handful of historical figures whose lives spotlight different aspects of the relationship between mental health and leadership, and for whom there is particularly strong documentary evidence. General Sherman and cable entrepreneur Ted Turner exemplify how the symptoms of bipolar disorder can enhance creativity. The careers of Abraham Lincoln and Winston Churchill show the special relationship between depression and realism. So too do Mahatma Gandhi and Martin Luther King Jr.; their lives also highlight the strong link between depression and empathy. Franklin D. Roosevelt and John F. Kennedy, both of whom had hyperthymic personalities (that is, mildly manic traits), demonstrate the close connection between mental illness and resilience. Kennedy's experiences with medication also show the dramatic power of drugs to enhance the positive aspects of mental illness—or to make those illnesses even worse. Adolf Hitler's treatments provided similar, and more horrible, lessons.

To sharpen our understanding of successful crisis leaders, I will compare several of them to well-known, mentally healthy contemporaries who failed in crises. So, for instance, I'll contrast Sherman with

General George McClellan, who thrived in the Union army before the Civil War but failed notoriously and repeatedly during the war. And I'll show how Churchill's realistic assessment of the Nazi threat contrasts with the infamous inability of his eminently sane colleague Neville Chamberlain to recognize that threat.

I focus on historical leaders because, as a psychiatrist, I am eager to understand the benefits, as well as drawbacks, that can accompany mental illnesses. Clinical research has demonstrated these benefits—resilience, realism, empathy, and creativity. Yet most people haven't taken much note of this research. Showing the link between these strengths and madness in several of our most celebrated leaders could raise our awareness about the strengths that some mental illnesses can bestow on anybody who suffers from them. Furthermore, going back into history, rather than simply discussing contemporary figures, offers the advantage of hindsight. We see the past more clearly than the present; our current biases and hopes and uncertainties make our grasp of today much less solid than our hold on yesterday. If I were to focus on the current president or prime minister, my readers and I would automatically apply many of our own biases to those people. On the other hand, we can all be more objective about Churchill and Lincoln, much more so than their contemporaries were. (This doesn't mean we can make no inferences at all about contemporary leaders, as I'll do in chapter 15, but that such inferences are less definitive than with prior historical figures.) Historical perspective may allow us to perceive the impact of mental illnesses on leadership more clearly, not less so, than analyzing today's leaders.

BEFORE WE EXPLORE the links between mental illness and leadership, it's essential to understand what mental illness is—and is not.

First and most important, mental illness doesn't mean that one is simply insane, out of touch with reality, psychotic. The most common mental disorders usually have nothing to do with thinking at all, but rather abnormal moods: depression and mania. These moods aren't

constant. People with manic-depressive illness aren't always manic or depressed. Thus they aren't always insane; in fact, they're usually sane. Their illness is the *susceptibility* to mania or depression, not the fact of *actually* (or always) being manic or depressed. This is important because they may benefit as leaders not just directly from the qualities of mania or depression, but also indirectly from entering and leaving those mood states, from the alternation between being ill and being well.

Contrary to popular belief, the psychiatric concept of clinical depression is different from ordinary sadness. Depression adds to sadness a constellation of physical symptoms that produce a general slowing and deadening of bodily functions. A depressive person sleeps less, and the nighttime becomes a dreaded chore that one can never achieve properly. Or one never gets out of bed; better sleep, if one can, since one can't do anything else. Interest in life and activities declines. Thinking itself is difficult; concentration is shot; it's hard enough to focus on three consecutive thoughts, much less read an entire book. Energy is low; constant fatigue, inexplicable and unyielding, wears one down. Food loses its taste. Or to feel better, one might eat more, perhaps to stave off boredom. The body moves slowly, falling to the declining rhythm of one's thoughts. Or one paces anxiously, unable to relax. One feels that everything is one's own fault; guilty, remorseful thoughts recur over and over. For some depressives, suicide can seem like the only way out of this morass; about 10 percent take their own lives.

The most popular psychological theory about depression these days is the *cognitive-behavioral model*, which views depression as distorting our perception of reality, making our thoughts abnormally negative. This model, the basis for cognitive-behavioral therapy, is contradicted by another theory that has a growing amount of clinical evidence behind it: the *depressive realism hypothesis*. This theory argues that depressed people aren't depressed because they distort reality; they're depressed because they see reality more clearly than other people do.

The notion of depressive realism implies that the disease has an upside, but I don't want to misrepresent how deeply dangerous and

painful depression is. If untreated, it becomes a game of Russian roulette, with nature pulling the trigger when she decides, and with suicide the outcome. "Depression is a terrifying experience," said one of my patients, "knowing that somebody is going to kill you, and that person is *you*." Suicidal thoughts occur in about half of clinical depressive episodes.

The anger and despondency of depression (as well as the impulsivity of mania) can also cut a person off from the people he loves most. Divorce and broken relationships are the rule. Said one patient, "The illness is a kind of robbery; it robs you of those you love. I don't want money or power or fame. I just want to keep those I love. And this illness robs them from me. They wake up one day, and I am not the same person, and they say, 'Who is this?' And they leave." The benefits of depression come at a painful, if not deadly, price.

IF THE NUANCES of depression are confusing, mania seems even more complicated. Here mood is generally elated, even sometimes giddy, often alternating with anger. One doesn't need to sleep much; four hours can do it. While the rest of the world is sleeping, one's energy level is as high as it might be at 11 a.m. Why not clean the entire house at 3 a.m.? Things need to get done, even if they don't. Redecorate the house; do it again; buy a third car. Work two or three extra hours every day: the boss loves it. One's thoughts pour forth; the brain seems to be much faster than the mouth. Trying to keep up with those rapid thoughts, one talks fast, interrupting others. Friends and coworkers become annoyed; they can't get a word in edgewise. This may make one more irritable; why can't everyone else get up to speed? "Mania is extremity for one's friends," Robert Lowell remarked, "depression for oneself."

Self-esteem rises. Sometimes it leads to great successes, where one's skills are up to the task at hand. But often it leads to equally grand failures, where one oversteps one's bounds. But for someone in a manic state, there is no past; there is hardly today; only the future counts, and

there, anything is possible. Decisions seem easy; no guilt, no doubt, just do it. The trouble is not in starting things, but in finishing them; with so much to do and little time, it's easy to get distracted.

Mania often impairs one's judgment, and bad decisions typically fall into four categories: sexual indiscretions, spending sprees, reckless driving, and impulsive traveling. Sex becomes even more appealing; one's spouse may like it, or tire of it. The urge is so strong that one might look to satisfy it elsewhere; affairs are common; divorce is the norm; HIV rates are high. Divorce, debt, sexually transmitted diseases, occupational instability: mania is the perfect antidote to the cherished goals of most people—a family, a home, a job, a stable life. The depressed person is mired in the past; the manic person is obsessed with the future. Both destroy the present in the process. In the worst-case scenario, the depressed person takes her life, the manic ruins hers. In manic-depressive illness, one suffers from both tragic risks.

Yet for all its dangers, mania can confer benefits that psychiatrists and patients both recognize. A key aspect of mania is the liberation of one's thought processes. My patients are sometimes eloquent when describing this freedom of thought (which psychiatrists label "flight of ideas"):

"Everything was swirling like a whirlwind; you just had to reach up to grab a word. You could see it, but you couldn't say it, like the word 'flower.' But when it got faster, you couldn't even see it."

Or: "My thoughts were like fireworks, going up and then exploding in all directions."

This emancipation of the intellect makes normal thinking seem pedestrian: "It felt like my mind was a fast computer," said one patient.

This produces the swell of creativity that only great poets who have themselves been manic can describe. Like William Blake:

> *To see a world in a grain of sand*
> *And heaven in a wild flower*
> *Hold infinity in the palm of our hand*
> *And eternity in an hour.*

Or Robert Lowell:

For months
My madness gathered strength
To roll all sweetness to a ball
In color, tropical . . .
Now I am frizzled, stale and small.

THEORIES OF MANIA do not abound. It's as if traditional psychiatry saw the condition as too superficial to merit explanation.

The psychoanalytic view, which sees mania as a defense against depression, is the most coherent but probably the most wrongheaded. Some of my own patients offer a version of this explanation. "Sometimes I think I make myself become manic to ward off a depression," one patient told me. "I make myself be happy about everything and I do a lot of things and I stop sleeping because I know if I don't do this, I'll become depressed." Such rationales seem logical, but I'm skeptical about them. Mania often occurs without any preceding depression, and in fact more commonly, depression follows mania, suggesting that mania causes depression, rather than the reverse.

For psychoanalysts, depression was respectable; mania was not. Freud at least was honest about this: he wrote practically nothing about mania, and he admitted that psychoanalysis had no role in understanding or treating manic-depressive illness. His followers spoke where he was silent, blaming manic patients for being too childish to face their depressions. Mania does seem to hamper self-awareness, perhaps another reason why psychoanalysts looked askance at it. In my practice, I often see patients who are manic but don't realize it. Some others only see the benefits of mania: enhanced creativity, energy, sociability. Mania becomes a kind of temporary "personality transplant" where people take on the kind of charisma that our society rewards. But they don't fully realize the negative aspects of the disease, which are usually even

more pronounced than its benefits: irritability, promiscuous sexuality, and lavish spending.

Mania is like a galloping horse: you win the race if you can hang on, or you fall off and never even finish. In Freudian terms, one might say that mania enhances the id, for better or worse. All energies, sexual and otherwise, overwhelm the usual controls that we learn to impose over a lifetime. The core of mania is *impulsivity with heightened energy*. If to be manic means to be impulsive, then perhaps the expression of mania depends on how far the civilized veneer that holds our lives together is stretched. If it is stretched only a little, manic-depressive persons may function fine and actually be rewarded for their creativity and extraversion. If it is stretched too much, society disapproves, and tragedy may ensue.

SOME PEOPLE ARE neither depressed nor manic, but they aren't mentally healthy either. They have *abnormal personalities or temperaments*. Personality or temperament is just as biological as mental illness, though most of us think otherwise. Our basic temperaments are set by the time we reach kindergarten; studies show that those basic temperaments measured at age three persist and predict adult personality at age eighteen. From then onward as well, despite what many intuitively believe, our basic personality traits change little throughout adulthood and into old age. We may get wiser as we get older, but we do not become less introverted, or more open to experience, or less neurotic (to mention three basic personality traits).

Usually we don't think about personality in relation to mental illness. Indeed, my main focus in this book will be to apply the psychiatric concepts of depression and mania to history. But many leaders, though not manic-depressive, have abnormal temperaments that are mild versions of manic-depressive illness.

Personality traits are like height and weight—variables that describe the shape of our minds, just as height and weight describe the shape of

our bodies. A century of research on personality has produced some consensus. Most studies on personality identify at least three basic traits common to all people: neuroticism, extraversion, and openness to experience. One of these traits is anxiety—we're all more or less anxious (neuroticism). Another is sociability—some of us are more extraverted, some more introverted (extraversion). Another is experience seeking—some of us are curious and take risks, others are more cautious (openness to experience). We each have more or less of these traits, and, with well-designed psychological tests, one can establish how they're distributed among thousands of normal people. One can then know where any single person stands on each trait, near the middle of a normal curve—and thus near the average—or toward the extremes.

These traits can combine to form specific personality types. Some people are always a little depressed, low in energy, need more than eight hours' sleep a night, and introverted. This personality type is called *dysthymia*. Other people are the opposite: always upbeat, outgoing, high in energy. They need less than eight hours' sleep a night and have more libido than most of us. This type is called *hyperthymia*, and it occurs often in great leaders, like Franklin Roosevelt and John F. Kennedy. And some people are a little of both, alternating between lows and highs in mood and energy. This type is called *cyclothymia*.

These abnormal temperaments are mild versions of depression, mania, and bipolar disorder; as such, they're abnormal personality traits, which a person has all the time, not mood episodes that come and go. They can occur by themselves, without any episodes of mania or depression, or they can occur alongside bipolar disorder or severe depression (for instance, someone might have episodes of mania or depression every other year, and in between those episodes have a dysthymic personality). In fact, these abnormal personalities occur more often in those with bipolar disorder or severe depression than they do in people without mental illness. They also occur much more frequently in relatives of people with severe depression and mania than in the normal population.

These temperaments were described by the early-twentieth-century German psychiatrist Ernst Kretschmer, the first modern researcher on abnormal personality, who also noted the link between insanity and genius. He recognized the benefit of a little mental abnormality, either in "the initial stages" of severe mental illness, or in "mild, borderline states of mental disease," which is what I mean by abnormal personalities or temperaments. If we removed the insanity from these people, Kretschmer said, we would convert their genius into merely ordinary talent. Insanity is not a "regrettable . . . accident" but the "indispensable catalyst" of genius.

SURPRISINGLY, MENTAL HEALTH can be as challenging to define as mental illness, because our sense of one is informed by our sense of the other. To keep it simple, I define mental health as *the absence of mental disease, plus being near the statistical average of personality traits.* Thus, *mental illness* means the presence of disease, like manic-depressive illness; and *mental abnormality* means being at the extremes, not near the average, of personality traits. Mental abnormality means having abnormal temperaments—like dysthymia, cyclothymia, hyperthymia—that don't occur in the vast majority of normal people. Therefore, these conditions aren't part of mental health; they are essentially milder versions of mental illness.

With these definitions, the theme of this book can be stated this way: *The best crisis leaders are either mentally ill or mentally abnormal; the worst crisis leaders are mentally healthy.*

In times of peace, mental health is useful. One meets the expectations of one's community, and one is rewarded for doing so. In times of war or crisis, it is the misfits who fill the bill. Kretschmer noticed this pattern and explained it using the metaphor of bacteria, which replicate and survive only in times of crisis. "The brilliant enthusiast, the radical fanatic and the prophet are always there, just as the tricksters and criminals are—the air is full of them," but they flourish only

during crisis. In peacetime, they are our patients, he famously wrote; we rule them. In crisis periods, they rule us.

Great crisis leaders are not like the rest of us; nor are they like mentally healthy leaders. They're often intelligent, prone to poor physical health, the products of privileged backgrounds, raised by parents in conflict, frequently nonreligious, and ambitious. All these personality traits and experiences are also associated with mental illness, like mania and depression, or with abnormal temperaments, like hyperthymia. Much of what passes for normal is not found in the highly successful political and military leader, especially in times of crisis. If normal, mentally healthy people—what I will later define scientifically as "homoclites"—run for president, they tend not to become great ones.

A FINAL DISCLAIMER: the true mark of science (as opposed to its many masquerades) is an attempt to refute one's hypothesis, to be self-critical, to examine one's assumptions, and to point out ways to further test one's theory. I will strive to do all of these things throughout this book. Science makes probabilistic claims; it is not usually about proving that something is *always* the case, or *never* the case. Almost all science is about showing a greater probability that something is *usually* the case. On most scientific matters, especially in medicine and on the topic of disease, no single exception is a disproof. The preponderance of the evidence represents scientific knowledge.

I don't claim that depression *invariably* leads to realism, nor that mania *always* enhances creativity, nor that depression *on every occasion* increases empathy, nor that hyperthymia *inevitably* promotes resilience. Rather, I argue that, *on the whole*, *more often than not*, *those mental illnesses enhance or promote those qualities more frequently than is the case in the absence of those mental illnesses.* Some people with manic-depressive illness are unrealistic (even psychotic), unempathic, and unresilient. We shouldn't romanticize this condition; in its most extreme forms, it is highly disabling and dangerous. But most people have less severe

forms of these illnesses; there will be many more manic-depressive leaders showing the beneficial traits discussed in this book than manic-depressive leaders who are dangerously crazy.

We will see that our greatest crisis leaders toil in sadness when society is happy, seeking help from friends and family and doctors. Sometimes they're up, sometimes they're down, but they're never quite well. Yet when calamity occurs, if they are in a position to act, they can lift up the rest of us; they can give us the courage we may have temporarily lost, the fortitude that steadies us.

Their weakness is, in short, the secret of their strength.