



ENRIQUE MARTÍNEZ CELAYA, *THE SECRET*. 2012, OIL AND WAX ON CANVAS, 44 × 60".
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THIN PLACES

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THE ELECTRODE IS THE WIDTH of angel-hair pasta. A surgeon has threaded it through one of the four dime-size holes in the patient's skull, and it is advancing into her one millimeter at a time, controlled by a small knob that another surgeon is turning and turning with great concentration.

This morning a nurse shaved off the patient's hair, and the surgeon drilled these holes around the crown of her head, two in her temples and two in the back. Then he fastened a metal brace the size of a dog cage around her head to hold the wires steady as they enter her brain. Surrounding the patient, the brace, and the doctor is a giant O-shaped machine the color of tangerine sherbet, which is taking live images inside her head. The patient is awake.

First, the electrode passes through the part of the brain closest to the bone, the part of her that knows the names of things and left from right. Then it bores down through the part of her that knows how to draw, the part that recognizes her mother's face and remembers what she said to the nurse when he asked about the birthmark on her temple. Down through the part of her that likes sex and the part that knows how to talk. Down almost to the deepest part of the brain, the stem, which is responsible for her breath and her heart. This movement, from outside the patient's body through the opening in her skull and into the core of her brain, is called transversal.

The transversal has been plotted carefully. The path of the needle is precise to the millimeter, avoiding important veins and arteries as well as nerve clusters better left untouched. The destination is Area

24, also known as the ventral anterior cingulate. Hers is suffering from either underdevelopment or hyperactivity, depending on which doctor is explaining it. The electrode will stay inside her to deliver electric currents to Area 24 for the next several years, or possibly forever.

The patient finds herself strapped to a gurney with wide belts, naked under her paper gown, because this morning, like every morning, she thought, 117 times, “I am going to kill a stranger.” A pacifist by nature and in her politics, she finds this thought sickening and goes to great lengths to ensure that it doesn’t come true. An elaborate protocol has arisen: every time the thought “I am going to kill a stranger” pops into her mind she jerks her head hard and declares silently, “I am a peaceful person, I am a peaceful person, I am a peaceful person.” This quells the panic that rises—*is* she peaceful? What if she killed someone by accident? What if she flew into a sudden rage? What if she is, at heart, monstrous?—and works like penance: three peaceful thoughts for every murderous one keeps the balance tipped in the right direction. This becomes more difficult when the thoughts come quickly. The number of times she thinks “I am going to kill a stranger” has to be prime or the thought’s power increases, so she’ll restart the cycle as many times as necessary to bring the count to a prime number. A twenty-minute reprieve is as much as she hopes for in a day.

She has thrown out all her knives, scissors, heavy blunt objects, needles, and sharp pens. She stopped driving a long time ago. She never stands near train tracks or close to people on the sidewalk, just in case something were to come over her and she were to push someone into traffic. Despite being shy, she feels compelled to introduce herself to almost everyone she sees. Once she meets them, they are no longer strangers and therefore no longer in danger of her. This became exhausting—and alarming to the strangers—so a few years ago she stopped leaving her house altogether. Now she lives in terror of what she might do to deliverymen.

Over the years, doctors have prescribed nine medications in various combinations, as well as talk therapy, exposure therapy, cognitive behavioral therapy, and electroconvulsive shock therapy, all with meager results. Her case is, to use their terminology, “intractable.” She had to sign all manner of paperwork formally acknowledging this, attesting, for example, that she knows what the word *intractable* means, before she could find

herself in this room with Frankensteinian screws in her temples, counting the ceiling tiles. She consented to everything without hesitation.

The first electrode's transversal produces soft, whooshy noises from the monitor in the corner. These noises are her brain waves, tracked by the exploratory electrode, which will forge the correct path before the doctor inserts the permanent electrode. His target is two-and-a-half or three millimeters wide. Once he's reached it, he will remove the exploratory electrode and thread in the one that will be wired to a battery pack sewn in under her collarbone. It will pulse electricity into Area 24 at a constant rhythm for several years, until the battery dies and needs to be changed. She has to be awake during the insertion so that she can tell them what it feels like.

The patient is not altogether articulate about what it feels like. She has been strapped down to prevent her from bolting or fighting or trying to tear the metal cage off her head. This is both terrifying and comforting, as the thoughts are coming in inexorable waves now and she is grateful for anything that will help her keep them from coming true. This is a familiar scene: the afflicted tied down while being ministered to by some credentialed man in a robe carrying an instrument. It used to be books and crucifixes. There used to be prayer and incantation. Now there are only the muted sounds of her brainwaves, the rhythmic beeps and clicks of the vitals monitor, and the voice of the doctor as he murmurs to her through her thought torrent. He sounds calm.

The goal is to alter her experience of reality "with minimal side effects." No one has been able to tell her whether or why this will work. Only a few dozen people have ever had this treatment for a psychological condition, and so every new patient is an experiment. Initially, doctors hypothesized that the electricity would curb overactive neurons; now they suspect it may actually stimulate neurons, or change the types of information neural pathways can transmit, but they're not sure, just as they're unsure precisely where in her brain to place the electrodes for best results. They are learning as they go; once this is all over, her experience will be another data point.

What the doctors do know is what the anterior cingulate cortex does, generally speaking. It houses consciousness, in the existential sense, and emotional pain. It regulates motivation, impulse control, and the anticipation of both delight and catastrophe. Francis Crick proposed

it as the center of free will. It's also responsible, in part, for the human capacity for empathy.

There are, naturally, a number of things that could go wrong. Possible but unlikely: hemorrhage, brain damage, stroke, seizure, infection, death. Possible but slightly more likely: memory "problems," trouble speaking, depression, and mania. These latter risks have an aftertaste of irony. The electrode might turn her from a person who speaks compulsively to strangers to a person who cannot speak well at all; it may transform her mind from one reduced to four obsessive thoughts to one hyperexpansive with mania. She wonders what it would be like to go from having one mind to another and then remembers she has already done that.

The doctor in the paper bonnet interrupts this line of thinking to announce that they're ready to begin testing voltages. The electrode has arrived at what they think will be the right place, and now it is time to see what happens to her mind when they turn it on.

She closes her eyes and waits.

THIS PROCEDURE IS CALLED deep brain stimulation (DBS). The patient described above is a composite of people I've met, people I've read about, and people whose surgeries I've seen in videos. She is fashioned after the few dozen patients who have undergone DBS to treat severe obsessive-compulsive disorder, an experimental application now in clinical trials at Mount Sinai Hospital in New York, Brown University, the University of Rochester, and a handful of other medical centers. Her symptoms aren't so much fictional as typical: thousands of people are crippled by fears of hurting others. It is shocking how many have thrown out their knives.

Deep brain stimulation has been used for years to diminish tremors in people with Parkinson's disease, but it's experimental and controversial as a treatment for psychiatric disorders.* Only a few OCD patients have undergone it (roughly two dozen so far in the current, FDA-approved study, and no more than a hundred in the US total), and like many historical attempts to alter the mind, it seems halfway

* Nevertheless, it's being researched with enthusiasm as a possible alternative to the neurosurgical protocol that preceded it, ablation, in which targeted parts of the brain circuitry are burned by lasers until permanently "neutralized." Deep brain stimulation, for all its echoes of dystopian sci-fi, has the benefit of being adjustable and, for the most part, reversible.

magical because no one really understands its mechanisms. Obsessive-compulsive disorder is not like Parkinson's disease—the symptoms aren't visible and physical (trembling hands) so much as experiential and behavioral—so neurosurgery-as-treatment becomes more existential in its implications. Compounding this is the fact that, neurochemically, obsessive-compulsive disorder bears a conspicuous resemblance to falling in love. Scientists have scanned the brains of the pathologically obsessive and held them up next to brain scans of the love-struck, and the images turned colors in the same places. Doctors drew blood and found the same chemical imbalances—namely, a serotonin deficit. The philosophical distinction between deactivating a part of someone's brain and deactivating some part of their mind or self begins to blur.

I've done months of research about deep brain stimulation—reviewing articles, deciphering studies, interviewing physicians, scrolling through procedure videos on YouTube—for no special reason other than what you might call—ahem—a persistent curiosity. While reading the literature, it's easy to think in clinical abstractions, but then I watched a video of an older woman undergoing the procedure and was struck by the way her voice was muffled by the nest of equipment. The doctors kept having to ask her to speak up during the adjustment phase, when she was supposed to be reporting changes in her psychological state. "I said I almost just laughed," she repeated, gazing at the equipment before her with an expression of wonder. "I haven't laughed in . . . a very long time." The doctor nodded dispassionately. "Can you describe that for us?"

It seems important to cling to the concrete, to remember that illness is not a metaphor or a study but a phenomenon unfolding in (and on) real bodies in real rooms. Its qualia, the crinkly paper hospital gown and metallic adrenaline taste, the mutable and inexpressible shades of pain, demand articulation because they matter. We work so hard at telling others *what it is like* to be sick in whichever particular way we are sick; we are reassured to hear that our particulars fit within larger known narratives of illness. With sickness as with anything else, communicating what it is like so others can know, or understanding others in precisely the way they wish we could, is next to impossible. We try anyway.

Admittedly, most OCD patients are not like my imagined girl. Usually, the disease is damaging but not devastating in a relationship-ruining,

inpatient-care, life-disintegrating way. It is considered a less challenging diagnosis than, for example, bipolar disorder, schizophrenia, or any of the personality disorders.* It is “neurosis” not “psychosis,” “mental illness” as opposed to “insanity.” The existence of the DBS study, though, and the interest it draws from patients and practitioners alike, subtly undermines this differentiation. Extreme treatment reflects the disease’s extreme power to cripple. Neurologically, OCD seems to act on similar parts of the brain as schizophrenia; experientially, both diseases are marked by foreign-seeming intrusions on the mind. Both patients are overcome with thoughts, images, and impulses that are, to use the clinical word, ego-dystonic: they feel alien to and in conflict with the self. They feel other. In obsessive-compulsive patients, these thoughts tend to be violent or violating, obscene, immoral, or some other shade of horrifying.

What distinguishes obsessive-compulsive patients from schizophrenic patients is their ability to live inside a paradox: the thoughts hijacking their minds feel urgently not “theirs,” but the thoughts are nevertheless something going on in their own minds and bodies. These thoughts are alien, but they have not been planted by aliens. In the medical community, this is known as “insight.”

Having insight is not enough to make the thoughts go away. A little while ago, I was talking to a writer who has to touch things—all the slats on the staircase, all the poles as he walks down the street. He knows this doesn’t make sense. Sometimes, though not terribly often, he has to go back home to make sure that he didn’t leave a cigarette burning, even when he can remember perfectly well that he didn’t. He only has to do this when alone. When he’s with people, he doesn’t have to touch anything.

He told me that since childhood he’s been fascinated with the idea that everyone is God. I asked him what he meant, and he said that he had a suspicion that God was everywhere and everyone, and all our souls are the same soul, God’s soul, but we’re just walking around in different meat suits. That’s how he said it: “We’re all stuck in our own meat suits.”

* It’s worth noting, though, that OCD has something like a 91 percent lifetime comorbidity with other Axis-I diseases, most commonly depression, generalized anxiety disorder, panic disorder, addiction, and anorexia/bulimia. In a study published in 2008, three-quarters of OCD patients from a clinical sample met the criteria for lifetime mood disorders, nearly 40 percent were unable to work because of psychopathologies, and 14 percent were on disability specifically for OCD. In light of these numbers, a diagnosis of OCD is plenty grim.

I suddenly felt very aware of how different he and I look—his height and beard and age, his ruddiness, his tie; my stringy arms, bitten nails, and freckles. He is older than I am, and bigger, and embodied in a sort of ragged, robust way that I am not. At first I couldn't quite tell whether he was fucking with me when he leaned in and looked into my brown eyes with his blue ones and said, "What I'm saying is that maybe we're all the same, we just don't know it because we're separated into our own bodies," but then I decided that he was not fucking with me and was serious, at least partly, about this hypothetical.

And part of me was thinking, *Get a grip.*

Another part was thinking, *Well, exactly.*

Which did not signal that I was on board with the meat-suit theory per se, only that I was not surprised, even a little, to discover another person with OCD who'd been worrying his whole life about the distinctions and correspondences between himself and other people, and between himself and God. You don't have to have OCD or any mental illness to have concerns like this, but the urgency of locating the boundaries of the self, the distinction between what is inside and outside, you and not-you, becomes particularly acute when your mind seems a little too permeable.

OBSESSION WAS INITIALLY a term of warfare. In Latin, *obsessio* indicated the first phase of a siege on a city, when the city was surrounded on all sides but its citadel remained intact. *Obsessio* was followed by *possessio*, when the attacker breached the walls and took the city from the inside. In *Obsession: A History*, Lennard Davis explains the way these two words were adapted to explain demonic possession in the third century: "In the case of *obsession*, that person was aware of being besieged by the devil since the demon did not have complete control, had not entered the city of the soul, and the victim could therefore attempt to resist." Demonology was, for many centuries thereafter, the only language available for explaining obsession and other insanities. Obsession was understood as a torment of the soul and, often, a spiritual punishment. The cure was exorcism.

This went on for more than a thousand years, until some Protestant churches began to retreat from the idea of possession (piqued at the way the Catholic Church had, per Davis, "the inside track on exorcisms"). In 1731, the English Parliament repealed laws banning witchcraft, which

had been the most common grounds for exorcism. Modern medicine was in its nascent stages, and as it developed it annexed mental affliction, recategorizing madness as a physical rather than a spiritual problem. The demonological model was replaced by the medical model. Scientists discovered the nervous system and, with it, “nerves,” and the possibility of a physiological source of mental states.* Davis notes, “The nerves are the physical link to the mental—they are dissectible, discernible, and physical, yet their effects are metaphysical, symbolic, and affective.”

In the same era, roughly the late 17th to early 18th century, the notion of “partial madness” emerged to accommodate people who were mentally ill but tethered enough to reality to recognize their illness or sane enough to function within society. One could be “a conscious ‘I’ who is watching an obsessed self instead of a deranged and unconscious self dwelling in a lunatic.” Sanity went from a binary category (sane/insane) to a triad: you could be lucid, a lunatic, or a neurotic. The “monomaniacs,” as obsessives came to be known, were the stars of this new formulation. The monomaniac tended to be high functioning and highly thought of. Davis writes, “A certain cachet developed, a notion of being fashionable, in having one of these partial, intermittent conditions.” Neurosis was constructed as intrinsic to character, but as a possible asset. It was a sign of advancement, complexity, genius, cosmopolitanism, and, so to speak, *heightened sensibilities*.**

Such was the case with Sigmund Freud’s most famous obsessive. The Rat Man, as Freud nicknamed him to protect his identity, was clever and charming, a successful professional man who was nevertheless ruled by disturbing fantasies of rodents attacking his father and fiancée. Freud, writing in 1909, took a therapeutic approach to the Rat Man that became typical for a time: the man’s problems were purely

* In the 17th and early 18th centuries, nerves were thought of primarily as connective tissues in musculature. It wasn’t until later in the 18th century that the nervous system was understood to have any relationship with emotion. With this switch came the association of the word *nerves* with anxiety, nervousness, hysteria, and other “morbid affections,” an evolution to which we owe dubious thanks for the nervous Nellie, Jane Austen’s exquisitely irritating Mrs. Bennett (who won’t stop mewling, “My poor nerves!”), fashionable neuroses, and Woody Allen.

** The particular metaphors that arose around neurosis, or “nervous diseases,” are suspiciously similar to the metaphors that, in *Illness as Metaphor*, Susan Sontag argued were associated with tuberculosis in the 19th century: nobility of soul, creativity, Romantic melancholy, et cetera. Sontag was unimpressed with this

issues of the psyche. His obsessions stemmed from the fact that he'd been punished for masturbating as a child, and had formed as a defense mechanism against the anger, aggression, and anxiety he felt in his adult relationships. The cure: analysis.

A hundred years later, we don't think of the mind as something that can be entered, invaded, or deciphered so much as something that can be altered and adjusted. The mind is less the point, actually—Freud's methods have become passé. Now we talk about the brain, which is not parametric in that our metaphors for it do not indicate that the brain has parameters that can be violated. Insanity is now more biological than spiritual. "Mental illness" is no longer a breach of the self but a neurochemical event happening to—but separate from—the self. Like hypertension, it happens in our cells, and we swallow pills to get rid of it.†

This is more or less how grown-ups talked about what was wrong with me for several years after I was diagnosed with OCD at 13. I was, clinically, a nervous wreck, and many of my fears were about the transformation of my own mind. Was I insane? Was I doomed? Was this who I really was? Therapists and my parents were ready with reassurances that what was happening was only an accident of serotonin, a mysterious but correctable "imbalance" no more essential to who I was than a flu or a sunburn. I balked at taking medication, worried it would change who I was. "You have an illness, and this is just medicine to correct that illness," I was told. "It's like having diabetes. You wouldn't refuse insulin because your body's 'authentic' state is to have diabetes." In the end, I couldn't take the panic attacks, so I took the Prozac and, with it, this narrative of what was happening. It worked. The pills made my hands shake, but my mind was transformed back, more or less, to the healthy, stable state I remembered.

equation: "My point is that illness is *not* a metaphor," she wrote, "and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking. Yet it is hardly possible to take up one's residence in the kingdom of the ill unprejudiced by the lurid metaphors with which it has been landscaped." Later in the book, she lambasted the modern impulse to psychologize disease, declaring psychology a "sublimated spiritualism" with such sneering conviction that Denis Donoghue, reviewing the book for the *New York Times*, was emboldened to declare her mind "powerful rather than subtle," a critique it might have been entertaining to witness Sontag read in the paper.

† Incidentally, since the dawn of psychotropic medications, the incidence of OCD in the general population has jumped from .005 percent to 3 percent.

When I was 17, not long after weaning myself off Prozac, I relapsed. It happened sort of slowly. The thoughts came back, but at first I could fend them off. I blew past them with the buoyancy of a teenager whose life was going well. I was a few months away from leaving for what seemed like the most exciting college in the world, and I had my first boyfriend. Gradually, though, I stopped being able to ignore the thoughts. They came too quickly, and one day they seemed to bring real danger with them. Something darkly magical began to happen: I would gaze out at sunny days, beach days, Southern California sunsets, and feel the sidewalks began to warp. The sky was cloudless, but something was terribly wrong. This feeling would steal an hour one day, and then I'd be myself again. The next day, two hours. As weeks passed, the sinister entered, and sick fear took over.

At the time, I worked as a barista for a local breakfast-and-lunch place on the beach, pulling espresso and pouring green-tea lattes in an eight-by-eight-foot alcove off the restaurant's kitchen. A wall obstructed my view of the line cooks, so I spent my shifts in isolation, handing cup after cup out a window the size of a cereal box to a man named Fernando who ate toast with whipped cream for breakfast. I'd be pouring cappuccinos and humming in my little wall-hole and then suddenly, as if from nowhere, a terrifying sentence would appear in my mind. Then another. Then a dozen. Panic attacks rolled in hourly. I began taping poems to the espresso machine to memorize, figuring that if I had to entertain thoughts that weren't mine I might at least try to make them beautiful. I knew what was happening, but knowledge didn't help. Diagnostic categories, the language of treatment—they weren't enough. My teenage hair started to gray; my hands shook at the machine. I was growing desperate. One afternoon, I stepped into the back alley behind the restaurant, dialed my therapist, and told her that I thought I might not survive it.

I was understudying Juliet that summer for a local production of *Romeo and Juliet*, which meant sitting in on rehearsals and learning the lines and blocking. This should have been fun and exciting—and it was some days, particularly when the handsome blue-eyed actor playing Romeo made a point of flirting with me. (The regular Juliet was sleeping with Mercutio.) But most days it felt like something was very, very wrong. People often describe the way your body senses instinctually that you're in the presence of a sociopath or in physical danger. The feeling can be confusing at first, because your body is telling you something that your

rational mind doesn't yet know. *Why do I feel so unsettled and skin-crawly when she's so nice? This party is so fun; why do I feel like I have to get out of here?* I spent benign afternoons in rehearsal forcing myself not to bolt from the room. The theater, the restaurant, my bedroom—every place seemed menacing and uncanny. I spent hours in complex, circuitous rationalizations and self-assurances that boiled down to, in endless repetition: “But nothing's wrong, but nothing's wrong, but nothing's wrong.”

Of course, something was wrong. The imminent danger was my misfiring sense of imminent danger, the revelation that the stability and habitability of the world can change as the mind changes. Minds are not reliably stable or habitable. They are subject to radical and sometimes horrible transformation. This is a danger of the world that is, as I was discovering, intangible but absolutely real.

Juliet has a monologue in the fourth act, spoken alone in her bedroom as she prepares to take a potion that will plunge her into a sleep so profound she'll appear dead. She and Romeo have agreed that she'll drink this potion, and once she's been mourned and entombed in the family mausoleum he'll come to wake her, and they'll sneak out of Verona under cover of night and begin their life together. She's resolved, even impatient, to go through with the plan and reunite with Romeo, but as she uncorks the vial, a thought occurs to her. “What if it be a poison, which the friar subtly hath minister'd to have me dead?” Fairly quickly she dispenses with this anxiety (the friar is a holy man and a trustworthy friend), but another pops up to fill its place: What if she wakes up before Romeo arrives? What if she suffocates in the tomb? Her nervousness takes on a tinge of panic. What if, worse yet, she wakes too early but does *not* suffocate, and is left alone in the vault “where, for these many hundred years, the bones of all my buried ancestors are packed: where bloody Tybalt lies festering in his shroud?” Then she strikes on the most frightening thought: what if she, surrounded by bodies and smells and “shrieks like mandrakes torn out of the earth, that living mortals, hearing them, run mad,” is so overwhelmed that she loses her mind? Will I “madly play with my forefathers' joints,” she wonders,

And pluck the mangled Tybalt from his shroud?

And, in this rage, with some great kinsman's bone,

As with a club, dash out my desperate brains?

O, look! Methinks I see my cousin's ghost

Seeking out Romeo—

Quickly, she is hallucinating with panic. The loss of her own mind, imagined in the grotesque vision of herself fondling dead bodies in the dark, is made real by her own terror. The figure of Tybalt rises before her to kill Romeo. Desperate to make Tybalt—and the vision—stop, she seizes the potion bottle and, in a gesture that's not a little suicidal, swallows it all. She collapses. End scene.

I dreaded this monologue, but I memorized it, made notes on it, even diagrammed it. I was convinced that the young woman playing Juliet, beautiful as she was in the balcony scene, failed to capture this movement from nervousness to wild, unhinged fear. But I also hoped I'd never have to perform the scene myself. It felt too close. Acting demands letting go of the self in a way that is usually considered self-destructive or pathological in real life; acting demands that you make way for other selves.

But then there's the trick of coming back, of reconstructing the boundaries between your mind and your character's mind. Sometimes this is hard to do. There are characters you don't want to play because you know they'll be frightening to expand into or difficult to come back from.

That summer when I was feeling very much like Juliet holding the potion, the therapist would tell me, "Just know that those thoughts aren't you. That's the OCD, it's not you." It was a kind gesture—she was offering me the illness narrative that reigns now, the one that constructs very, very firm boundaries between brain and self, illness and consciousness, self and other. I clung to that for a while, the notion that the maelstrom happening in my brain was not *of* me but *outside* me, happening to me. That there was a tidy line dividing "me" from "disease," and the disease was classifiable as "other." But then it became difficult to tell whether certain thoughts should go in the me box or the disease box—where did "I want to throw a rock through the kitchen window" belong? Eventually I could no longer avoid the fact that mental illness is not like infection; there's no outside invader. And if a disease is produced in your body, in your mind, then what is it if not you?

Recently I found an image of Juliet and the potion, a film still taken from Franco Zeffirelli's 1968 rendition that is famous even though it didn't make the movie's final cut. Juliet is shown in profile, dressed in a beautiful white nightgown with long sleeves draping to her waist. Her dark hair, a little tangled, hangs loose down her back like mine did when I was 17. She is kneeling at what appears to be an altar but is in fact the carved headboard of her bed; what seems to be the prayer cushion is her

pillow, where Romeo's head lay not long ago. We know she's no longer a virgin, but she looks virginal, like one of the saints offering herself up. Her eyes are closed in fear or love or ecstasy, head tilted back in the light that glows down on her wrists and cheekbones. Her hands are clasped at her mouth in what looks like prayer, but if you look closely you can see the vial at her lips. She's imbibing something, but what?

IN A SENSE, what keeps an OCD patient rooted in the world of the neurotic rather than the psychotic, what tethers her to a certain agreed-on reality, the adherence to which seems to be our measure of functional sanity, is her healthy sense of the boundaries of her own ego—her ability to toggle complex and contradictory conceptions of self and other, real and not real, rational and irrational. She is obsessed, not possessed. She has insight. Most patients, though, have moments when their grip on me/not-me slips. In the medical community, this is known as magical thinking.

Obsessions often feel like the work of some cruel and sentient force equipped with its own devious logic, showering you with the exact thoughts and images you find most disturbing and devising new monstrosities as you defuse the old ones. Obsession knows you better than you know yourself. It outwits you. For this reason and others, insight is slippery even for diagnosticians. How is it defined, and how much of it is a patient supposed to have? Are lapses in insight allowed? What sort? How many? In his 1996 book, *Theoretical Approaches to Obsessive-Compulsive Disorder*, the clinical psychologist Ian Jakes writes:

The absence of reported insight cannot distinguish all obsessions from delusions. . . . Further difficulties . . . may be raised by those patients who are classified by some diagnosticians as “partially deluded.” These patients are held to have beliefs that would otherwise satisfy the criteria for delusions but do not hold these beliefs with absolute conviction. . . . How, then, are obsessions to be distinguished from partial delusions, and how are those cases of OCD where reported insight is absent to be distinguished from delusions?

Nearly twenty years later, these categories and definitions are still fluid: in 2013, the *DSM-5* altered OCD's diagnostic criteria to allow for patients who have only “partial insight” or, within certain parameters, lack insight altogether.

Later in this section, Jakes describes a young woman whose case was typical but challenging theoretically. He gives her only five sentences, but the portrait is complex and, in a way, complete. D. S. was 29 and afraid that she might lose possession of her own thoughts, that they might travel from her head down her arms and escape through her fingertips into the world. She worried that she would leave a trail of ideas and images in her wake, clinging like residue to everything she touched. D. S. knew, for the most part, that this wasn't possible, but sometimes she wasn't sure. Her frontiers, the places where she stopped and everything and everyone else began, seemed changeful and pervasive. Jakes calls this phenomenon "ego boundary confusion."

I love this young woman with anxious fingers. I wonder about her—what she looks like, where she is, whether she ever got better. If she is still living, she is 47 now. Her fears have such poetic overtones; they riff on common fears of contagion, which are often amplified and uncontrollable in patients with OCD. "Our bodies are not our boundaries," writes Eula Biss in *On Immunity*. "Fear of contamination rests on the belief, widespread in our culture as in others, that something can impart its essence to us on contact. We are forever polluted, as we see it, by contact with a pollutant." This notion extends past the physical realm of germ contamination and into metaphor. We worry about the "bad seed" and fear that someone's awful luck, lousy attitude, or even insanity will "rub off" on us.* At the same time, the things most precious to us often risk—or demand—this kind of contagion. The "sacred" places of the body are the ones where membranes are exposed: our mouths, our eyes, our genitals, the places where we connect with others and make ourselves vulnerable to them.

Accordingly, it is just as common to look for membranes where there are none. We trace our fingers over the faces or bodies of people we love as if we wish we could leave unspoken thoughts and feelings behind like residue. We place our foreheads together and press gently, as

* Two roommates, one family member, and a handful of acquaintances have reported to me, independently of one another, that they "caught" OCD after watching the television show *Monk*, by which they usually meant that they'd started buying hand sanitizer and color-coding their folders. These are instances of the way we subtly assume mental states can be "catching," but also examples of the way OCD has become equated with desirable perfectionism, much as it was equated with sophistication in the 19th century. In certain circles, it is now a form of poorly disguised self-congratulation to profess, in confessional tones, that you are "totally OCD" about your work, your house, your record collection, eating organic. Like gluten intolerance, it's an ailment that has taken on chic associations, especially to people who don't really have it.

if to see whether we can merge that way. We struggle toward each other out of our little meat suits.

Sometimes, it works. There is a kind of love where you start to lose track of where you start and stop. It isn't typically sustainable over long periods—it can come and go—but this version of total connection, or total mutual contamination, feels in the moment like the central operating miracle of the universe. Near the end of Toni Morrison's *Beloved*, the prose breaks down in an ecstatic rush:

I am Beloved and she is mine. . . . how can I say things that are pictures I am not separate from her there is no place where I stop her face is my own and I want to be there in the place where her face is and to be looking at it too a hot thing

This is an exact description of that love. In the book, though, it is also a description of a furious, sublimated obsession, a daughter haunting the mother who killed her. It's a story about love but, just as importantly, about horror; a thwarted love so ferocious it manifests and turns its object from memory to flesh. *Beloved* is in one sense a fable about the chiaroscuro of staying half-merged to someone else, the redemptive power and the unholy danger of "not separate from."

This is one danger that the current, hyperclinical story of illness seems designed to protect us from. If we are permeable the risks are infinite, and it's comforting to imagine firm borders guarding our soft places. Though as Biss points out, when it comes to the body, those borders are largely imagined. For the mind, whose boundaries are literally imagined, the notion of borderlessness, of endless susceptibility to mimetic contagion, is overwhelming. But by denying it entirely, by constructing unimpeachable binaries (me/you, mind/brain, illness/self), we create an experience of the world that's soothing but radically impoverished. If the truth lies somewhere in the middle, then the trick is the mapping. The other day, I found something in an old notebook that I don't remember writing. At the end of a long list of notes I had given up and scrawled, in big letters, *Where do I start and stop, is what I want to know.*

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SOMETIMES I IMAGINE my fictional girl well again. Out of the hospital, electrodes safely implanted, and responding with promise. Depending on which hospital treated her, she might be sent to an outpatient group therapy called “narrative enhancement.”

Dr. Philip Yanos, who developed narrative enhancement therapy, explained to me that its function is to help mentally ill patients overcome internalized stigmas about their conditions. They learn about the ways they have been taught ideas like “I can’t have a normal life” or “I’m a bad person” or “There’s just something wrong with me.” Then they tell the stories of their lives over and over and over to one another. They talk about their lives before they got sick, and they talk about what it was like to be sick, and they talk about now. The therapist and the other patients repeat back to the patient the story she’s telling, but suggest more empowering language, and then the patient tells the story again but more like the way they said it.

The goal is to help patients integrate their notions of who they were before their sicknesses with who they are now. The task is to go back and find a thread of a story that can be pulled across the hospitalization or the psychotic break or the shock therapy, from then to now, from “her” to “me.” It matters what stories you tell yourself about yourself. When the integrity of the story is violated, people get stuck at the point of fracture. They might re-form themselves around the brokenness, or they might restlessly circle forever, trying to understand what broke and why. The importance of the “coherent narrative self” is paramount: without it, even if the symptoms subside, you might never move on, which is another way of saying get well.

THIS IS THE STORY of how my obsessive-compulsive disorder began: When I was 12, I had a friend who was going through some major psychological disturbance. She was a new friend, because I was new that year in school, and she revealed her problems to me incrementally, each confession like a gift signifying a deeper level of intimacy. First she showed me the box of safety pins and thumbtacks. She pulled them out of her backpack while we sat knee-to-knee on the bus and told me that she used them to cut herself. Next she told me she was bulimic and suicidally depressed. Eventually she told me that there was “a thing in her head” named Ailis, and that Ailis wanted her dead. Ailis, I gathered, was something between a voice and a demon. My friend talked

about Ailis all the time, as if she were a mutual acquaintance. On days when I'd been a particularly sweet or loyal friend, she would smile at me meaningfully and say, "Ailis really doesn't like you."

We looked a little alike. (Her breasts were bigger.) We enjoyed the same things. (She turned me on to theater.) Teachers sometimes mixed up our names, and I was quietly pleased at being one of a pair. When she started telling me about thumbtacks and Ailis, I was fascinated and curious and, most of all, thrilled to be brought in. This was interesting, and presented an exciting challenge: I would love her to health. She would ask, "Why doesn't it scare you to hear about these things?" and I would tell her blithely, "Because these problems are yours, not mine. You are you, and I am me." This answer seemed to annoy her, and she would change the subject.

One night, we were up late talking on the phone while I babysat for the neighbors. *Vertigo*, which I'd never seen, was on TV. In the film, Kim Novak's character appears to be possessed by a ghost that is driving her to suicide. "There's a woman in my head who wants me dead," she confesses to Jimmy Stewart after trying to hurl herself off a cliff. "She talks to me all the time." Stewart, a sucker for a blonde with a dark streak, falls in love anyway. Unfortunately, he isn't able to love her to health. He takes her to a place she keeps seeing in her nightmares, an old Spanish mission on the coast, hoping to convince her that she can overcome her fears and exorcise the ghost, but she breaks away from him, dashes up the bell tower, and jumps to her death. This moment at the film's half-way point marks a shift in focus from her possession to his obsession: her madness transfers to him. Unable to let her go, he is ruined by her.

It was during the bell-tower scene—can this possibly be true? This is how I remember it—as Novak dashed up the steps, that my friend asked me again why I was never frightened by her confessions. I repeated my usual answer—you are you, and I am me—and she replied, "You never think you're going to be one of these people, like me, until you are one." Suddenly something came open inside me, and I knew she was right. I hung up the phone and had my first panic attack.

It's uncanny how closely Novak's confession ("There's a woman in my head who wants me dead. She talks to me all the time") matches my friend's description of Ailis as I remember it, and how closely Ailis and Novak's homicidal ghost resemble each other. The synchronicity unnerves me, particularly because I had 100 percent forgotten Novak's

imagined woman until I watched the movie again recently. For fifteen years—years during which I carefully avoided *Vertigo*—I remembered only the bell-tower scene, her gray suit ascending the stairwell and then falling past the window.

Did I drastically conflate memories and invent all the details of Ailis in the years since that night? Had my friend seen *Vertigo*, and was it she who suggested I watch it, hoping that I'd see she was not the first person to be visited by an Ailis, perhaps even hoping that I might be visited next—and if so, *why*? I've been asking myself these questions for a while now. Neither scenario makes sense. I am sure I didn't invent Ailis, and yet the diabolical, premeditated manipulation required for the second scenario is so extreme I'd rather find it implausible. Any other possibility demands a coincidence on the level of an act of God. This is a fault in this story I can't overlook and can't heal. It just is.

I've been considering that uncanny confluence for months, but the thing I've been considering for fifteen years is the moment that came next. When my friend said, "You could be like me," and I was plunged irreversibly into a new kind of fear—what was that? In so many ways the moment marks a before and an after, but I don't really know how to talk about it. You could say it was ego boundary confusion. You could say it was mimetic contamination. You could say, maybe, that it was the beginning of real empathy. What I will not say is that it was only a chemical reaction, because while that might be correct, it isn't true.

The summer I was 17 and relapsing, I ran across a moment in the *Phaedrus* when Socrates theorizes that madness "is the channel by which we receive the greatest blessings. . . . So, according to the evidence provided by our ancestors, madness is a nobler thing than sober sense . . . madness comes from God, whereas sober sense is merely human."

Fuck you, Socrates, I thought.

I have said in my darker moments that I would never wish this mess on anyone, even the girl I got it from. (As if that mattered.) I will probably say this again someday, my whining masquerading as largesse, and I will mean it, but it is also true that I know something I did not know before, which is that we are more expansive than we imagine. And this expansiveness is both powerful and frightening. It can ruin you to madness, or fate or God or disease or demons or whatever you call the unknowables. But it is gorgeous, too. It's how the better unknowables get in. I think about being 13 and hanging up the phone, standing

frozen in the middle of the carpet in the neighbor's living room while Jimmy Stewart watched Kim Novak's body plummet to the terra-cotta and looking at him and looking at her with my friend's voice ringing in my mind and feeling like I was being cracked wide at the sternum and the top of the head at once, being opened and emptied and invaded, aware suddenly of the way poor, monomaniacal Jimmy could be me and strange, possessed Kim could be me, and my friend with that creature in her head could be me, too.

The warping force of that first panic was truly horrifying. Madness is not some holy blessing; pathology is not the same as pathos. And yet that vertigo has echoes in other rooms and reckonings I've seen, other moments of being opened and emptied and invaded by another person but beautifully, of flinging or being flung wide by radical, magical ego boundary confusions and quiet acts of self-extension over breakfast.

THE OTHER MORNING, I heard a woman on the radio describe her art, enormous conceptual installations that involve manipulations of breath and light. As she was explaining her process, this artist used a phrase I'd never heard before: "thin places." It's a Celtic concept, one that stems from an old proverb that says, "Heaven and earth are only three feet apart, but in the thin places that distance is even smaller." In thin places, the folklore goes, the barrier between the physical world and the spiritual world wears thin and becomes porous. Invisible things, like music or love or dead people or God, might become visible there, or if they don't become visible they become so present and tangible that it doesn't matter. Distinctions between you and not-you, real and unreal, worldly and otherworldly, fall away.

The original thin places were wild landscapes because the idea was born in the heaths of Connemara, a place that's so austere and ancient, so full of twists and hiding places and divots a thousand years old, that it seems somehow likely you might poke a hole through to another reality. But the radio lady said that the delight of thin places was the unpredictability of their location. You can find them someplace with magic written all over it, like Connemara or the Himalayas, but they also pop up in dive bars, bedrooms, hospital rooms. They can appear and disappear.

Because thin places involve an encounter with the ineffable they're hard to talk about. You know something has happened, some dissolution or expansion, but like most things that feel holy and a little dangerous, it

just sounds weird in post-factum description. It helps to have someone with you there, someone else to feel what's happening so you can look at each other in awe. Afterward, when you are trying to explain it to other people and sounding like a New Age crank or genuinely insane, you can turn to that person and know that it was real. Or you can choose never to talk about it to anyone else and only sometimes turn to each other and say, What was that? *What was that?*

But then, the thin places I've known aren't always places, per se. Sometimes a thin place appears between people. Sometimes it happens only inside you.

"It could be said, even here, that what remains of the self / Unwinds into a vanishing light, and thins like dust, and heads / to a place where knowing and nothing pass into each other, and through," wrote Mark Strand for his friend Joseph Brodsky:

What remains of the self unwinds and unwinds, for none
Of the boundaries holds—neither the shapeless one between us,
Nor the one that falls between your body and your voice.

Here, transversal takes on a quality of communion, the kind that arises when frontiers fall—a quality that seems inherent, even in the modern transversals of operating rooms where the new exorcism comes in rubber gloves and medical is miracle and knowing and nothing pass into each other and through. Before the word became the name of a medical technique, it was geometry's nod to the importance of the in-between: a transversal is the line that connects other lines. You use it to discern parallels; taking the transverse of two lines reveals whether they'll eventually touch.

After neurosurgical transversal for OCD, the improvements, if they come, will arrive with time. For patients with movement disorders the new world comes all at once, and the first sign is their hands. As the transversal proceeds, the doctors instruct them to hold out one hand and watch the tremors change. The arms start out waving crazily like hoses left unattended but then, within seconds, shudder to stillness. For the first time in years, the fingers can bend to hold a pill or a pen or just to touch lightly. Whatever possessed the muscles is gone, and while it's only electrical impulses, it really does look like a miracle. As a matter of course, the patients weep.

One woman whose name I no longer remember did something extraordinary as she cried. In the recovery room, she sat up immediately without saying a word and extended her new hand to her husband.* Improbably, it stayed obediently outstretched, quivering only a little. The room went still. The doctors and nurses stopped their work and watched as her husband quietly extended his palm toward hers. The air between them grew warm and vanished, and then everyone was weeping in the fluorescent light. +

* The exact same gesture sets the events of *Romeo and Juliet* in motion: "palm to palm is holy palmer's kiss." A young man and woman press their hands together at a dance, and whatever happens just then transforms them. I think of the play as orchestrated around two thin places: the holy's palmer's kiss (two hands) and Juliet taking the potion (only her hand).