A REPORTER AT LARGE

MARY HAD *SCHIZOPHRENIA*—THEN *SUDDENLY SHE* DIDN'T

Some psychiatric patients may actually have treatable autoimmune conditions. But what happens to the newly sane?

By Rachel Aviv

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When Mary was treated for cancer, the drugs also relieved her psychosis of twenty years. Her daughter Christine described her as a "psychological débutante." Illustration by Emiliano Ponzi

When Christine was nine years old, her mother, Mary, said, "Come here. I want to tell you a secret." They sat on a brown couch in their living room, in Santa Ana, California. Mary, who was forty-three, said that a man she had known in medical school, a professor, was sending her messages about a plan to take her away and live in a mansion together. "I remember feeling really excited, because that fit with my sense of what should be happening," Christine said. "I was really into 'Harry Potter' and the idea that, if you are part of the select, you can see a bigger story happening out there."

Mary leaned over and began separating strands of Christine's hair, as if searching for lice. "Does he put listening devices in your hair?" Mary asked, about the professor. "Does he ever ask you to say things to me?"

Christine, the older of two sisters, said, "I believed everything she said until she accused me of something that I knew wasn't true." Mary had always been tender and doting and practical, and, Christine said, "I just had this feeling in my body that she was not the same."

Her sister, Angie, who is seven years younger, learned to follow their mother's instructions, whether or not they made sense. "I was taught the rules of her delusions at the same time as I was taught other rules and norms about the world," Angie said. She came to view her mother's stories about the professor, and about

friends who were part of his mission, as akin to tales in the Bible. “It’s kind of like, O.K., some of these people are real, and some of these people aren’t real,” she said.

Christine was often cast in the role of the villain. Her mother would yell at her for poisoning her pizza or hiding her keys or other menacing deeds, even as Christine tried to explain that she hadn’t done them. Sometimes Mary smacked her. (Mary doesn’t remember this.) Christine began to mistrust her own memory, too. “My mom would accuse me of things, and then I’d be, like, Maybe I did do these things,” she said. In fifth grade, she asked Santa Claus for a polygraph machine. “I just had this baseline sense of: I could be doubted at any time.”

She felt that people might help her mother if she could just find the right language to describe her transformation. By high school, she was spending so much time studying the *Diagnostic and Statistical Manual of Mental Disorders* that she texted a friend that she had actually “married the dsm-iv.” She explained that her mother suffered from the “fregoli delusion,” a belief that strangers were disguised as doubles of people she knew. In her journal, Christine wrote, “My mom has erotomanic delusion disorder with a splash of persecutory delusions.” She asked for help from teachers and a school counsellor, but, she said, the “message I got was, basically, Everybody has their shit, and you have to just deal with it and keep getting good grades.”

Angie has no memories of Mary before her psychosis, but Christine remembers her as a “magical, glowing figure.” Photograph courtesy the family

Mary, who was from India and had worked as a physician there for a decade, spoke so much about the professor that her husband, Chris, who worked at the California Department of Motor Vehicles, eventually found the professor's number and called him. "He said, 'I am not in contact with her,' " Chris recalled. " 'I didn't even know your wife came to America.' " At the professor's suggestion, Chris scheduled an appointment for Mary with a psychiatrist. Christine sat in the waiting room, hoping that this would be the beginning of getting back the mother of her early childhood, whom she remembered as a "magical, glowing figure." But when Mary finished the appointment she said that the psychiatrist thought she was fine. Not long afterward, Mary kicked Chris out of the apartment and barricaded the door with a desk and two heavy suitcases. Christine and Angie allotted extra time to get to school each morning so they could remove the obstacles.

Karl Jaspers, the German psychiatrist and philosopher, has described what he calls the "delusional atmosphere," a profound alteration in the way certain people experience the world. "There is some change which envelops everything with a subtle, pervasive and strangely uncertain light," he wrote. People in this state search for a story that explains why everything suddenly feels uncanny and ominous. The "vagueness of content must be unbearable," he wrote. "To reach some definite idea at last is like being relieved from some enormous burden."

Mary had landed on a story that overwrote the reality of her daughters' lives, but they also recognized in it a kind of emotional logic. Mary had been pressured to marry Chris, in an arranged match, and, when they settled in America, he had traditional ideas about a woman's role and restricted her freedom to pursue her career. Christine and Angie came to feel that their mother's delusions—that her former colleagues would free her from marriage and she'd be restored to her place in the medical community—were "a way of explaining how she ended up trapped in this position," Christine said. "We theorized that psychosis was almost a reasonable response."

Christine moved to New York after high school, because her favorite book, "Underworld," by Don DeLillo, was set there, and because it seemed like the city where people went to escape their homes. She lived in the Bronx, near her father's brother, and got a job at Planet Hollywood. She wanted to be a novelist, and obsessively re-read "Underworld," covering the pages with determined annotations: "integrated dialogue"; "meta commentary"; "sensation of young immediacy."

Angie and her mother would text Christine asking for groceries or pizza, and she would order the food for them from across the country. Mary was still barricading the door. Chris slept in his car. (Eventually, he moved in with a girlfriend.) Christine worried that Angie, who was eleven, was growing up in a kind of folie à deux, a delusional system that structures two lives. Angie said, of her mother, "I could never figure out why she was doing these things to me, and I had this kind of emotional explanation: Other things are just more important to her. I'm only there as a vessel for the magical thinking." After about a year, Christine arranged for her mother and Angie to move to New York, too. (Mary asked me to use only her middle name, to protect her privacy.)

Mary moved into an apartment in the Bronx, in the same building as her brother-in-law, and plastered the walls with tape, to prevent reality-TV shows from recording her and Angie through the cracks. Angie tried to bathe while her mother was asleep because Mary believed there was a camera in the showerhead, and had covered it with a sock. Angie felt as if she were living in a kind of urban version of "Grey Gardens," a formative movie for her. The documentary chronicles the lives of a mother and daughter, relatives of Jacqueline Kennedy Onassis, who live together for years, piles of trash accumulating around them, social conventions becoming remote.

After two years in New York, Mary seemed increasingly unable to care for herself, so Christine, who had enrolled at Columbia, called the city's mobile crisis unit, a team that assesses people in psychiatric distress. The crisis unit knocked on Mary's

door, and, after a conversation in which she described receiving electric transmissions through a filling in her tooth, she was admitted to Mount Sinai Beth Israel hospital, in Manhattan.

Psychiatrists there petitioned a judge for permission to hospitalize her for a month and treat her with antipsychotics, over her objections. "I believe that she has no judgment concerning the nature of her illness," one of them wrote. On an evaluation form, another psychiatrist initially wrote that Mary had an "unspecified psychotic disorder." Then, perhaps uncomfortable with such a vague diagnosis, she crossed out the phrase and wrote, "Schizophrenia." Mary was fifty-five years old, and her symptoms had begun in her early forties, which is unusual for schizophrenia. Most people are diagnosed in their twenties or early thirties.

Christine moved into her mother's apartment and filed a petition for joint custody of Angie. Their father, who was living in California, did not contest the petition. "I make breakfast in the morning," Christine wrote in her journal, describing her new routine with Angie. "I wash the dishes. I lock the door at night. I have established, kicking and screaming, my own rightful place as an active agent in the universe."

When Mary was released from the hospital, she stopped taking her medications. Neither she nor her daughters thought they had helped her. For about a third of people with schizophrenia, antipsychotics do not work. "I wish my mother's delusions and paranoia were treatable," Angie wrote, in a college-application essay. "However, she has lived with them for 12 years, and her institutionalization last year had no effect."

Mary's admission to Beth Israel was the beginning of a nine-year cycle in which she was sent to psychiatric hospitals for weeks at a time before being released, unchanged. Mary said that each time she was admitted to a hospital the staff "kept asking the same questions, and it never made anybody have a different

outlook on the situation. Everyone stayed with the same thing. It was schizophrenia."

After five hospital stays, including one in which the police led her to an ambulance in handcuffs because she wouldn't leave her apartment, Mary was transferred to the Bronx Psychiatric Center, a state facility that provides long-term care. She observed that when patients refused medications staff would sometimes call security, and the patients would be injected with drugs, a prospect that terrified her. "I would take the medication without any question, because I'm not risking fighting with security," she told me. "These people are very sensitive to what they call 'challenging authority.' " She spent her days dreading the moment when she'd be forced to swallow her pills.
Mary sometimes imagined that God had a reason for keeping her in the hospital, but, she said, "I did not even want to go there, because the reasoning mind makes you feel very nervous and uncertain." Her daily life became so narrow that she stopped noticing the weather. "They don't remind you about the changing season —that spring is coming into summer or the winter is coming into spring," she said. "You just pass the days as quickly as possible."

Christine, who spoke to her mother every week, said that Mary never articulated her sorrow at the time. "I would have wanted to engage on the level of 'I'm sorry you're there, do you feel sad?' And I'm sure she was having those emotions, but she wasn't able to express them. It was always 'I'm being attacked. I'm being held like a prisoner here.' " Christine felt that her mother was safer at the Bronx Psychiatric Center than she would be anywhere else, but she felt guilty for hoping that Mary would stay there for the rest of her life.

Mary was discharged in September, 2023, after a year. A week later, she collapsed in her bathroom and struggled to move. She was taken to a hospital in Brooklyn, where the doctors told her to stop taking antipsychotics, because they thought her condition may have been a side effect of the drugs. Then they discovered that she actually had lymphoma, a sometimes fatal form of cancer.

She began seven cycles of a treatment that combined chemotherapy with rituximab, a medication that targets antibodies involved in the body's immune response.

When Christine and Angie visited her at the hospital, Mary responded to their questions with one-word answers. Her face had a vacant expression. Christine and Angie thought she was dying. Mary did, too. She dreamed about being a child, playing with her sister and four brothers, in Kolkata, where she grew up. "I told myself, 'This must be the end of it,' " Mary said.

Angie, who was now twenty-two and had recently graduated from Dartmouth, prepared in therapy for her mother's death. She said, "I had multiple sessions where I was just crying about the fundamental things I wish she had given me, like 'I wish she could have told me what was going on in her head,' or 'I wish she could have told me she was sorry for what she did.' "

By Christmas, two months after beginning chemotherapy, Mary was moving a little more freely, and she had begun to carry on conversations. Christine and Angie noticed that her personality seemed different: she was calm, outgoing, and polite, and she often expressed gratitude. Angie texted Christine that Mary seemed peaceful, as if maybe she was "getting some post-life or death clarity?"

Christine, who was twenty-nine and had settled in London, having moved there for a master's degree in psychology, was struck by her mother's ability to watch the news and absorb the information on its own terms. For years, the television had been a source of agitation; Mary had said that people were using her ideas and repeating her lines.

One day, when Christine was visiting the hospital, Mary asked for a phone. "I sort of teased her, 'Now you're asking for a phone?' " Christine said. "I wasn't really making much of it, but then afterward I thought, Why has she asked for a phone? That's quite unusual." Mary already had a phone, but it was in storage because she'd told Christine that it contained spyware.

Angie gave her a flip phone and, to be safe, covered the camera with a piece of tape. "She seemed fine using it, which was odd," Angie said.

In May, a month after Mary finished chemotherapy, Christine and Angie asked a psychiatrist at the hospital to examine her. Christine said, "The psychiatrist was, like, 'Why have you called me here? I don't understand. She has no symptoms.' And we were, like, 'Yeah, that's the reason we've called you here.' "

Christine had the same feeling in her body that she'd had when her mother first became ill—the sense that something at Mary's core had changed. She tried to get the doctors to grasp the scale of her mother's recovery. By the summer, her cancer was in remission. She hadn't taken antipsychotics for months, and yet "her psychotic symptoms are gone," a doctor wrote. Christine told the doctors, "She had a twenty-year psychiatric history. Have you heard of this? Could any of her medications have caused this?" She spoke with a neurologist at the hospital, but he didn't have an answer. Omid Heravi, one of Mary's oncologists, didn't understand what had happened, either. "Medicine is very specialized—we don't get involved in other fields," he said. He guessed only that one of the cancer drugs she'd been given had had collateral benefits. "In medicine, all side effects are not bad," he offered.

When a person recovers from an illness, it is usually seen as the end of the story. But becoming sane also causes a kind of narrative collapse, a confrontation with a personal history that is no longer recognizable. Christine encouraged her mother's friends and siblings, whom she'd been estranged from for years, to get back in touch. She wanted to restore her mother's sense of connection, but, she said, "I also wanted them to be able to tell me—outside of my childhood memories—if this is the person she used to be."

For years, Christine's friends had known little about her mother beyond the details of her mental illness. "Suddenly, I was, like, 'Hey, my mom's better now. Would you like to call her up and talk to her?' And that was a shocking concept for them," she said. "I mean, there are a lot of people who wouldn't necessarily be open to jumping on a call without planning, but my mom was now the type of person who is quite flexible and responsive and conversationally fluid." Christine described her as a "psychological débutante."

Angie, who was living in Queens and working at a firm where she analyzed data on sexual violence, felt skeptical that their mother's transformation was real. Christine said, "I felt like, If Mom can disappear, then she can come back."

But Angie didn't have memories of Mary from before the illness, and it felt to her like she was being asked to believe that her mother had become a new person. "I tend to choose security over the process of discovery," Angie told me. "I didn't have a curiosity that felt worth the emotional risks." Angie had always felt that, on some level, her mother had "chosen her delusions" over her children. She didn't want to experience that choice being made again.

Christine searched for medical papers that might explain her mother's recovery and allow Angie to believe in it. She read about each of the medications that her mother had taken and concluded that the key drug may have been rituximab, the immunosuppressant. "I have a new working theory," she texted Angie, in May, 2024. "Theoretically her chemo could have incidentally cured" her.

Christine found a handful of recent case studies that documented drastic psychiatric recoveries after people were treated with drugs that dampen immune activity. A 2017 study in *Frontiers in Psychiatry* described a woman with a twenty-five-year history of schizophrenia. She also had a skin disease, for which she was given drugs that reduced inflammation and suppressed her immune response. Her doctors noticed a pattern: when they treated her skin lesions, her psychosis went away. They hypothesized that the rash and the psychosis had been caused by a single autoimmune disorder, and were cured by the same drugs. Another paper in *Frontiers in Psychiatry* described a man with "treatment-resistant schizophrenia" who developed leukemia. After a bone-marrow transplant, which reconstituted his immune system, he startled his doctors by suddenly becoming sane. Eight years later, the authors wrote, "the patient is very well and there are no residual psychiatric symptoms."

Christine also discovered a Washington *Post* article from 2023 about a woman named April, who had fallen into a catatonic state at the age of twenty-one and been diagnosed with schizophrenia. Sander Markx, a professor of psychiatry at Columbia, first encountered April at a psychiatric hospital on Long Island when he was a medical student; twenty years later, he was dismayed to find her at the

same hospital, in the same condition. "She has not been outside for twenty years—out of sight," he said, at a symposium at Weill Cornell's medical school. He and his colleagues gave her an extensive workup and found that she had lupus, an autoimmune disorder that, in rare cases, can induce inflammation in the brain, causing symptoms that are indistinguishable from those of schizophrenia. After undergoing immunosuppressive therapy, including rituximab, April emerged from, essentially, a "twenty-five-year-long coma, and was able to tell us everything," Markx said. "We don't have a script for this. We don't see patients coming back from this condition."

April's case helped give momentum to the founding, in 2023, of the Stavros Niarchos Foundation (S.N.F.) Center for Precision Psychiatry and Mental Health, at Columbia, which is working to uncover biologically distinct subtypes of illness that have been obscured by the broad categories in the *DSM*. Christine sent an e-mail to Markx, a co-director of the S.N.F. Center, with a brief time line of her mother's life. "Her psychiatric symptoms disappeared and have yet to resurface months later," she wrote. "But her current clinicians are stumped as to why it has happened." When Markx didn't respond, Christine, who was visiting New York, decided that she and Angie should go to Columbia to introduce themselves in person. Markx wasn't in his office—he had just begun an ongoing medical leave—but they slipped a handwritten card in a pink envelope under his door and used inter-campus mail to send cards to the other directors of the center. They tried to think of this step, Angie said, as "the part in the documentary where the cameras go all shaky and you get the sense that someone is about to break a hole in the case."

Emil Kraepelin, who developed psychiatry's first modern diagnostic system, in the eighteen-nineties, defined the disease we now know as schizophrenia largely in terms of its hopelessness. The diagnosis allowed hospital administrators to separate patients with "periodic insanities" (like depression and bipolar disorder) from those who were believed to be incurable and belonged in asylums. Kraepelin

hoped that schizophrenia would eventually reveal itself to be a disease like neurosyphilis, which was then responsible for a large portion of the cases of insanity in psychiatry wards. In 1913, scientists demonstrated that bacteria had infected the brains of these patients. "The diseases produced by syphilis are an object lesson," Kraepelin wrote, four years later. "It is logical to assume that we shall succeed in uncovering the causes of many other types of insanity that can be prevented—perhaps even cured—though at present we have not the slightest clue."

Psychiatry and neurology were originally one medical discipline, but gradually neurologists took responsibility for diseases like neurosyphilis and dementia, in which the pathology could be seen in an autopsied brain, and psychiatrists handled the illnesses that were left behind, their causes still a mystery. Schizophrenia, which affects roughly one per cent of the population, became the disorder through which psychiatry worked out its identity, in part because it seemed to embody the mystery and intractability of madness, presenting basic questions about what it means to have a self. "The history of modern psychiatry is, in fact, practically synonymous with the history of schizophrenia, the quintessential form of madness in our time," the psychologist Louis Sass has written.

But psychiatrists struggled to pinpoint a single feature that unified the diagnosis. "The great question is what is this 'something' that underlies the symptoms," Karl Jaspers wrote, in 1963. Three decades later, the psychiatrist Ian Brockington warned that the obsession with schizophrenia had stifled clinical curiosity. "Smaller, more homogeneous entities have been sucked in by the gravity of the big idea, and annihilated," he wrote. For decades, scientists have been searching in vain for a biological marker that would confirm whether someone has schizophrenia. Last year, in a paper in *Schizophrenia Research*, seventeen international experts concluded that schizophrenia was defined by no single etiology, symptom, or

biological mechanism. “It is prudent to wonder if the construct around which we are organizing this information is fundamentally flawed,” the authors wrote. Perhaps the most vivid disruption to the idea of schizophrenia as a monolithic concept began in 2007, when Josep Dalmau, a neurologist at the University of Barcelona, started publishing papers with his colleagues which described young patients with delusions, hallucinations, and sudden changes in their behavior, like agitation and inappropriate giggling. Within days or weeks, they deteriorated, developing seizures, losing consciousness, or struggling to breathe. Dalmau discovered that they had a form of encephalitis, inflammation of the brain. Their immune systems had misidentified the NMDA receptor—a protein in the brain that affects mood and memory—as foreign and produced antibodies that attacked it. When these patients were treated with immunotherapy, the majority of them recovered completely, sometimes within a month.

Thomas Pollak, a neuropsychiatrist at King’s College London and the Maudsley Hospital, told me that treating patients with the condition was “revelatory and disquieting, because some of them looked exactly like the people I’d been seeing in the psychiatry ward. It was uncanny to see that a presumably totally different pathway could lead to this.” Their illness, which was named anti-NMDA-receptor encephalitis, usually began in their early twenties, just as schizophrenia often does. The discovery of the illness put pressure on the artificial division between psychiatry and neurology—the only two fields of medicine that focus on the same organ. “Many of the symptoms are shared, but we are using different words,” Pollak said.

In “Brain on Fire,” a memoir from 2012, the journalist Susannah Cahalan—the two hundred and seventeenth person in the world to be diagnosed with anti-NMDA-receptor encephalitis—describes how for a month, in which she swung between paranoid aggression and euphoria, some doctors treated her as if she were just a difficult psychiatric patient who drank too much. “If it took so long for one of the best hospitals in the world to get to this step,” she wrote, “how many other

people were going untreated, diagnosed with a mental illness or condemned to a life in a nursing home or a psychiatric ward?"

Since Dalmau's discovery, scientists have identified more than twenty new antibodies linked to psychiatric symptoms. In 2020, in a paper in *The Lancet Psychiatry*, some two dozen researchers proposed a new category of illness called "autoimmune psychosis," which may look like a milder or incomplete form of encephalitis, the illness never progressing beyond psychiatric symptoms. Christopher Bartley, the chief of a unit at the National Institute of Mental Health which investigates the role of immune dysfunction in mental illness, said that the twenty known antibodies may be a "drop in the bucket." There could be countless targets in the brain that antibodies attack, some subset of which may alter people's perceptions and behavior. "We have to have epistemic humility and accept that there are alternative models of disease," Bartley said.

To find psychiatric patients who might benefit from immunotherapy, researchers have set up centers, roughly similar to the one at Columbia, at Baylor College of Medicine, in Texas; King's College London; Uppsala University, in Sweden; and the University of Freiburg, in Germany, among other places. Some of the best research into the phenomenon has been conducted in Germany, where it's more common for patients in a first episode of psychosis to have lumbar punctures to access their spinal fluid, which can reveal the presence of antibodies. Bartley estimates that between one and five per cent of people who have been diagnosed with schizophrenia actually have an autoimmune condition—a figure he based on his own lab's research, which has not yet been published, and also on a German study of a thousand patients, the most extensive study of autoimmune psychosis so far. "Even one per cent ends up being almost a million people in the world who should be treated with a different kind of medicine," he said.

The pharmaceutical treatment for schizophrenia has not meaningfully changed in three-quarters of a century. Many pharmaceutical companies have left the field entirely. To get approved for the market, a medicine that works for one

schizophrenic patient must have a reasonable chance of working for another. But only blunt instruments have been effective in treating an illness that takes such varied forms. Newer antipsychotics are more refined than earlier ones, with fewer side effects, but almost all of them work in the same broad way, alleviating some symptoms, like hallucinations and delusions, but not other common ones, like lack of motivation and an inability to experience pleasure. Andrew Miller, the vice-chair for research in the psychiatry department at the Emory University School of Medicine, said that the field is haunted by the early success of antipsychotics, which were discovered by serendipity, in the nineteen-fifties. "You get lulled into this sense that, because the drugs are one-size-fits-all, the disease is also one-size-fits-all," he said. "With autoimmune psychosis, it's so clear that there is something different. And then you start to say, 'Hey, is it possible that there are other clear-cut mechanisms to pathology that we're missing because we're lumping everyone together and saying they all have the same illness?' "

The S.N.F. Center is embarking on a project, beginning this fall, to screen all the patients hospitalized in the New York State mental-health system for autoimmune, metabolic, and genetic disorders, to see if there are people whose symptoms can be traced to a distinct biological mechanism. "I've always been aware of the possibility that there are treatable causes for psychosis lurking in chronic long-term patients," Joshua Gordon, the executive director of the New York State Psychiatric Institute and a former director of the N.I.M.H., told me. "But the notion that we could make this work practically—that we could test for it—has really only become apparent in the last few years." The S.N.F. Center will do blood work for everyone in the state's psychiatric institutions, offering follow-up testing, such as lumbar punctures, to those with unusual results. Gordon said that, if the S.N.F. Center identifies a few dozen patients who can be treated effectively enough to leave the hospital, "we will be able to start answering the question of whether this is worth trying across the whole population of people with schizophrenia."

Psychiatry has a legacy of implementing drastic procedures, like lobotomies, that later come to seem like folly. But it also has a history of proffering psychological theories for illnesses that are not yet understood on a biological level. Several psychiatrists told me that they'd found themselves rereading the history of the discipline, wondering, for instance, if some of those patients of Emil Kraepelin's whose symptoms helped define schizophrenia might actually have had encephalitis or autoimmune conditions—specifically, a subset he described as having "spasmodic phenomena in the musculature of the face" and an inability to walk without falling. There were also questions about whether these diseases could explain a condition called "lethal catatonia," which was frequently described as a manifestation of schizophrenia: these patients became extremely agitated, and then slipped into a stupor. In 1986, in a study that inadvertently revealed the dangers of conceptual inertia, the *American Joumal of Psychiatry* reviewed nearly three hundred cases of lethal catatonia. Nearly all the patients in the study had been treated with antipsychotics, and more than half of them died.

After reading Christine's description of her mother's case, Steven Kushner, a co-director of the S.N.F. Center, arranged a meeting with her and Mary and Angie. Mary was living at a rehabilitation center in the Bronx while she regained her muscle strength. She was reluctant to meet another psychiatrist, she told me, but she felt she needed to "rise up to the level of my daughters' studiousness." In October, 2024, Kushner and three colleagues came to the rehabilitation center and spoke with Mary for three hours. "Her psychosis was gone," Kushner said. "There was no other conclusion. There was no way that she could have the quality of the conversation that we had and willfully suppress psychotic symptoms."

In the conversation, Mary recounted intimate details about her daughters' pasts—what they would eat for breakfast, their arguments at recess—but she made no reference to the delusional beliefs that had dominated their lives. When Angie told the doctors that her mother had sometimes prevented her from going outside, even to do homework with classmates, Mary offered a practical explanation: there was crime in the Bronx, and she worried about Angie's safety. To explain why she put a sock over the showerhead in her bathroom, she said that she'd hoped to filter sediment from the water. She seemed to have filled in gaps in her memory in a way that was consistent with her current identity, as a sane person.

In 1911, the psychiatrist Eugen Bleuler described how schizophrenic patients are capable of a kind of "double bookkeeping": they may simultaneously live in two "disjoint" worlds, one grounded in shared reality, the other in private delusions. They might believe that they are the center of a conspiracy involving nearly everyone they see but also make small talk at a deli and remember to give the correct change. It's as if the delusions occupy their own ontological category, sealed off from the logic used to move through the world. Now, when Mary recalls her decades of illness, it is as if she is accessing only the shared-reality side of the ledger. When she talks about her time at the Bronx Psychiatric Center, her memories sound like those of a person trapped in an environment where she doesn't belong. "Angie and I treat it as if she had two selves," Christine said. "But Mom describes her self as continuous."

The S.N.F. Center arranged for Mary to have a lumbar puncture, to see if she had any antibodies associated with known neuropsychiatric conditions. During the procedure, Kushner said, he could sense that Mary had once had a "fantastic professional identity: she was holding court, telling stories about the lumbar punctures she used to perform, how many patients she used to see in a day." The test came back negative. Kushner tried to recover a frozen sample of Mary's cerebral-spinal fluid from when she was ill—a test done on that fluid would have been more revealing—but the fluid had been discarded. He believed that the most

likely explanation was that she'd had a form of autoimmune psychosis for which the associated antibody has yet to be discovered. "I think the consensus is that we are probably only aware of the tip of the iceberg of different kinds of antibodies that can produce autoimmune diseases, and certainly that holds for autoimmune psychosis," he said.

Some people, when they recover from psychosis, understand that the strange enemies who plagued them never actually existed. Others say that they are relieved their enemies stopped pursuing them, but do not disavow the reality of the experience. "We don't know what happens for someone who was in a psychosis for twenty years and then they are—let's call it 'cured,' " Kushner told me. "And I hesitate to use that word, because the idea that this word is ever used in psychiatry is so exceptional." But, he said, "the treatment modified Mary's biology such that the disease is basically gone."

Kushner began meeting with Mary and her daughters every few weeks, in part to help monitor for possible signs of relapse. At the meetings, they mostly avoided talking about Mary's delusions. When the subject came up, Mary was quiet, or responded in a tangential way, changing the subject. "She has this extraordinarily pleasant way of disarming the situation," Kushner told me. The thought of having caused her daughters suffering seemed too painful to allow into her conscious awareness. "There's not an appointment that goes by where she doesn't remark, spontaneously, that her daughters are doing well," he said. "I don't think that's by accident."

Kushner did not believe that Mary's memory gaps reflected cognitive impairment —on a neuropsychological exam, her memory was better than average—but he also didn't believe that she was purposely not remembering. "To look back and say, basically, 'Twenty years of my life were out of reality'—that would be a fundamental blow to her identity as a physician and mom," he said, a challenge to "one of our most primitive instincts, that we can discern what is real." When I expressed concern about how to present the disparity in memories sensitively, he

told me, "I think that is the story. How do you reconcile with, and compensate for, all those missing years?"

When people emerge from chronic delusional states, the work of psychiatry is considered complete. They are largely left on their own, with two irreconcilable views of reality. "We need to really start thinking about what happens the morning after these disorders are treated," Kushner said.

Christine wasn't sure if she could call her mother "cured" simply because she lacked her previous symptoms. "She's not fixated on things like contamination and surveillance, but at no point has she said she's left those beliefs behind," she said. Christine felt that it was taboo to talk to her mother about who she had once been. She suffered from the intrusive thought that if she confronted her mother with destructive things she had done, Mary would somehow revert back to the patterns from that time and become psychotic again. "It is quite a traumatized-kid thing to say, but I sort of feel like, How greedy can you get? Don't look a gift horse in the mouth," she told me.

Christine didn't know how to have an ordinary conversation with her mother. For twenty years, Mary had been suspicious when Christine asked her questions about her life. Christine now felt like an adopted child "meeting my biological mom for the first time," she said. She bought a book by an anthropologist called "The Essential Questions: Interview Your Family to Uncover Stories and Bridge Generations" to help guide their conversations. "It says, 'Allow them to talk about what's important,' " Christine said, reading from the book, during a visit to her mother's rehabilitation center. "If no one has ever let you speak about yourself, it can be hard," Christine went on. "You have to kind of—"

"Think," Mary said.

"Maybe practice—gain your voice," Christine said.

Christine, who recorded the conversation, began with warmup questions: "When you were a kid, what was your favorite activity?"

"Running," Mary answered immediately.

"What did you like about running?"

"It makes you feel you have wings."

"What is your favorite TV show?" Christine asked.

" 'Seinfeld.' "

" 'Seinfeld'!" Christine said. "What did you like about 'Seinfeld'?"

"The absurdity."

Every few weeks, they tackled a new theme outlined in the book: time, identity, body, belief, possessions, memory, fear. Initially, Mary answered in few words, but eventually she became much more expansive. During one session, she offered that her views on physical discipline had evolved: she no longer thought that smacking was acceptable. Christine said, "Without relating it to me or Angie, she sort of said, 'That's what we were taught when we were younger, but I don't think that's the right way to raise a kid.' " Christine felt that her mother may have been reflecting, obliquely, on what had happened in their home. "The ability to say, 'I've changed my mind' felt like as much as I could ask for," Christine said.

For years, Christine had been documenting her life—keeping a journal, saving records, recording important conversations—to compensate for the fact that she, too, had blank periods in her memories, coinciding with traumatic events. She wasn't sure if her mother's breaks in memory—what she and Angie called "the missing years"—were different from her own. Recently, she had come across a proverb: "The axe forgets, but the tree remembers." She felt that maybe she and her mother had reached an impasse that was actually universal—children have

always formed their identities around blows that their parents don't even realize they inflicted.
Angie felt less accommodating: "I'm happy that my mom is normal now, that we can have a deep connection and I can share my life with her. And, at the same time, I want justice for the child who was hurt by that other mother."

Mary's sister, Nima, told me that before her illness Mary was "very enduring, very patient." Mary's recommendations from professors at medical school describe her as "kind and sympathetic," always "willing to shoulder any extra work." When she came out of her psychosis, Mary returned to this dutiful version of herself. She and her husband, Chris, began speaking on the phone every day. Chris told me that he felt as if he were re-meeting the woman he had known in the early years of their marriage. "How come I lived all these years of darkness, and she suddenly looks normal to me?" he said. "She gives me comfort. She gives me emotional support."

He asked her to do things, like travel to India to resolve a family financial dispute, that Christine and Angie found inappropriate. They encouraged Mary not to comply with the request. Mary had let go of her paranoia that everyone was targeting her, but they wished she could retain a wariness about people who had hurt her in the past. "Now that she's better, you can see how the delusions protected her from people stepping on her boundaries—and she doesn't have a replacement strategy," Christine said.

Mary readily agreed to speak with me for this story, but she struggled to imagine that she could be anything more than a marginal presence in it. For years, she had described how people on TV were lifting ideas and plots from her life story. "It was like she was saying, 'I'm important,' " Christine said. " 'I have value. I have things to say.' And now we're saying, 'You're important. You have value. You have things to say.' And she can't access that sense of deserving to be the main character."

When I first met Mary, on a Zoom call with her and Christine and Angie, I asked if I could read her psychiatric records. She said yes but warned that they would be very boring, adding that she couldn't remember any of her psychiatrists. "I left the memories long before I left the place," she said. Christine suggested that we interpret this as her mother's gentle way of saying no.

A few weeks later, Christine told me, Mary found a pile of psychiatric records in her room: "She was, like, 'I don't want to see them anymore, so Rachel can have them and can get rid of them.' And I was, like, 'Yes, Mom, but Rachel is a journalist. She's not just a professional shredder.' " She said that her mom responded, "I just don't want to see them myself."

Mary seemed to be working out her ambivalence about her memories through this pile of papers. After speaking on Zoom every week for two months, Mary and I met at her rehabilitation center, along with Christine and Angie. Toward the end of our conversation, she stood up without explanation, walked to a cabinet, retrieved the psychiatric records, and gave them to me. "I felt like what happened was a miracle," she told me. "If it will give anyone else confidence, I'll go with it."

There is almost no medical literature about the afterlife of madness, the experience of letting go of what Jaspers called the "definite idea." Autoimmune psychosis raises the possibility of a swift, full recovery—a trajectory not typically seen in schizophrenia—and in doing so supplies a new category of witness: a person who can describe what it feels like to look back on a self that is, in some sense, defunct. And yet sanity does not mean that a person views the past without defensiveness or distortion. (To see too clearly can lead to a different kind of insanity, depression.) One of Christine's fears was that, in talking with her mother about what she and Angie had been through, she would "rob her of the human capacity for denial."

During one of my visits to the rehabilitation center, I asked Mary if she'd like to know how I was writing about her daughters' memories of her illness, or if she'd

prefer not to listen to that part of the story. Christine and I sat in chairs, and Mary sat on the edge of her bed, beside a wooden table on wheels that she used both for eating and as a desk. Mary quickly responded that she wanted to know what her children recalled. "I'll go with that, because that way it will help me to remember," she said.

"You remember things very differently, and it might be painful," Christine said, gently. "Do you feel comfortable emotionally with that?"

"Yeah, go ahead!" Mary said. "I'll remember like a mother. I won't remember from your point of view." She told her, "This is the best time for me to relate to these memories and make amends."

Christine shared her first memory of the illness: sitting on the couch as her mother told her that the professor from medical school was in love with her.

Mary sat straight up on the bed, holding her arms over her stomach, staring intently at Christine. She had the bearing of a diligent student determined to pass a difficult test.

"You asked if they had ever put things in my hair so that"—

"Microphones," Mary said quickly. "Microphones." She said that the professor and his friends kept urging her to leave her husband: "They said, 'Don't worry about the in-laws and all—just move away and begin on your own.' " The friends were trying to help, but they were also harassing her, and she had no one to confide in. "I felt like she was supposed to be there for me," Mary said, gesturing toward Christine. "But she was talking on behalf of my friends."

"You would think that I was repeating phrases that were said to me by other people."

"I remember that very well," Mary said.

“As a kid, I found it very hurtful.”

“I never blamed you,” Mary said. “But my classmates—I trusted them so much.”

“I was not in contact with your classmates,” Christine said, in a measured tone. “I would explain that to you, but it felt like you didn’t believe me at that time.” She asked, “Now that I’m older, do you trust me when I say they weren’t talking to me?”

Mary said it was possible that Christine had been reading her e-mails, rather than talking directly to the classmates, or that Christine’s father was the one telling Christine what to say. “She was very articulate,” Mary said. “She would do everything he would tell her.”

Mary explained that the feeling of being harassed—sometimes by people from her past, sometimes by strangers—continued until several weeks after her cancer diagnosis. “I felt like they were working through the doctors, and I had to take the chemotherapy just to hurt me and make me bald and make me lose weight and humiliate me,” she said.

But then, a few weeks into her treatment, her dreams became uncharacteristically pleasant. She kept dreaming of her sister and brothers, and they were so sensitive and loving that she thought maybe this was the prelude to a kind of heavenly afterlife. In time, the dreams began to feel more conscious, as if she were guiding the scenes herself. Lying in her hospital bed, she tried to recall details about her childhood home which she hadn’t thought about in years. “Whatever I could catch on to, I would collect,” she said.

Her reëmergence seemed to have occurred weeks before her daughters grasped what was happening. Her muscles were so weak that she couldn’t say more than a word at a time, and she wished she could communicate to her daughters, “I’m smiling. I’m all right with this.”

The thought that people were secretly trying to punish her hadn't completely disappeared, but it felt distant, a relic of a different era. When the thought resurfaced, she said, "I take myself out of it, and I say, 'It's not my burden.' I put the whole thing, like a gift basket, to God." She'd been taught this coping mechanism as a schoolgirl, but until recently it hadn't worked.

Christine felt both validated and disoriented by the idea that, between her and her mother, the facts were never really in question. "It is painful to hear that she still thinks I was spying on her all those years, but now she says, 'I am so proud of my daughters—they take care of me,' " she said. "Maybe her interpretation is that through the power of forgiveness she can now interact with me as her loving daughter. So can I make do with that?"

For a year, Christine and Angie had been speaking on Zoom with a family therapist, to help process the changes in their mother. Recently, Mary had begun participating in the conversations, too. During a session, Christine suggested that the three of them begin a process of sharing grievances, each taking a turn. "There were different times when each of us was a flawed caretaker," Christine said. She knew that her mother must have felt betrayed when she called the mobile crisis unit. Mary agreed: "I felt very let down because nobody trusted me enough to share that information." Christine began by telling her, "I did my best, and yet I'm sorry I hurt you."

Although Christine and Angie felt they had already worked out the conflicts in their own relationship, they tried "performing a kind of play," as Christine put it: they shared resentments—Angie's feelings of abandonment, Christine's sense that Angie didn't want her help—and then apologized, "so that at some point she can say the words to us." Each emphasized that she didn't think the other was a bad person, and that it was O.K. that they remembered things differently. They tried any exonerating phrase they could think of, "in case these might be the mental blocks for her," Christine said.

Mary was enthusiastic about the process, but Christine sensed that she didn't quite know what to say when it was her turn. A lifelong student of her mother's mind, Christine had several justifications for her mother's failure to respond in kind: she had not grown up in a culture where regrets were aired in this way; the inability to see her daughter's perspective was a lingering cognitive symptom; in her fragile state, apologizing required a level of confidence she didn't yet have. "At this stage of my life, I need to feel like my mother is back," Christine told me. Later on, maybe in a few years, she said, "I'll deal with the fact that it was an imperfect mother who was returned to me." ♦

An earlier version of this article misstated the Texas institution that houses a center similar to the one at Columbia.

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