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DEPRESSION, TOO, IS A THING WITH FEATHERS

Abstract: This article is a survey of the field of depression that looks at the illness in social and cultural terms, attempting to examine how it functions across history, across cultures, and across socioeconomic categories. It is also an examination of the mechanisms of resilience through which some people manage to integrate their depression better than others and so achieve some measure of competence despite the persistence of chronic illness.

Keywords: depression, resilience, poverty, alternative treatments, Ndeup, cingulotomy, antidepressants, ECT

I HAVE ALWAYS REGRETTED that standard practice is to go on book tour only after you have published a book. There is a great deal that one learns by lecturing on a topic: it becomes clear what is engaging and what is not engaging; and it also becomes clear what lay audiences have already assimilated and what is new to them, a distinction that can become obscure when you are working on something so closely that everything about it feels familiar. You synopsise your project twice: once before you embark on it, when you are seeking a publisher and know very little of what you are talking about, and again when you are explaining it to people in professional contexts after it is completed and you can encapsulate years of research. My anticipatory synopsis took the form of a story in *The New Yorker*, "Anatomy of Melancholy" (1998), in which, still writing largely from within it, I spoke about my own depression. In 2001, I published *The Noonday Demon: An Atlas of Depression*, and since that time, I have done extensive lecturing, given grand rounds two dozen times, and talked in print and on radio and television about my topic. Here I have entered, with some minor editing, a version of the talk I now give, the synopsis of my book, informed by more recent experience and information.

My book on depression, *The Noonday Demon: An Atlas of Depression* (2001), drew from my own experience and the experience of many other people. What I really set out to accomplish was to write a book that

would answer some of the needs that I had when I myself was severely depressed. I had several objectives when I set out, and they shifted a bit as I went along. First, I wanted to unify the field, because, while I found books about depression in the areas of philosophy, neurology, psychodynamics, economics, theology, self-help, memoir, autobiography, sociology, anthropology, and history, there was chaos in the kingdom; these different schools of wisdom were not integrated and they were not united. For a layman trying to get some understanding of depression, it was very difficult to put all these different ideas together into anything coherent. So my initial objectives were to find a single voice that pulled all of them together and to show that what are seen as conflicting ideas about depression are actually just multiple vocabularies for the description of a single set of phenomena.

I was also interested in breaking down the idea of depression as a modern, Western, middle-class illness by describing how depression has been conceived of and recognized historically, by looking at different cultural models, and by examining depression in impoverished populations. Beyond all that, as I worked on the book, I was increasingly struck by the fact that some people had what, as they described it, sounded like a relatively minor illness but were nonetheless completely and utterly disabled by it; while others had what sounded like major symptoms and very severe illness, but somehow in the interstices between their episodes managed to have lives that had some quality and meaning. Level of function and severity of illness were not necessarily correlated. This revelation led me to become fascinated by the relationship between personality and illness, and so I attempted, ultimately, to understand what depression is ontologically and why it can affect people so differently.

I came to this subject not by way of abstract curiosity, but because I suffered from severe depression and had had several real breakdowns. I had always thought of myself as fairly tough, fairly strong, and fairly able to cope with anything. And then I had a series of personal losses. My mother died. A relationship that I was in came to an end, and a variety of other things went awry. I managed to get through those crises more or less intact. Then, a couple of years later, I suddenly found myself feeling bored a lot of the time. The opposite of depression is not happiness, but vitality, and it was vitality that seemed to seep out of me. I didn't feel very excited or enthusiastic about any of the things that had previously filled me with joy and pleasure. I remember particularly that, coming home and listening to the messages on my answering machine, I would feel tired instead of

being pleased to hear from my friends, and I'd think, That's an awful lot of people to have to call back. I was publishing my first novel at the time, and it came out to rather nice reviews. I simply didn't care. All my life I had dreamed of publishing a novel, and now here it was, but all I felt was nullity. That went on for quite a while.

Then the sense of life's being effortful kicked in. Everything began to seem like such an enormous, overwhelming effort. I would think to myself, Oh, I should have some lunch. And then I would think, But I have to get the food out. And put it on a plate. And cut it up. And chew it. And swallow it. And it all began to seem like the stations of the cross. It was just inconceivable for me to get through all that. Then I would think, Oh, I should have a shower. But I just couldn't organize myself enough for that. One of the things that frequently gets lost in descriptions of depression is that it is a ludicrous state. The depressed person often recognizes that it is ludicrous to feel so disabled by the ordinary business of quotidian life. Frequently people who are depressed actually sit there knowing, as I knew then, that most people shower every day and eat lunch; they don't think about it and they do fine. And so, while this was going on, I became annoyed at myself, because I knew that what I was experiencing was idiotic. It was nonetheless vivid and physical and acute, and I was helpless in its grip. As time went on, I found myself doing less, going outside less, interacting with other people less, thinking less, and feeling less.

Then the anxiety set in. If someone were to say to me that I had to be depressed for the next month, I would say that, as long as I knew it was temporary, I could do it. The most acute hell of depression is the feeling that you will never emerge. If you can alleviate that feeling, the state, though miserable, is bearable. But, if someone were to say to me that I had to have acute anxiety for the next month, I would kill myself, because every second of it would be so intolerably awful. It is the constant feeling of being absolutely terrified and not knowing what it is that you're afraid of. It resembles the sensation you have if you slip or trip, the feeling you get when the ground is rushing up at you before you land. That feeling lasts about a second-and-a-half. The anxiety phase of my first depression lasted six months. It was incredibly paralyzing.

At the time, I was in treatment with someone whom I fondly call the incompetent psychoanalyst, who kept telling me that it was very courageous of me to avoid medication and to try to work all this through at a psychodynamic level. And, although I think psychodynamics is very powerful, and I have gained great insight into my own depressive tendencies

through continuing analytic work, I was at that time headed into a serious breakdown. It was a breakdown that could readily have been controlled. Had it been controlled sooner, had it been turned around sooner, I wouldn't have written my book, which would have been a shame for me professionally. But in all other ways things could have gone a great deal better than they did. I got sicker and sicker until finally one day I woke up and actually thought that perhaps I'd had a stroke. I remember lying in bed and thinking that I'd never felt so bad in my life and that I should call someone. From my bed I looked at the telephone on my nightstand, but I could not reach out and dial a number. I lay there for four or five hours, just staring at the telephone. And finally it rang. I managed to answer it. I said, "I'm in terrible trouble." And that was when I finally sought antidepressants and began the serious treatment of my illness.

I am a staunch believer in approaching the problem with multiple strategies. For me, the medication was an absolutely necessary step to assuage the destructive emptiness of my terrible depressive episodes. Once I had begun to return to some reasonable facsimile of myself, though, there was the need for a different kind of work. I had to figure out what triggered my episodes and how to control them. This I did with the analytically trained therapist with whom I had begun working after ending my treatment with the analyst who had failed to help me in my initial crisis. Our work drew mostly on psychoanalytic thought, though it incorporated some aspects of cognitive-behavioral models. My therapist was not only a fount of insight, but also a benign and highly informed mental health professional who was watching me and could comment if I seemed to be headed in a bad way—which is to say that he served a very practical function quite apart from any theory. The real work, however, was the analytic-type work. Once you have been depressed, and particularly once you have allowed medication to reshape your mental states, you need to understand who you are at the most fundamental level. You need to sort out the chemical facts of depression from the experiential; you need to gain insight into the patterns that depressive tendencies doubtless forged in your earlier life. You need to examine the relationship between love and depression in your own experience. You need to make sense of the idea that you are on medication and determine whether the medication has made you more truly yourself or has shifted you into being someone else. You need to know what grief is all about, where it is lodged in you, and how it overlaps with depression as an illness. All these issues are best understood and resolved through psychodynamic work and the framing

vocabularies of analysis. I now have a psychopharmacologist and a psychoanalyst, and I would not be who I am today without their work and without the work I have done with them both. The fashion for biological explanations of depression seems to miss the fact that chemistry has a different vocabulary for a set of phenomena that can also be described psychodynamically. Neither our pharmacology nor our analytic insight is advanced enough to do all the work; to approach the problem of depression from both angles is to figure out not only how to recover, but also how to live the life that must follow on recovery.

That is a little précis of my own depression. It is important also to look at descriptions of depression by some of the people whom I interviewed when I was working on my book, because depression is an illness that has many shapes and many forms, and, people describe it in many different ways. Laura Anderson was one of the people who wrote to me after my *New Yorker* piece about depression (1998) came out. She and I exchanged daily emails through the entire time that I was writing my book. When she first wrote, she was on something of a manic high. I don't know if she is really bipolar, but she was definitely up. And then it all began again for her. Depression tends to be cyclical. The initial episode frequently combines a biological vulnerability with an environmental trigger. Some people are enormously vulnerable and will become depressed after a very minor environmental trigger. Others are not very vulnerable and require a really major trigger to lapse into acute depression. Once the illness takes off, one gets to the point at which, with or without environmental triggers, one tends to cycle through phases of being well and phases of being depressed. Laura Anderson had been going along fairly well, and then she began, predictably, to cycle again. She wrote in an email to me, "I am not yet in a full-blown depression. But I'm slowing down a little. I mean that I have to focus on each thing I do on more and more levels. I'm not completely depressed at this point. But I have entered a recession." A few days later she wrote to me, "I only take baths now because the water beating down on me from the shower is too much to deal with in the morning and seems these days like a violent way to begin the day. Driving seems like such an effort. So is visiting the ATM. Shopping. You name it." And a few days later: "The whole day thus far has been an exercise in forcing myself to do the tiniest things and trying to evaluate how serious my situation is. Am I really depressed? Am I just lazy? Is this anxiety from too much coffee? Or from too much antidepressant? The self-assessment process itself made me start to weep." And then a week later: "I looked at old photos today.

And they seemed like snapshots of someone else's life. My mood continues to be grim. Morning terror and abject helplessness by late afternoon." And finally: "My boyfriend dragged me to the Botanical Garden today. And by the description of one tree there was a sign that said 'all parts deadly poisonous.' I thought maybe I could find the tree, chew on a leaf or two, and curl up under a rock ledge and drift off. I miss the Laura who would have loved to put on her bathing suit and lie in the sun today and look at the blue, blue sky. She has been plucked out of me by an evil witch. Depression takes away whatever I really like about myself, which is not so much in the first place. Feeling hopeless and full of despair is just a slower way of being dead."

It is that feeling of deadness that tempts people to achieve an actual deadness. One feels in a depression so utterly destroyed, so much not oneself, which can lead into suicidality. According to the World Health Organization (1999), depression is one of the most disabling illnesses in the world; in terms of loss of useful life years, it will within the next decade be the world's leading cause of disability. It is a gigantic, epidemic illness. Nonetheless, people often trivialize it, for a variety of reasons. The first is that in most Western languages, unfortunately, a single word describes the spectrum of emotion that ranges from how a small child feels when it rains on his birthday to how people who have committed suicide in the most atrocious ways felt. It is a strange poverty in these languages. It means that when you say about someone, Oh, he has acute depression, people tend to think, Well, I get depressed, too, and I deal with it just fine. They don't understand the difference. And that is partly, I think, because there is an ongoing and significant question of the extent to which depression is part of the normal mood spectrum and is on a continuum with ordinary sadness, difficulty, or despair, and the extent to which it is actually a separate clinical condition. In the mode of the integrative approaches, it is important to say that it is both. It serves a great evolutionary advantage for us to have a mood spectrum and to be capable of joy, of sorrow, and of anger and distress. It is when that mood spectrum moves beyond its useful extent and into some other arena that it becomes something else. It is like having a fence that gets a little rusty; that's fine. And then it gets more rusty, and it wobbles. And then, when it gets really rusty, it falls over and is no longer there. It has simply turned to powder. Is that really the same as just a little normal rusting? In clinical depression, you have something that is continuous with the normal emotional range but that nonetheless becomes categorically different when it gets to that extreme point.

There is, in my view, a very sharp distinction between depression and sadness. Sadness is highly important. And anticipatory, and, to some degree, anxious sadness are equally important and are part of our experience, in fact, of love. If you love someone, but you are feeling, Well, if she dies, I'll be fine, I'll meet someone else, that would not be love as we know it. Love has to do with a holding on. It has to do with what Rilke (1909) described as holding on and letting go. There is no way that you can have love without the potential for sadness, without that experience of sadness. On the other hand, there is a point at which you become so sad that you are utterly, totally paralyzed and useless to yourself, useless to the rest of the world, and completely nonfunctional.

I am often asked to distinguish between grief and depression. Grief is explicitly reactive. Essentially, if something terrible happens and you experience grief and a year later you are still feeling sad about it but less sad than before, then you are probably feeling grief, which will eventually ameliorate. But, if something happens and you feel terrible about it, and six months later you feel worse and less able to function, and six months after that you feel as though you cannot see beyond your own ego world, then that is depression. The trajectory, I think, is often the most important yardstick, more significant than the degree of affliction in any isolated moment.

Here is another description of depression. This is from Maggie Robbins, who has been one of my very best friends since I was 16. Maggie has acute bipolar disorder and had the first real breakdown that I ever saw, when we were in our freshman year of college. She had several episodes of depression and mania. She was eventually made well. She was then seeing someone who told her, after she had been fine for 10 years, that she had done so well that perhaps she should try going off her lithium. That was horrifyingly poor advice. She had another serious depressive episode, the worst I have ever seen up that close. She moved into her parents' apartment and sat catatonic in a corner for weeks on end. When she and I talked about it afterwards, she said, "I would lie in bed singing 'Where Have All the Flowers Gone?' over and over to occupy my mind. I realize now that I could have had some other drugs or that I could have asked someone to come and sleep in my room. But I was just too sick to think of that. I couldn't say what scared me so much. But I thought I would explode from the anxiety. I just went down and down and down and down. We kept changing medications. And I just kept going further down. I believed my doctors. I always accepted that I would eventually come back to normal. But I couldn't wait. I couldn't even do the next

minute. I was singing to blot out the things my mind said, which were, “You are . . . you don’t even deserve to live. You are worthless. You are never going to be anything. You’re nobody.” And that was when I really started thinking about killing myself. You don’t think in depression that you’ve put on a gray veil and are seeing the world through the haze of a bad mood. You think that the veil has been taken away, the veil of happiness, and that now you’re seeing truly. You try to pin the truth down and take it apart. And you think that truth is a fixed thing. But the truth is alive, and it runs around. You can exorcise the demons of schizophrenics who perceive that there’s something foreign inside them. But it’s much harder with depressed people, because we believe we are seeing the truth. But the truth lies.”

That formulation of a truth that lies is extremely powerful. When people are depressed, they have a whole string of negative perceptions. Some of the perceptions are very easy to contradict, because they are inaccurate. Someone who is depressed will say, “No one loves me. There’s just no point because no one loves me.” And it is very easy to say to a person like that, “I love you. Your mother loves you. Your children love you. Your friends love you.” You can come back with all those answers, at least for a person who is, in fact, loved by somebody. It can also be the case that people who are depressed have accurate perceptions but with exaggerated affect associated with them. So people will say, “You know, whatever we do in this life, in the end we’re all just going to die anyway.” Or they say, “There can never be any real union between two people. We’re each trapped alone in our own single body.” And you have to be able to say to them, “That’s true. But let’s focus on breakfast for right now.” It’s terribly difficult to handle that shift in affect. When one stops to think about it, one realizes that there is a great deal that is inherently tragic about the human condition, about the process of aging and the isolation in which everyone ultimately dies.

What is extraordinary is that most of us are able to go right on with life without being distracted and disabled by those things. It is an evolutionary and a social advantage to have some degree of protective optimism that allows one to ignore the darkness of human experience. The question of whether depressed people see the world more accurately than others has been much debated. I was particularly taken by a study in which a group of depressed people and a group of nondepressed people were given a video game for an hour and then were asked how many little monsters they thought they had killed. The depressed people were by

and large accurate to within eight or nine percent. And the nondepressed people guessed between eight and twelve times as many little monsters as they had actually killed (see Taylor, 1989). But they are the normal cohort. If you have too optimistic a view, you take idiotic risks, which is very destructive. Mild optimism, however, is the state on which lives and societies are most successfully built. It is a very difficult point to argue with depressed people, because they will frequently say, "What I have here is not illness, it's insight." One has to be able to articulate that it is insight, that insight is illness, and that, assuming that the person is having trouble tolerating it, the illness needs to be treated.

One of the issues that has most interested me as I have worked in this field is that of effective modes of treatment. I started off as a real medical conservative. I felt that there were a few kinds of psychotherapy that seemed to be effective and that cognitive behavioral and interpersonal therapies seem to have the best record. I thought there were a few medications that worked. I thought that was really it. As I worked on my book, I began looking at different kinds of treatment, and my perspective shifted. What worries me—and it is why I recently refused to endorse a book about alternative treatments—is the implication, frequently promoted by people who are behind a variety of alternative treatments, that those treatments are somehow more "natural" than conventional treatments and that therefore they are what people *should* turn to. I resent this false moral imperative. I do not think there is any rule about what people *should* turn to, but I do think it is dangerous for people to turn to something without a proven track record. They are thus delaying the the start of something that does have proven efficacy. Consequently, depression can escalate, becoming harder to control. Some of those people kill themselves.

That said, however, I was amazed to find so many different treatments to which people have been responsive. If you have brain cancer and you say it makes you feel better to stand on your head for 20 minutes every morning, it may make you feel better at some level, but you still have brain cancer, and you're still likely to die from it if it doesn't get any other kind of treatment. But if you have depression, depression is an illness of how you feel. And if you decide that standing on your head for 20 minutes every morning cheers you right up, then it has worked. You are not depressed anymore. You don't have depression because you don't feel depressed. As I met more and more people who had responded to different kinds of treatment, I became increasingly accepting. Some of these treatments work as placebos, but a robust placebo response is a cure in

this field. Some of them seem to work mystically. Some of them represent very advanced scientific ideas. I have been tremendously impressed by the range of things that have worked.

Another person I interviewed when I was working on my book is Frank Rusakoff. Frank was in a terrible state when I met him. He had extremely severe refractory depression. He had been just fine throughout his days in college. He had been on the soccer team at Northwestern. He had been popular and cheerful; he is nice and good looking. One day, while he was watching a movie, he suddenly became overwhelmed with a wish to die that was so acute that he left the theater and drove himself to a hospital and checked himself in. In the eight or nine years that followed, he got worse and worse. He was unresponsive to all medications. He was doing all kinds of therapy. He eventually turned out to be responsive to ECT, which is in many ways the most effective, although not the most pleasant, treatment that we have. However, he had a very limited, brief response to it.

When I met him, he was having ECT at the beginning of each month. He then had four or five days of being rather disoriented. He then had about a week of being fine, after which he had 10 or 12 days of really going downhill again. Then he was back in for another go of ECT; he was having monthly maintenance ECT. He was thin and pale, drawn, sweaty, and miserable. He said that he just didn't see how he could go on staying alive, although, he added, "I know if I committed suicide, it would destroy my parents. I can't bear to do it. But I also can't bear to go on living this way, and I'm trying to figure a way out." He had read about the cingulotomy protocol at Massachusetts General. This is an intervention in which a small lesion is burned into the anterior cingulum. He applied to the program. I remember being absolutely astonished that someone who had been in that degree of pain for that length time, who had tried so many treatments and had them fail one after the next, could possibly still have buried in him under this depression enough optimism to try another kind of treatment.

He had a cingulotomy, which he said was a frightening and strange experience. In the period since then, with additional medication and ongoing therapy, he has done better and better. He is now doing very well, has married, and has two children; he's a wonderful husband and father. He has a life completely unrelated to the life he had when I met him. A year after the surgery took place, he wrote me this letter at Christmastime: "My dad gave me two presents this year. First, a motorized CD rack from the Sharper Image. It's totally unnecessary and extravagant, but he knew I'd

get a kick out of it. I opened this huge box and saw something I didn't actually need at all, and knew my dad was celebrating the fact that I'm living on my own, have a job I seem to love, and can pay my own bills. The other present was a photo of my grandmother, who committed suicide. As I opened the present, I began to cry. She was beautiful. She's in profile looking downward. My mom came over to the chair and asked if I was crying because of all the relatives I never knew, and I said, 'She had the same disease I have.' I'm crying now. It's not that I'm so sad, I just get overwhelmed. Maybe it's that I could have killed myself but didn't because those around me convinced me to keep going. And I had the surgery. I'm alive and grateful to my parents and the doctors. We live in the right time, even if it doesn't always seem like it."

I want to emphasize for a moment the idea of living in the right time, because I think that so many of the people I meet are, as I am, able to lead such an extraordinarily rich life because of the advances that have been made in the understanding of depression. There is still a long way to go. There is still an enormous amount to be achieved. I hope that when I am older, people will say to me, "Oh my God, what was it like when you had to take those terrible medications that worked so inconsistently and had all those horrible side effects? What was it like to spend all that time trying to figure out which ones were going to work for you?" I hope that it will all seem barbaric. I hope that the advances in imaging will allow us to understand better what is going on instead of trading on the vague sentimentality about neurotransmitters that seems to be the way people understand the illness now. Having said all that, however, I feel incredibly lucky to have been able to get the treatment that is available today, which is so much better than anything available even a few decades ago.

I feel lucky also in relation to two other topics, one being stigma. The existence of better treatment has caused people to speak more openly about this illness—not always as openly as I have chosen to, but more openly in general. That eases the pain of people who are dealing with depression. When I was at a conference a few years ago on another topic, a woman came up to me and said, "You know, I've been dealing with depression. I don't talk about it very much, and nobody really knows. But I want to get your advice on the medication I've been taking. Please don't say anything to my husband. He's the kind of guy who just wouldn't understand this." I gave her such advice as I felt qualified to give. At the end of the conference, her husband, who was also attending, took me aside and said, "Please don't say anything about this to anyone, and especially my wife, because

she thinks I'm a real guy, and she wouldn't if she knew about this. I'm taking medication for depression and I wanted your advice."

It turned out they were taking the same medication and hiding it in two different places in the same bedroom. I felt that part of their complaint might be poor marital communication and that resolving that could be a way forward. But as I talked to them, I was overwhelmed by the burdensome nature of their mutual secrecy. Depression is so exhausting. It takes up so much of your consciousness. It is so long-term, not something that you quickly medicate and then you're over it. For almost everyone who has it, it is a recurrent, lifelong condition. The idea of having this strain of silence added to such lives only serves to make the depression itself more acute and more obtrusive.

I met someone a while ago, someone I have known for many years, who had had several severe depressive episodes and who was incredibly proud that she was not taking medication or getting treatment. She had instead just simplified her life. She described her life to me. She had given up her work. She had enough income to be able to do that, just barely scraping by in a rather dreary way. She had stopped going on dates because it was all too stressful. She had cut down her life to a morass of nothingness. I am grateful for the medication, partly because it has enabled the remission of my most acute symptoms and partly because it has given me the resilience to continue the rich and interesting I now have, engaged with the world and engaged with other people. The medication allows me to be upset not because it is so overwhelming for me to listen to my answering machine, eat lunch, and take a shower, but because I am overwhelmed by the war in Iraq, by the suffering of friends who are ill, by the loneliness of the people about whom I have written. It's not that I am any less sad. In fact, in some ways I am more sad because the nullity has been controlled. But I am sad about things that warrant that sadness. I am sad in ways that I hope are fruitful or meaningful or are components of love.

One person I interviewed described depression as the family secret that everyone has. People say to me that it must be so stressful to talk about my depression. Sometimes it is stressful because I am overwhelmed by the confessions that it seems to invite from others. But I have not had very much experience of people seeming to look down on me because of it. Mostly I find that people who I never dreamed would have the slightest experience with depression say, "Oh, me, too." Or, "Let me tell you about my daughter." Or, "Oh, God, I'm so worried about this friend of mine." The ubiquity of this illness is indeed overwhelming.

The world of alternative treatments is huge. At the opposite end of the spectrum from Frank Rusakoff and his cingulotomy are the ceremonies of tribal peoples. I had heard that there were rituals for the treatment of mental illness that were popular in certain parts of West Africa. I traveled to Senegal because a friend had a Senegalese girlfriend, Helene, who had a friend whose cousin knew someone whose mother had a connection, and so on, a long line of connections that led to someone involved in the practice of the ritual called the Ndeup. I asked Helene if she would take me to this woman so that I could interview her. We drove off into the countryside and arrived at a small village, where we went off to a hut. I met with this woman, who was a very big, theatrical, powerful presence. We talked about the Ndeup for about an hour. She explained all kinds of things. As we came to the end of the interview, I said to her, "Look, this sounds mind boggling. Is there any chance that I could actually come to see an Ndeup being performed?" She answered, "Well, I've certainly never done one with a foreigner present. But you seem serious about this. You've come with Helene. Yes, you can come if you would like." I said, "That's fantastic. When will you next be doing one?" She answered, "Oh, some time in the next six months." I said, "That's quite a long time for me to stay here waiting. Is there anyone who might need one to be expedited a little that you could do a little sooner?" She said, "No, no, it really doesn't work that way." I said, "Well, that's a shame. I guess it's not going to work out." Just as I was leaving, she said, "I hope you won't mind my saying this, but you don't look that great yourself. I've certainly never done this for a foreigner, but I could actually do an Ndeup on you." I answered, "Oh . . . okay . . . sure. Yes, that would be terrific." And so, she gave us some instructions. As we walked out, Helene turned to me and said, "Do you have any idea what you're getting yourself into? Are you completely crazy?" I said, "Well, that's sort of the idea."

Without running through the whole procedure, I will say that the high point was when, four days later, I found myself lying in a makeshift wedding bed with a ram. I was in the town square of this little village while the entire population of the village danced around us in concentric rings, and drums were being very loudly played. Sheets of cloth were being thrown over me and the ram. I had been told that if the ram escaped, it was very bad luck, so I had to hold on to it, an arrangement with which I was not particularly thrilled. At a certain key moment, the fabric was all yanked back, and I was pulled to my feet. The loin cloth that was all I was wearing was pulled off me, the ram's throat was slit, and I was covered in the

blood of the freshly slaughtered ram. It was a far cry from psychotherapy as practiced on the Upper West Side in Manhattan. I had very interesting conversations with the villagers afterwards. Several had had their own Ndeups; one said, "I had an Ndeup, and it was transforming. It saved me." Of course, it helps if you believe that an invasive spirit causes the depression and can be cast out of the body in this ritual. Even without such belief, it was exhilarating, partly because I knew it was going to make incredible copy, but also because there is a power in the fact that these people, who could ill afford a day away from the fields, had all taken all this time for me and devoted all this close attention to my mental state.

I subsequently met someone in Paris who was a famous expert in this particular area and had worked on tribal ritual. He said that I was the only Westerner he had ever heard of who had undergone an Ndeup, but he confirmed that it is a classic ceremony and that there are variants of it over quite a wide area. I had an illuminating conversation with someone a few years later. I was doing research in Rwanda on another topic entirely, and I met someone there who worked in the mental hospital in Kigali. I told him about my experience, and he said, "We have some things that are not that similar, because that's West Africa and this is East Africa, but they're a little similar." Then he said, "We had some trouble actually with foreign mental health workers who came here after the genocide, some of whom caused a lot of trouble." I asked, "What happened? What was the issue?" He said, "Well, they came here and their practice didn't have any of the strengths of the ritual you just described. They did not identify the illness as an invasive external thing. They did not get the entire village to come together and acknowledge it together and all participate in trying to support the person who was getting treated. Treatment was not out in the bright sunshine where you feel happy. There was no music or drumming to get the heart running as the heart should run. Instead, they took people one at a time into sort of dingy little rooms for an hour at a time and asked them to talk about the bad things that had happened to them. Which, of course, just made them feel much worse, almost suicidal. We had to put a stop to it." So cultural relativism cuts both ways.

Part of my goal has been to counteract the idea of depression as a modern illness. And to do that, I went back and looked at historical documents about depression. Depression has been described for at least 2,500 years and known, I'm sure, for much longer than that. Hippocrates's (n.d.) definition, as far as I'm concerned, is closer to the mark than the strange mathematics of the DSM-IV (American Psychiatric Association, 1994),

with its checklists of symptoms. Hippocrates described an illness that afflicted his patients. He said it occurred most frequently in the autumn and winter. The symptoms were “sadness, anxiety, moral dejection, tendency to suicide, aversion to food, despondency, sleeplessness, irritability, and restlessness, accompanied by prolonged fear.” I think that is very clearly depression as we know it. There was tension between Hippocrates, who said that was this was an organic dysfunction of the brain that should be treated with oral remedies—which is to say that he did not have the SSRIs, but he had the idea of the SSRIs—and Plato, who insisted that it was a philosophical problem that needed to be addressed through dialogue (see Simon, 1980)—which is essentially the idea of psychoanalysis or of the talking therapies as a general category. They argued about it quite a lot. And they argued about it with much the same fervor with which it is argued today. Denouncing Plato’s version, Hippocrates said that all that philosophers had written on these natural sciences pertained no more to medicine than to painting (quoted in Galdston, 1967). Plato, meanwhile, had harsh words for Hippocrates’s failure to understand the complexity of the human soul. (see Simon, 1980)

The search for oral remedies became wonderfully bizarre. Chrysippus of Cnidus, one of Hippocrates’s followers, believed that the answer to depression was the consumption of more cauliflower, and he cautioned against basil, which he said was likely to make people depressed (see Roccatagliata, 1986) And Philagrius, another follower, believed that depression came from the loss of too much sperm in wet dreams; he prescribed a mixture of ginger, pepper, epithem, and honey to control them (see Roccatagliata, 1986)—a remedy that seems to have gone out of vogue. In the ancient world, depression was seen as no more stigmatized or terrible than something like dyspepsia. It was talked about quite openly. The people who had it used the word “melancholy” or various versions of the word “melancholia” quite readily. And that remained true through the early Christian period.

Then St. Thomas Aquinas (1265–1273) categorized all illnesses as illnesses of the body or illnesses of the soul, and he classified the mental illnesses as illnesses of the soul. It was at that time that an enormous stigma became attached to depression, because an illness of the soul was a mark of God’s disfavor and therefore very shaming. Shortly thereafter, during the Spanish Inquisition, the idea was put forward that people who were severely depressed had despaired of ultimate redemption and therefore were not true believers. So one could be imprisoned, or even executed,

for being depressed in Inquisition Spain. It was from this medieval theology that the stigma that still holds to depression originally arose. What is extraordinary about all this historical material is how specific and how peculiar the arguments are about depression's being a shameful business.

As we see with Hippocrates and Plato, many of the arguments that we think of as contemporary have actually run throughout history. After the medieval period, when there was an enormous stigma attached to depression, there followed a Renaissance tendency to glamorize depression and to look at it as reflecting a depth of feeling and soul. This is the time of the wonderful writings of Robert Burton (1632) on the subject of depression. The Age of Reason saw depressive persons as not having very much reasoning ability, and they were therefore dealt with quite harshly. So things have swung back and forth throughout history. One thing that does seem to be true is that the more effective the treatment, the more readily an illness is acknowledged. Chekhov once said that if many treatments are prescribed for an illness, you may be certain it has no cure (quoted in Kenyon, 1993). And depression certainly has no cure. But it does have many treatments. As these treatments have proliferated, acknowledging the illness has come to be more fruitful. If you acknowledged that you were depressed in medieval Spain, not only were you in trouble with the Inquisition, but also, what could you do once you'd acknowledged it? There was nothing to be achieved; you were given emetics and told to get on with your life. Now there is a great value to acknowledging that you are depressed because you can seek out meaningful treatment. As people understand that, more people talk about their troubled moods.

I have said that I wanted to contradict the idea of depression as being middle class. I therefore went out to look at depression among the indigent, a cohort that is virtually invisible to the mainstream. It is invisible, in part because indigent people tend not to recognize their depression.

Depression is caused by the intersection of a genetic vulnerability, which is presumably evenly distributed across the population, and triggering external circumstances. People who are living in poverty have more triggering external circumstances than anyone else does. If you have a relatively nice life and you begin feeling miserable all the time, you think to yourself, What is wrong with me? Why am I feeling like this? You seek treatment because the treatment is going to help you to get back to what seems to you to be normal and appropriate to your life. If you have a life that is grim and brutal and terrible in every way, and you feel really horrible all the time, it does not occur to you that you might have an illness,

because the way that you feel seems to be commensurate with the way that your life is. And so, impoverished people who are experiencing acute depression by and large do not seek treatment, because it does not occur to them that there is anything aberrant about what they are feeling. But the reality, as I found when I began doing this research work, is not that people are in general depressed because they are so poor, but, rather, they are poor because they are so depressed. People who are depressed cannot hold down jobs and cannot sustain relationships, and their lives become terribly bleak. In the popular perception, the cause and the effect have been reversed.

What is needed to deal with depression among the indigent is a process of identifying those people who have depression and introducing them to treatment, which they will not ask for, not only because they may be intimidated by the medical system, but also because it has never crossed their minds. I remember one woman who came from the inner city just outside Washington, DC. She had gone to a family planning clinic because she was in an abusive relationship with a very cruel man. She had seven children and was terrified of having more. While she was at the clinic, she was selected by an academic who was doing the screening for a pilot study. This is how she described her situation: "Yes, I had a job, but I had to quit because I just couldn't do it. I didn't want to get out of bed, and I felt like there was no reason to do anything. I'm already small, and I was losing more and more weight. I wouldn't get up to eat or anything. I just didn't care. Sometimes I would sit and just cry, cry, cry. Over nothing. Just cry. I just wanted to be by myself. My mom helped with the kids. I had nothing to say to my own children. After they left the house, I would get in bed with the door locked. I fear when they come home, three o'clock, and it just comes so fast. My husband tells me I'm stupid, I'm dumb, I'm ugly. I'm tired. I'm just so tired. I've been taking a lot of pills, mostly painkillers. It could be Tylenol or anything for pain. A lot of it though. Anything I could get to put me to sleep."

She was included in a protocol that provided six months of treatment. She had group therapy and was prescribed Zoloft. At the end of the six months she had left the abusive man and had gotten a job working in child care for the U.S. Navy. She was set up in a new apartment. She was physically unrecognizable. She said, "My kids are so much happier. They want to do things all the time now. We talk hours every day, and they are my best friends. As soon as I come in the door, I put my jacket down, purse, and we just get out books and read. Doing homework all together

and everything. We joke around. We all talk about careers, and before they didn't even think careers. My eldest wants to go to the Air Force. One wants to be a firefighter. One a preacher. And one of the girls is going to be a lawyer. I talk to them about drugs, and they've seen my sister, and they keep clean now. They don't cry like they used to and they don't fight like they did. I let them know they can talk to me about anything. I don't care what it is. There's one room in the new place for the boys. And one for the girls. And one for me. But they all just like to get up on my bed with me, and we're all sitting around there at night. That's all I need now is my kids. I never thought I would get this far. It feels good to be happy. I don't know how long it's going to last, but I sure hope it's forever. And things keep on changing. The way I dress. The way I look. The way I act. The way I feel. I'm not afraid anymore. I can walk out the door not being afraid. I don't think those bad feelings are coming back. And if it weren't for Dr. Miranda and that, I'd still be at home in bed, if I was still alive at all. I asked the Lord to send me an angel, and he heard my prayers."

A good many of the people I met who were impoverished and who were helped did not emerge from their depression as exquisitely articulate as that woman did. But I heard repeatedly stories of people who had marked an extraordinary improvement. It struck me as something of a humanitarian crime that we do not have outreach programs to identify these people and help them. Beyond the humanitarian disaster, it struck me as economic idiocy. The children of that woman had been headed into the juvenile prison system but were now talking about joining the Air Force and going to law school; the woman herself had been receiving various kinds of social assistance and was now functioning well in a job. Such a shift is to the advantage of everyone in the most dramatic and extraordinary way. I was distressed that programs of outreach do not exist in the United States, that most impoverished, depressed people do not identify their own illness and therefore do not receive treatment, and that there is no attempt to screen such people for mental illness or to encourage them to avail themselves of treatment.

So I went to talk to people in Congress. The people with whom I spoke were the late Senator Paul Wellstone, Democrat of Minnesota, and Senator Pete Domenici, Republican of Arizona, each of whom has severe mental illness in his family; they are the two people who had dealt the most with mental health issues within American congressional politics. Pete Domenici said to me, "There is no question that what you're saying is true and that treating this population would serve the humanitarian and economic interests of the United States. But it isn't going to happen. It isn't going to

happen because we have a line-item budget, and I can't take the money this year out of juvenile justice to put it into this program. And the long-term effects are too difficult to quantify for me to be able to use those as a feasible argument for budget restructuring. It isn't going to happen because this Congress opposes directives in general, but especially directives in the area of health care policy." He went on with a whole variety of technical issues that would obstruct legislating into action any kind of outreach and treatment programs for the poor.

Then I met with Paul Wellstone, who said, "Well, all of these things are true. But the real reason that it isn't going to happen is that we live in an electoral democracy, and in an electoral democracy, all the voters have representation here on Capitol Hill. And all of them have a voice in what happens in American politics. The people you're describing are not in the polling places on election day. They're at home in bed with the covers pulled over their head. They're not voters, and they don't have any effect on what happens up here. And nobody else knows about them or cares about them. To set up an administration to handle what you're describing would be enormously effortful. Unless there's popular pressure to do it, people in an elected governmental body can't dedicate the time that would be required to do it. The only chance of there being a change is for consciousness to be raised about the existence of these people, about the fact that they are, in fact, subject to having their lives improved and to doing better. If you want to see a change, what you need to do is talk about this out in the world."

Conclusion

To repeat my original question, Why is it that some people with very acute depression manage fairly well? What is the nature of that resiliency in the face of acute illness? I chose the people I wrote about in my book quite carefully. I did not choose them as people whose illness was more or less severe but, rather, as people who I thought were in some way courageous in handling their own illness. And I realize that being able to handle your own illness courageously reflects essential qualities of character, which may also have a genetic and chemical base. I am not saying that they are superior in this or that everyone can achieve such resilience. But I do believe they are models that can be useful to other people.

There are many people who, when they are depressed are in anguish, and when they are recovered do not want to talk or think about it. They

do not want to look at it or acknowledge it, because they want to shut it out of their lives. What I found, ironically, was that those are the very people in whose lives the depression remains most acutely present all the time. The effort involved in that attempt to block it out tends, in fact, to exacerbate the condition itself. There are other people who say, "I was depressed, and I wouldn't have chosen to be depressed. But I was depressed, and here's something I learned from it, or here's something I got out of it." Even when that was a little bit delusional, those people who had integrated the experience of depression into their character and personality were the ones who did best in making their way through.

Frank Rusakoff, the fellow who had the cingulotomy, said, "If I had it to do over, I wouldn't do it this way. But I think I've gained a lot and grown a lot because of it. I think I'm a lot closer to my parents, to my brother, to friends. I have this experience with my doctor that's been very good. I said I would do it differently if I had it to do over again, and I guess I would. But now that I feel like the worst is over, I'm grateful for having been where I've been. I do believe I am better off having been to the hospital 30 times and having had brain surgery. I've met a lot of good people along the way. I've loved them a lot."

Maggie Robbins, who talked about the veil of happiness and who had suffered from acute manic-depression, told me, "I used to get nervous a lot. And I would just talk and talk. And I started volunteering at an AIDS residence. They had teas there, and I was supposed to help get the tea and cake and juice for the patients and sit with them and chat, because many of them didn't have people to visit them and were lonely. I remember one day early on I sat down with some people and tried to kick off a conversation by asking them what they'd done for their Fourth of July. They told me, but they just weren't keeping up their end of the conversation at all. I thought, this is not very friendly or helpful of them. And then it hit me. These guys aren't going to make small talk. In fact, after those first brief answers, they weren't going to talk at all. But they didn't want me to leave. So, I decided, I'm here with them and I'm going to be with them. It's simply going to be an occasion where I'm a person who doesn't have AIDS and doesn't look really sick and isn't dying, but who can tolerate the fact that they do, and they are. And so I just stayed with them that afternoon without talking. The loving is that you are there, simply paying attention unconditionally. If suffering is what the person is doing right then, that's what they're doing. You're being with that, not trying like crazy to do something about it. I've learned how to do that. Our needs

are our greatest assets. I am able to just be there with people because of the stuff I've needed from people. I guess I've learned to give all the things I need."

Finally, Laura Anderson, who wanted to chew on a leaf and curl up under a tree, said, "Depression has given me kindness and forgiveness where other people don't know enough to extend it. I'm drawn toward people who might put off others with a wrong move or a misplaced barb. I had an argument about the death penalty tonight with someone, and I was trying to explain, without being too self-referential, that one can understand horrifying actions, understand the terrible links between mood and job and relationships and the rest of everything. I would never want depression to be a public or political excuse, but I think once you have gone through it, you get a greater and more immediate understanding of the temporary absence of judgment that makes people behave so badly. You learn even, perhaps, how to tolerate the evil in the world."

It is not that depressions are wonderful and everyone should have one, but if you have gone through this experience, there is a great deal of insight that you can get from it. While you are in it, it is really barren and void and terrible and agonizing. You emerge from an episode, acknowledging always that, because depression is a chronic illness, there is a pretty good chance that at some stage you will have another relapse. If you can value the depression in some way, it is not that you are less likely to relapse, but that you are better able to tolerate both the relapse itself and the knowledge that that relapse may be around the corner. That ability to tolerate your own depression is what that allows you, I believe, to achieve some resilience. The opening line of my book is that depression is the flaw in love. And I think that there is an incredibly intimate connection between the things. I discovered when I was depressed the extent to which an emotion can take you over and define everything around you and become more real and more acute than reality. That knowledge has allowed me also to experience positive emotion in a more intense and focused way, and with a greater sense of its overwhelming power. I have a sense of joy every day that I wake up and am not depressed, because I know how awful it was. And even though, at some level now, I can almost not remember it, I know that I have had relapses and that I will have other relapses. When I wake up and think, Oh, I'm fine today. It's thrilling. I think that what I have learned from all of it is that the very vitality that the depression at one point robbed me of has returned newly strong and has caused me to live more richly. That may be a delusion that

I have talked myself into. But if it is, it has been a very productive illusion for me. And it's what I recommend to everyone else.

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Andrew Solomon's *The Noonday Demon: An Atlas of Depression* won the 2001 National Book Award, was a finalist for the Pulitzer Prize, and has now been published in 24 languages. A fellow of Berkeley College at Yale University and a member of the National Advisory Board of the Depression Center at the University of Michigan, he is a regular contributor to *The New York Times*, *The New Yorker*, and various other publications.

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