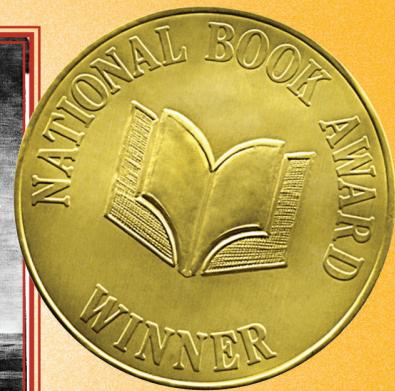
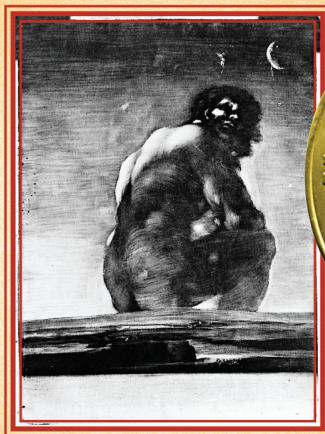


THE NEW YORK TIMES BESTSELLER

"All encompassing, brave, and deeply humane. . . . It is open-minded, critically informed, and poetic at the same time, and despite the nature of its subject it is written with far too much élan and elegance ever to become depressing itself."

—RICHARD BERNSTEIN, *The New York Times*

The
Noonday
Demon



*An Atlas of
Depression*



ANDREW SOLOMON

PULITZER PRIZE FINALIST

Praise for
The Noonday Demon

“An amazingly rich and absorbing work....In its flow of insights and its scope—encompassing not only the author’s own ordeal but also keen inquiries into the biological, social, and political aspects of the illness.”

– WILLIAM STYRON, AUTHOR OF *SOPHIE’S CHOICE*

“A brilliant, kaleidoscopic portrayal of the human experience of depression.” – JAMES D. WATSON, WINNER OF THE NOBEL PRIZE

“All encompassing, brave, and deeply humane...It is open-minded, critically informed, and poetic at the same time, and despite the nature of its subject it is written with far too much élan and elegance ever to become depressing itself.” – THE NEW YORK TIMES

“Both heartrending and fascinating...the book has a scope and passionate intelligence that give it intrigue as well as heft.”

– THE BOSTON GLOBE

“The book for a generation...Solomon interweaves a personal narrative with scientific, philosophical, historical, political, and cultural insights... The result is an elegantly written, meticulously researched book that is empathetic and enlightening, scholarly and useful...Solomon apologizes that ‘no book can span the reach of human suffering.’

This one comes close.” – TIME

The Noonday Demon

An Atlas of Depression

Andrew Solomon

The Noonday Demon examines depression in personal, cultural, and scientific terms. Drawing on his own struggles with the illness and interviews with fellow sufferers, doctors and scientists, policy makers and politicians, drug designers and philosophers, Andrew Solomon reveals the subtle complexities and sheer agony of the disease. He confronts the challenge of defining the illness and describes the vast range of available medications, the efficacy of alternative treatments, and the impact the malady has on various demographic populations—around the world and throughout history. He also explores the thorny patch of moral and ethical questions posed by emerging biological explanations for mental illness. With uncommon humanity, candor, wit, and erudition, award-winning author Solomon takes readers on a journey of incomparable range and resonance into the most pervasive of family secrets. His contribution to our understanding not only of mental illness but also of the human condition is truly stunning.

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Everything passes away—suffering, pain, blood, hunger, pestilence. The sword will pass away too, but the stars will still remain when the shadows of our presence and our deeds have vanished from the earth. There is no man who does not know that. Why, then, will we not turn our eyes toward the stars? Why?

—Mikhail Bulgakov, *The White Guard*

A Note on Method

The writing of this book has been my life for the past five years, and it is sometimes hard for me to trace my own ideas back to their various sources. I have attempted to credit all influences in the notes at the back of the book, and not to distract readers with a cascade of unfamiliar names and technical jargon in the main text. I asked my subjects to allow me to use their actual names, because real names lend authority to real stories. In a book one of the aims of which is to remove the burden of stigma from mental illness, it is important not to play to that stigma by hiding the identities of depressed people. I have, however, included the stories of seven people who wished to remain pseudonymous and who persuaded me that they had significant reason to do so. They appear in this text as Sheila Hernandez, Frank Rusakoff, Bill Stein, Danquille Stetson, Lolly Washington, Claudia Weaver, and Fred Wilson. None of them is a composite personality, and I have taken pains to change no details. The members of Mood Disorders Support Groups (MDSG) use first names only; these have all been changed in keeping with the private nature of the meetings. All other names are actual.

I have allowed the men and women whose battles are the primary subject of this book to tell their own stories. I have done my best to get coherent stories from them, but I have not in general done fact-checking on their accounts of themselves. I have not insisted that all personal narrative be strictly linear.

I have often been asked how I found my subjects. A number of professionals, as noted in the acknowledgments, helped me to gain access to their patients. I met an enormous number of people in my ordinary life who volunteered, upon learning of my subject, their own copious histories, some of which were extremely fascinating and ultimately became source material. I published an article about depression in *The New Yorker* in 1998 and received over a thousand letters in the months imme-

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diately following publication. Graham Greene once said, “I sometimes wonder how all those who do not write, compose, or paint can manage to escape the madness, the melancholia, the panic fear which is inherent in the human situation.” I think he vastly underestimated the number of people who do write in one way or another to alleviate melancholia and panic fear. In responding to my flood of mail, I asked some people whose correspondence had been particularly moving to me whether they would be interested in doing interviews for this book. Additionally, I spoke at and attended numerous conferences where I met consumers of mental health care.

I have never written on any subject about which so many people have so much to say, nor on any subject about which so many people have chosen to say so much to me. It is frighteningly easy to accumulate material about depression. I felt in the end that what was missing in the field of depression studies was synthesis. Science, philosophy, law, psychology, literature, art, history, and many other disciplines have independently taken up the cause of depression. So many interesting things are happening to so many interesting people and so many interesting things are being said and being published—and there is chaos in the kingdom. The first goal of this book is empathy; the second, which has been for me much more difficult to achieve, is order: an order based as closely as possible on empiricism, rather than on sweeping generalizations extracted from haphazard anecdotes.

I must emphasize that I am not a doctor or a psychologist or even a philosopher. This is an extremely personal book and should not be taken as anything more than that. Though I have offered explanations and interpretations of complex ideas, this book is not intended to substitute for appropriate treatment.

For the sake of readability, I have not used ellipsis marks or brackets in quotations, from spoken or written sources, where I felt that the omitted or added words did not substantially change meaning; anyone wishing to reference these sources should go back to the originals, which are all cataloged at the end of this book. I have also avoided use of “[sic]” in the eighth chapter, where historical sources use obsolete spellings. Quotations for which citations are not furnished are from personal interviews, most of which were conducted between 1995 and 2001.

I have used those statistics that come out of sound studies and have been most comfortable with statistics that have been extensively replicated or frequently cited. My finding, in general, is that statistics in this field are inconsistent and that many authors select statistics to make an attractive ensemble in support of preexisting theories. I found one major study, for example, that showed that depressed people who abuse sub-

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stances nearly always choose stimulants; and another, equally convincing one that demonstrated that depressed people who abuse substances invariably use opiates. Many authors derive a rather nauseous air of invincibility from statistics, as though showing that something occurs 82.37 percent of the time is more palpable and true than showing that something occurs about three out of four times. It is my experience that the hard numbers are the ones that lie. The matters that they describe cannot be defined so clearly. The most accurate statement that can be made on the frequency of depression is that it occurs often and, directly or indirectly, affects the lives of everyone.

It is hard for me to write without bias about the pharmaceutical companies because my father has worked in the pharmaceutical field for most of my adult life. As a consequence of this I have met many people in that industry. It is fashionable at the moment to excoriate the pharmaceutical industry as one that takes advantage of the sick. My experience has been that the people in the industry are both capitalists and idealists—people keen on profit but also optimistic that their work may benefit the world, that they may enable important discoveries that will put specific illnesses into obsolescence. We would not have the selective serotonin reuptake inhibitors (SSRIs), antidepressants that have saved so many lives, without the companies that sponsored the research. I have done my best to write clearly about the industry insofar as this is part of the story of this book. After his experience of my depression, my father extended the reach of his company into the field of antidepressants. His company, Forest Laboratories, is now the U.S. distributor of Celexa. To avoid any explicit conflict of interest, I have not mentioned the product except where its omission would be ostentatious or misleading.

I was frequently asked, as I wrote this book, whether the writing was cathartic. It was not. My experience conforms to that of others who have written in this field. Writing on depression is painful, sad, lonely, and stressful. Nonetheless, the idea that I was doing something that might be useful to others was uplifting; and my increased knowledge has been useful to me. I hope it will be clear that the primary pleasure of this book is a literary pleasure of communication rather than the therapeutic release of self-expression.

I began by writing about my depression; then about the similar depression of others; then about the different depression of others; and finally about depression in completely other contexts. I have included three stories from outside the first world in this book. The narratives of my encounters with people in Cambodia, Senegal, and Greenland are provided in an attempt to counterbalance some of the culturally specific ideas of depression that have circumscribed many studies in the area. My

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trips into unknown places were adventures tinged with a certain exoticism, and I have not suppressed the fairy-tale quality of those encounters.

Depression, under various names and in various guises, is and has always been ubiquitous for biochemical and social reasons. This book strives to capture the extent of depression's temporal and geographical reach. If it sometimes seems that depression is the private affliction of the modern Western middle classes, that is because it is in this community that we are suddenly acquiring new sophistication to recognize depression, to name it, to treat it, and to accept it—and not because we have any special rights to the complaint itself. No book can span the reach of human suffering, but I hope that by indicating that reach, I will help to liberate some men and women who suffer from depression. We can never eliminate all unhappiness, and alleviating depression does not assure happiness, but I hope the knowledge contained in this book will help to eliminate some pain for some people.

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Depression is the flaw in love. To be creatures who love, we must be creatures who can despair at what we lose, and depression is the mechanism of that despair. When it comes, it degrades one's self and ultimately eclipses the capacity to give or receive affection. It is the aloneness within us made manifest, and it destroys not only connection to others but also the ability to be peacefully alone with oneself. Love, though it is no prophylactic against depression, is what cushions the mind and protects it from itself. Medications and psychotherapy can renew that protection, making it easier to love and be loved, and that is why they work. In good spirits, some love themselves and some love others and some love work and some love God: any of these passions can furnish that vital sense of purpose that is the opposite of depression. Love forsakes us from time to time, and we forsake love. In depression, the meaninglessness of every enterprise and every emotion, the meaninglessness of life itself, becomes self-evident. The only feeling left in this loveless state is insignificance.

Life is fraught with sorrows: no matter what we do, we will in the end die; we are, each of us, held in the solitude of an autonomous body; time passes, and what has been will never be again. Pain is the first experience of world-helplessness, and it never leaves us. We are angry about being ripped from the comfortable womb, and as soon as that anger fades, distress comes to take its place. Even those people whose faith promises them that this will all be different in the next world cannot help experiencing anguish in this one; Christ himself was the man of sorrows. We live, however, in a time of increasing palliatives; it is easier than ever to decide what to feel and what not to feel. There is less and less unpleasantness that is unavoidable in life, for those with the means to avoid. But despite the enthusiastic claims of pharmaceutical science, depression cannot be wiped out so long as we are creatures conscious of

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our own selves. It can at best be contained—and containing is all that current treatments for depression aim to do.

Highly politicized rhetoric has blurred the distinction between depression and its consequences—the distinction between how you feel and how you act in response. This is in part a social and medical phenomenon, but it is also the result of linguistic vagary attached to emotional vagary. Perhaps depression can best be described as emotional pain that forces itself on us against our will, and then breaks free of its externals. Depression is not just a lot of pain; but too much pain can compost itself into depression. Grief is depression in proportion to circumstance; depression is grief out of proportion to circumstance. It is tumbleweed distress that thrives on thin air, growing despite its detachment from the nourishing earth. It can be described only in metaphor and allegory. Saint Anthony in the desert, asked how he could differentiate between angels who came to him humble and devils who came in rich disguise, said you could tell by how you felt after they had departed. When an angel left you, you felt strengthened by his presence; when a devil left, you felt horror. Grief is a humble angel who leaves you with strong, clear thoughts and a sense of your own depth. Depression is a demon who leaves you appalled.

Depression has been roughly divided into small (mild or disthymic) and large (major) depression. Mild depression is a gradual and sometimes permanent thing that undermines people the way rust weakens iron. It is too much grief at too slight a cause, pain that takes over from the other emotions and crowds them out. Such depression takes up bodily occupancy in the eyelids and in the muscles that keep the spine erect. It hurts your heart and lungs, making the contraction of involuntary muscles harder than it needs to be. Like physical pain that becomes chronic, it is miserable not so much because it is intolerable in the moment as because it is intolerable to have known it in the moments gone and to look forward only to knowing it in the moments to come. The present tense of mild depression envisages no alleviation because it feels like knowledge.

Virginia Woolf has written about this state with an eerie clarity: “Jacob went to the window and stood with his hands in his pockets. There he saw three Greeks in kilts; the masts of ships; idle or busy people of the lower classes strolling or stepping out briskly, or falling into groups and gesticulating with their hands. Their lack of concern for him was not the cause of his gloom; but some more profound conviction—it was not that he himself happened to be lonely, but that all people are.” In the same book, *Jacob’s Room*, she describes how “There rose in her mind a curious sadness, as if time and eternity showed through skirts and waistcoats, and she saw people passing tragically to destruc-

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tion. Yet, heaven knows, Julia was no fool.” It is this acute awareness of transience and limitation that constitutes mild depression. Mild depression, for many years simply accommodated, is increasingly subject to treatment as doctors scrabble to address its diversity.

Large depression is the stuff of breakdowns. If one imagines a soul of iron that weathers with grief and rusts with mild depression, then major depression is the startling collapse of a whole structure. There are two models for depression: the dimensional and the categorical. The dimensional posits that depression sits on a continuum with sadness and represents an extreme version of something everyone has felt and known. The categorical describes depression as an illness totally separate from other emotions, much as a stomach virus is totally different from acid indigestion. Both are true. You go along the gradual path or the sudden trigger of emotion and then you get to a place that is genuinely different. It takes time for a rusting iron-framed building to collapse, but the rust is ceaselessly powdering the solid, thinning it, eviscerating it. The collapse, no matter how abrupt it may feel, is the cumulative consequence of decay. It is nonetheless a highly dramatic and visibly different event. It is a long time from the first rain to the point when rust has eaten through an iron girder. Sometimes the rusting is at such key points that the collapse seems total, but more often it is partial: this section collapses, knocks that section, shifts the balances in a dramatic way.

It is not pleasant to experience decay, to find yourself exposed to the ravages of an almost daily rain, and to know that you are turning into something feeble, that more and more of you will blow off with the first strong wind, making you less and less. Some people accumulate more emotional rust than others. Depression starts out insipid, fogs the days into a dull color, weakens ordinary actions until their clear shapes are obscured by the effort they require, leaves you tired and bored and self-obsessed—but you can get through all that. Not happily, perhaps, but you can get through. No one has ever been able to define the collapse point that marks major depression, but when you get there, there’s not much mistaking it.

Major depression is a birth and a death: it is both the new presence of something and the total disappearance of something. Birth and death are gradual, though official documents may try to pinion natural law by creating categories such as “legally dead” and “time born.” Despite nature’s vagaries, there is definitely a point at which a baby who has not been in the world is in it, and a point at which a pensioner who has been in the world is no longer in it. It’s true that at one stage the baby’s head is here and his body not; that until the umbilical cord is severed the child is physically connected to the mother. It’s true that the pensioner may

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close his eyes for the last time some hours before he dies, and that there is a gap between when he stops breathing and when he is declared “brain-dead.” Depression exists in time. A patient may say that he has spent certain months suffering major depression, but this is a way of imposing a measurement on the immeasurable. All that one can really say for certain is that one has known major depression, and that one does or does not happen to be experiencing it at any given present moment.

The birth and death that constitute depression occur at once. I returned, not long ago, to a wood in which I had played as a child and saw an oak, a hundred years dignified, in whose shade I used to play with my brother. In twenty years, a huge vine had attached itself to this confident tree and had nearly smothered it. It was hard to say where the tree left off and the vine began. The vine had twisted itself so entirely around the scaffolding of tree branches that its leaves seemed from a distance to be the leaves of the tree; only up close could you see how few living oak branches were left, and how a few desperate little budding sticks of oak stuck like a row of thumbs up the massive trunk, their leaves continuing to photosynthesize in the ignorant way of mechanical biology.

Fresh from a major depression in which I had hardly been able to take on board the idea of other people’s problems, I empathized with that tree. My depression had grown on me as that vine had conquered the oak; it had been a sucking thing that had wrapped itself around me, ugly and more alive than I. It had had a life of its own that bit by bit asphyxiated all of my life out of me. At the worst stage of major depression, I had moods that I knew were not my moods: they belonged to the depression, as surely as the leaves on that tree’s high branches belonged to the vine. When I tried to think clearly about this, I felt that my mind was immured, that it couldn’t expand in any direction. I knew that the sun was rising and setting, but little of its light reached me. I felt myself sagging under what was much stronger than I; first I could not use my ankles, and then I could not control my knees, and then my waist began to break under the strain, and then my shoulders turned in, and in the end I was compacted and fetal, depleted by this thing that was crushing me without holding me. Its tendrils threatened to pulverize my mind and my courage and my stomach, and crack my bones and desiccate my body. It went on glutting itself on me when there seemed nothing left to feed it.

I was not strong enough to stop breathing. I knew then that I could never kill this vine of depression, and so all I wanted was for it to let me die. But it had taken from me the energy I would have needed to kill myself, and it would not kill me. If my trunk was rotting, this thing that fed on it was now too strong to let it fall; it had become an alternative support to what it had destroyed. In the tightest corner of my bed, split

and racked by this thing no one else seemed to be able to see, I prayed to a God I had never entirely believed in, and I asked for deliverance. I would have been happy to die the most painful death, though I was too dumbly lethargic even to conceptualize suicide. Every second of being alive hurt me. Because this thing had drained all fluid from me, I could not even cry. My mouth was parched as well. I had thought that when you feel your worst your tears flood, but the very worst pain is the arid pain of total violation that comes after the tears are all used up, the pain that stops up every space through which you once metered the world, or the world, you. This is the presence of major depression.

I have said that depression is both a birth and a death. The vine is what is born. The death is one's own decay, the cracking of the branches that support this misery. The first thing that goes is happiness. You cannot gain pleasure from anything. That's famously the cardinal symptom of major depression. But soon other emotions follow happiness into oblivion: sadness as you had known it, the sadness that seemed to have led you here; your sense of humor; your belief in and capacity for love. Your mind is leached until you seem dim-witted even to yourself. If your hair has always been thin, it seems thinner; if you have always had bad skin, it gets worse. You smell sour even to yourself. You lose the ability to trust anyone, to be touched, to grieve. Eventually, you are simply absent from yourself.

Maybe what is present usurps what becomes absent, and maybe the absence of obfuscating things reveals what is present. Either way, you are less than yourself and in the clutches of something alien. Too often, treatments address only half the problem: they focus only on the presence or only on the absence. It is necessary both to cut away that extra thousand pounds of the vines and to relearn a root system and the techniques of photosynthesis. Drug therapy hacks through the vines. You can feel it happening, how the medication seems to be poisoning the parasite so that bit by bit it withers away. You feel the weight going, feel the way that the branches can recover much of their natural bent. Until you have got rid of the vine, you cannot think about what has been lost. But even with the vine gone, you may still have few leaves and shallow roots, and the rebuilding of your self cannot be achieved with any drugs that now exist. With the weight of the vine gone, little leaves scattered along the tree skeleton become viable for essential nourishment. But this is not a good way to be. It is not a strong way to be. Rebuilding of the self in and after depression requires love, insight, work, and, most of all, time.

Diagnosis is as complex as the illness. Patients ask doctors all the time, "Am I depressed?" as though the result were in a definitive blood test. The only way to find out whether you're depressed is to listen to and

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watch yourself, to feel your feelings and then think about them. If you feel bad without reason most of the time, you're depressed. If you feel bad most of the time with reason, you're also depressed, though changing the reasons may be a better way forward than leaving circumstance alone and attacking the depression. If the depression is disabling to you, then it's major. If it's only mildly distracting, it's not major. Psychiatry's bible—the *Diagnostic and Statistical Manual*, fourth edition (*DSM-IV*)—ineptly defines depression as the presence of five or more on a list of nine symptoms. The problem with the definition is that it's entirely arbitrary. There's no particular reason to qualify five symptoms as constituting depression; four symptoms are more or less depression; and five symptoms are less severe than six. Even one symptom is unpleasant. Having slight versions of all the symptoms may be less of a problem than having severe versions of two symptoms. After enduring diagnosis, most people seek causation, despite the fact that knowing why you are sick has no immediate bearing on treating the sickness.

Illness of the mind is real illness. It can have severe effects on the body. People who show up at the offices of their doctors complaining about stomach cramps are frequently told, "Why, there's nothing wrong with you except that you're depressed!" Depression, if it is sufficiently severe to cause stomach cramps, is actually a really bad thing to have wrong with you, and it requires treatment. If you show up complaining that your breathing is troubled, no one says to you, "Why, there's nothing wrong with you except that you have emphysema!" To the person who is experiencing them, psychosomatic complaints are as real as the stomach cramps of someone with food poisoning. They exist in the unconscious brain, and often enough the brain is sending inappropriate messages to the stomach, so they exist there as well. The diagnosis—whether something is rotten in your stomach or your appendix or your brain—matters in determining treatment and is not trivial. As organs go, the brain is quite an important one, and its malfunctions should be addressed accordingly.

Chemistry is often called on to heal the rift between body and soul. The relief people express when a doctor says their depression is "chemical" is predicated on a belief that there is an integral self that exists across time, and on a fictional divide between the fully occasioned sorrow and the utterly random one. The word *chemical* seems to assuage the feelings of responsibility people have for the stressed-out discontent of not liking their jobs, worrying about getting old, failing at love, hating their families. There is a pleasant freedom from guilt that has been attached to *chemical*. If your brain is predisposed to depression, you need not blame yourself for it. Well, blame yourself or evolution, but remember that

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blame itself can be understood as a chemical process, and that happiness, too, is chemical. Chemistry and biology are not matters that impinge on the “real” self; depression cannot be separated from the person it affects. Treatment does not alleviate a disruption of identity, bringing you back to some kind of normality; it readjusts a multifarious identity, changing in some small degree who you are.

Anyone who has taken high school science classes knows that human beings are made of chemicals and that the study of those chemicals and the structures in which they are configured is called biology. Everything that happens in the brain has chemical manifestations and sources. If you close your eyes and think hard about polar bears, that has a chemical effect on your brain. If you stick to a policy of opposing tax breaks for capital gains, that has a chemical effect on your brain. When you remember some episode from your past, you do so through the complex chemistry of memory. Childhood trauma and subsequent difficulty can alter brain chemistry. Thousands of chemical reactions are involved in deciding to read this book, picking it up with your hands, looking at the shapes of the letters on the page, extracting meaning from those shapes, and having intellectual and emotional responses to what they convey. If time lets you cycle out of a depression and feel better, the chemical changes are no less particular and complex than the ones that are brought about by taking antidepressants. The external determines the internal as much as the internal invents the external. What is so unattractive is the idea that in addition to all other lines being blurred, the boundaries of what makes us ourselves are blurry. There is no essential self that lies pure as a vein of gold under the chaos of experience and chemistry. Anything can be changed, and we must understand the human organism as a sequence of selves that succumb to or choose one another. And yet the language of science, used in training doctors and, increasingly, in nonacademic writing and conversation, is strangely perverse.

The cumulative results of the brain’s chemical effects are not well understood. In the 1989 edition of the standard *Comprehensive Textbook of Psychiatry*, for example, one finds this helpful formula: a depression score is equivalent to the level of 3-methoxy-4-hydroxyphenylglycol (a compound found in the urine of all people and not apparently affected by depression); minus the level of 3-methoxy-4-hydroxymandelic acid; plus the level of norepinephrine; minus the level of normetanephrine plus the level of metanephrine, the sum of those divided by the level of 3-methoxy-4-hydroxymandelic acid; plus an unspecified conversion variable; or, as CTP puts it: “D-type score = C_1 (MHPG) - C_2 (VMA) + C_3 (NE) - C_4 (NMN + MN)/VMA + C_0 .” The score should come out between one for unipolar and zero for bipolar patients, so if you come up

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with something else—you’re doing it wrong. How much insight can such formulae offer? How can they *possibly* apply to something as nebulous as mood? To what extent specific experience has conduced to a particular depression is hard to determine; nor can we explain through what chemistry a person comes to respond to external circumstance with depression; nor can we work out what makes someone essentially depressive.

Although depression is described by the popular press and the pharmaceutical industry as though it were a single-effect illness such as diabetes, it is not. Indeed, it is strikingly dissimilar to diabetes. Diabetics produce insufficient insulin, and diabetes is treated by increasing and stabilizing insulin in the bloodstream. Depression is *not* the consequence of a reduced level of anything we can now measure. Raising levels of serotonin in the brain triggers a process that eventually helps many depressed people to feel better, but that is *not* because they have abnormally low levels of serotonin. Furthermore, serotonin does *not* have immediate salutary effects. You could pump a gallon of serotonin into the brain of a depressed person and it would not in the instant make him feel one iota better, though a long-term sustained raise in serotonin level has some effects that ameliorate depressive symptoms. “I’m depressed but it’s just chemical” is a sentence equivalent to “I’m murderous but it’s just chemical” or “I’m intelligent but it’s just chemical.” Everything about a person is just chemical if one wants to think in those terms. “You can say it’s ‘just chemistry,’ ” says Maggie Robbins, who suffers from manic-depressive illness. “I say there’s nothing ‘just’ about chemistry.” The sun shines brightly and that’s just chemical too, and it’s chemical that rocks are hard, and that the sea is salt, and that certain springtime afternoons carry in their gentle breezes a quality of nostalgia that stirs the heart to longings and imaginings kept dormant by the snows of a long winter. “This serotonin thing,” says David McDowell of Columbia University, “is part of modern neuromythology.” It’s a potent set of stories.

Internal and external reality exist on a continuum. What happens and how you understand it to have happened and how you respond to its happening are usually linked, but no one is predictive of the others. If reality itself is often a relative thing, and the self is in a state of permanent flux, the passage from slight mood to extreme mood is a glissando. Illness, then, is an extreme state of emotion, and one might reasonably describe emotion as a mild form of illness. If we all felt up and great (but not delusionally manic) all the time, we could get more done and might have a happier time on earth, but that idea is creepy and terrifying (though, of course, if we felt up and great all the time we might forget all about creepiness and terror).

Influenza is straightforward: one day you do not have the responsible

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virus in your system, and another day you do. HIV passes from one person to another in a definable isolated split second. Depression? It's like trying to come up with clinical parameters for hunger, which affects us all several times a day, but which in its extreme version is a tragedy that kills its victims. Some people need more food than others; some can function under circumstances of dire malnutrition; some grow weak rapidly and collapse in the streets. Similarly, depression hits different people in different ways: some are predisposed to resist or battle through it, while others are helpless in its grip. Willfulness and pride may allow one person to get through a depression that would fell another whose personality is more gentle and acquiescent.

Depression interacts with personality. Some people are brave in the face of depression (during it and afterward) and some are weak. Since personality too has a random edge and a bewildering chemistry, one can write everything off to genetics, but that is too easy. "There is no such thing as a mood gene," says Steven Hyman, director of the National Institute of Mental Health. "It's just shorthand for very complex gene-environment interactions." If everyone has the capacity for some measure of depression under some circumstances, everyone also has the capacity to fight depression to some degree under some circumstances. Often, the fight takes the form of seeking out the treatments that will be most effective in the battle. It involves finding help while you are still strong enough to do so. It involves making the most of the life you have between your most severe episodes. Some horrendously symptom-ridden people are able to achieve real success in life; and some people are utterly destroyed by the mildest forms of the illness.

Working through a mild depression without medications has certain advantages. It gives you the sense that you can correct your own chemical imbalances through the exercise of your own chemical will. Learning to walk across hot coals is also a triumph of the brain over what appears to be the inevitable physical chemistry of pain, and it is a thrilling way to discover the sheer power of mind. Getting through a depression "on your own" allows you to avoid the social discomfort associated with psychiatric medications. It suggests that we are accepting ourselves as we were made, reconstructing ourselves only with our own interior mechanics and without help from the outside. Returning from distress by gradual degrees gives sense to affliction itself.

Interior mechanics, however, are difficult to commission and are frequently inadequate. Depression frequently destroys the power of mind over mood. Sometimes the complex chemistry of sorrow kicks in because you've lost someone you love, and the chemistry of loss and love may lead to the chemistry of depression. The chemistry of falling in love can

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kick in for obvious external reasons, or along lines that the heart can never tell the mind. If we wanted to treat this madness of emotion, we could perhaps do so. It is mad for adolescents to rage at parents who have done their best, but it is a conventional madness, uniform enough so that we tolerate it relatively unquestioningly. Sometimes the same chemistry kicks in for external reasons that are not sufficient, by mainstream standards, to explain the despair: someone bumps into you in a crowded bus and you want to cry, or you read about world overpopulation and find your own life intolerable. Everyone has on occasion felt disproportionate emotion over a small matter or has felt emotions whose origin is obscure or that may have no origin at all. Sometimes the chemistry kicks in for no apparent external reason at all. Most people have had moments of inexplicable despair, often in the middle of the night or in the early morning before the alarm clock sounds. If such feelings last ten minutes, they're a strange, quick mood. If they last ten hours, they're a disturbing febrility, and if they last ten years, they're a crippling illness.

It is too often the quality of happiness that you feel at every moment its fragility, while depression seems when you are in it to be a state that will never pass. Even if you accept that moods change, that whatever you feel today will be different tomorrow, you cannot relax into happiness as you can into sadness. For me, sadness always has been and still is a more powerful feeling; and if that is not a universal experience, perhaps it is the base from which depression grows. I hated being depressed, but it was also in depression that I learned my own acreage, the full extent of my soul. When I am happy, I feel slightly distracted by happiness, as though it fails to use some part of my mind and brain that wants the exercise. Depression is something to do. My grasp tightens and becomes acute in moments of loss: I can see the beauty of glass objects fully at the moment when they slip from my hand toward the floor. "We find pleasure much less pleasurable, pain much more painful than we had anticipated," Schopenhauer wrote. "We require at all times a certain quantity of care or sorrow or want, as a ship requires ballast, to keep on a straight course."

There is a Russian expression: if you wake up feeling no pain, you know you're dead. While life is not only about pain, the experience of pain, which is particular in its intensity, is one of the surest signs of the life force. Schopenhauer said, "Imagine this race transported to a Utopia where everything grows of its own accord and turkeys fly around ready-roasted, where lovers find one another without any delay and keep one another without any difficulty: in such a place some men would die of boredom or hang themselves, some would fight and kill one another, and thus they would create for themselves more suffering than nature inflicts

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on them as it is . . . the polar opposite of suffering [is] boredom." I believe that pain needs to be transformed but not forgotten; gainsaid but not obliterated.

I am persuaded that some of the broadest figures for depression are based in reality. Though it is a mistake to confuse numbers with truth, these figures tell an alarming story. According to recent research, about 3 percent of Americans—some 19 million—suffer from chronic depression. More than 2 million of those are children. Manic-depressive illness, often called bipolar illness because the mood of its victims varies from mania to depression, afflicts about 2.3 million and is the second-leading killer of young women, the third of young men. Depression as described in *DSM-IV* is the leading cause of disability in the United States and abroad for persons over the age of five. Worldwide, including the developing world, depression accounts for more of the disease burden, as calculated by premature death plus healthy life-years lost to disability, than anything else but heart disease. Depression claims more years than war, cancer, and AIDS put together. Other illnesses, from alcoholism to heart disease, mask depression when it causes them; if one takes that into consideration, depression may be the biggest killer on earth.

Treatments for depression are proliferating now, but only half of Americans who have had major depression have ever sought help of any kind—even from a clergyman or a counselor. About 95 percent of that 50 percent go to primary-care physicians, who often don't know much about psychiatric complaints. An American adult with depression would have his illness recognized only about 40 percent of the time. Nonetheless, about 28 million Americans—one in every ten—are now on SSRIs (selective serotonin reuptake inhibitors—the class of drugs to which Prozac belongs), and a substantial number are on other medications. Less than half of those whose illness is recognized will get appropriate treatment. As definitions of depression have broadened to include more and more of the general population, it has become increasingly difficult to calculate an exact mortality figure. The statistic traditionally given is that 15 percent of depressed people will eventually commit suicide; this figure still holds for those with extreme illness. Recent studies that include milder depression show that 2 to 4 percent of depressives will die by their own hand as a direct consequence of the illness. This is still a staggering figure. Twenty years ago, about 1.5 percent of the population had depression that required treatment; now it's 5 percent; and as many as 10 percent of all Americans now living can expect to have a major depressive episode during their life. About 50 percent will experience some symptoms of depression. Clinical problems have increased;

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treatments have increased vastly more. Diagnosis is on the up, but that does not explain the scale of this problem. Incidents of depression are increasing across the developed world, particularly in children. Depression is occurring in younger people, making its first appearance when its victims are about twenty-six, ten years younger than a generation ago; bipolar disorder, or manic-depressive illness, sets in even earlier. Things are getting worse.

There are few conditions at once as undertreated and as overtreated as depression. People who become totally dysfunctional are ultimately hospitalized and are likely to receive treatment, though sometimes their depression is confused with the physical ailments through which it is experienced. A world of people, however, are just barely holding on and continue, despite the great revolutions in psychiatric and psychopharmaceutical treatments, to suffer abject misery. More than half of those who do seek help—another 25 percent of the depressed population—receive no treatment. About half of those who do receive treatment—13 percent or so of the depressed population—receive unsuitable treatment, often tranquilizers or immaterial psychotherapies. Of those who are left, half—some 6 percent of the depressed population—receive inadequate dosage for an inadequate length of time. So that leaves about 6 percent of the total depressed population who are getting adequate treatment. But many of these ultimately go off their medications, usually because of side effects. “It’s between 1 and 2 percent who get really optimal treatment,” says John Greden, director of the Mental Health Research Institute at the University of Michigan, “for an illness that can usually be well-controlled with relatively inexpensive medications that have few serious side effects.” Meanwhile, at the other end of the spectrum, people who suppose that bliss is their birthright pop cavalcades of pills in a futile bid to alleviate those mild discomforts that texture every life.

It has been fairly well established that the advent of the supermodel has damaged women’s images of themselves by setting unrealistic expectations. The psychological supermodel of the twenty-first century is even more dangerous than the physical one. People are constantly examining their own minds and rejecting their own moods. “It’s the Lourdes phenomenon,” says William Potter, who ran the psychopharmacological division of the National Institute of Mental Health (NIMH) through the seventies and eighties, when the new drugs were being developed. “When you expose very large numbers of people to what they perceive and have reason to believe is positive, you get reports of miracles—and also, of course, of tragedy.” Prozac is so easily tolerated that almost anyone can take it, and almost anyone does. It’s been used on people with

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slight complaints who would not have been game for the discomforts of the older antidepressants, the monoamine oxidase inhibitors (MAOIs) or tricyclics. Even if you're not depressed, it might push back the edges of your sadness, and wouldn't that be nicer than living with pain?

We pathologize the curable, and what can easily be modified comes to be treated as illness, even if it was previously treated as personality or mood. As soon as we have a drug for violence, violence will be an illness. There are many grey states between full-blown depression and a mild ache unaccompanied by changes of sleep, appetite, energy, or interest; we have begun to class more and more of these as illness because we have found more and more ways to ameliorate them. But the cutoff point remains arbitrary. We have decided that an IQ of 69 constitutes retardation, but someone with an IQ of 72 is not in great shape, and someone with an IQ of 65 can still kind of manage; we have said that cholesterol should be kept under 220, but if your cholesterol is 221, you probably won't die from it, and if it's 219, you need to be careful: 69 and 220 are arbitrary numbers, and what we call illness is also really quite arbitrary; in the case of depression, it is also in perpetual flux.

Depressives use the phrase "over the edge" all the time to delineate the passage from pain to madness. This very physical description frequently entails falling "into the abyss." It's odd that so many people have such a consistent vocabulary, because the edge is really quite an abstracted metaphor. Few of us have ever fallen off the edge of anything, and certainly not into an abyss. The Grand Canyon? A Norwegian fjord? A South African diamond mine? It's difficult even to *find* an abyss to fall into. When asked, people describe the abyss pretty consistently. In the first place, it's dark. You are falling away from the sunlight toward a place where the shadows are black. Inside it, you cannot see, and the dangers are everywhere (it's neither soft-bottomed nor soft-sided, the abyss). While you are falling, you don't know how deep you can go, or whether you can in any way stop yourself. You hit invisible things over and over again until you are shredded, and yet your environment is too unstable for you to catch onto anything.

Fear of heights is the most common phobia in the world and must have served our ancestors well, since the ones who were not afraid probably found abysses and fell into them, so knocking their genetic material out of the race. If you stand on the edge of a cliff and look down, you feel dizzy. Your body does not work better than ever and allow you to move with immaculate precision back from the edge. You think you're going to fall, and if you look for long, you will fall. You're paralyzed. I remember going with friends to Victoria Falls, where great heights of rock drop

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down sheer to the Zambezi River. We were young and were sort of challenging one another by posing for photos as close to the edge as we dared to go. Each of us, upon going too close to the edge, felt sick and paralytic. I think depression is not usually going over the edge itself (which soon makes you die), but drawing too close to the edge, getting to that moment of fear when you have gone so far, when dizziness has deprived you so entirely of your capacity for balance. By Victoria Falls, we discovered that the unpassable thing was an invisible edge that lay well short of the place where the stone dropped away. Ten feet from the sheer drop, we all felt fine. Five feet from it, most of us quailed. At one point, a friend was taking a picture of me and wanted to get the bridge to Zambia into the shot. “Can you move an inch to the left?” she asked, and I obligingly took a step to the left—a foot to the left. I smiled, a nice smile that’s preserved there in the photo, and she said, “You’re getting a little bit close to the edge. C’mom back.” I had been perfectly comfortable standing there, and then I suddenly looked down and saw that I had passed my edge. The blood drained from my face. “You’re fine,” my friend said, and walked nearer to me and held out her hand. The sheer cliff was ten inches away and yet I had to drop to my knees and lay myself flat along the ground to pull myself a few feet until I was on safe ground again. I know that I have an adequate sense of balance and that I can quite easily stand on an eighteen-inch-wide platform; I can even do a bit of amateur tap dancing, and I can do it reliably without falling over. I could not stand so close to the Zambezi.

Depression relies heavily on a paralyzing sense of imminence. What you can do at an elevation of six inches you cannot do when the ground drops away to reveal a drop of a thousand feet. Terror of the fall grips you even if that terror is what might make you fall. What is happening to you in depression is horrible, but it seems to be very much wrapped up in what is about to happen to you. Among other things, you feel you are about to die. The dying would not be so bad, but the living at the brink of dying, the not-quite-over-the-geographical-edge condition, is horrible. In a major depression, the hands that reach out to you are just out of reach. You cannot make it down onto your hands and knees because you feel that as soon as you lean, even away from the edge, you will lose your balance and plunge down. Oh, some of the abyss imagery fits: the darkness, the uncertainty, the loss of control. But if you were actually falling endlessly down an abyss, there would be no question of control. You would be out of control entirely. Here there is that horrifying sense that control has left you just when you most need it and by rights should have it. A terrible imminence overtakes entirely the present moment. Depression has gone too far when, despite a wide margin of safety, you

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cannot balance anymore. In depression, all that is happening in the present is the anticipation of pain in the future, and the present qua present no longer exists at all.

Depression is a condition that is almost unimaginable to anyone who has not known it. A sequence of metaphors—vines, trees, cliffs, etc.—is the only way to talk about the experience. It's not an easy diagnosis because it depends on metaphors, and the metaphors one patient chooses are different from those selected by another patient. Not so much has changed since Antonio in *The Merchant of Venice* complained:

It wearies me, you say it wearies you;
But how I caught it, found it, or came by it
What stuff 'tis made of, whereof it is born
I am to learn;
And such a want-wit sadness makes of me,
That I have much ado to know myself.

Let us make no bones about it: We do not really know what causes depression. We do not really know what constitutes depression. We do not really know why certain treatments may be effective for depression. We do not know how depression made it through the evolutionary process. We do not know why one person gets a depression from circumstances that do not trouble another. We do not know how will operates in this context.

People around depressives expect them to get themselves together: our society has little room in it for moping. Spouses, parents, children, and friends are all subject to being brought down themselves, and they do not want to be close to measureless pain. No one can do anything but beg for help (if he can do even that) at the lowest depths of a major depression, but once the help is provided, it must also be accepted. We would all like Prozac to do it for us, but in my experience, Prozac doesn't do it unless we help it along. Listen to the people who love you. Believe that they are worth living for even when you don't believe it. Seek out the memories depression takes away and project them into the future. Be brave; be strong; take your pills. Exercise because it's good for you even if every step weighs a thousand pounds. Eat when food itself disgusts you. Reason with yourself when you have lost your reason. These fortune-cookie admonitions sound pat, but the surest way out of depression is to dislike it and not to let yourself grow accustomed to it. Block out the terrible thoughts that invade your mind.

I will be in treatment for depression for a long time. I wish I could say

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how it happened. I have no idea how I fell so low, and little sense of how I bounced up or fell again, and again, and again. I treated the presence, the vine, in every conventional way I could find, then figured out how to repair the absence as laboriously yet intuitively as I learned to walk or talk. I had many slight lapses, then two serious breakdowns, then a rest, then a third breakdown, and then a few more lapses. After all that, I do what I have to do to avoid further disturbances. Every morning and every night, I look at the pills in my hand: white, pink, red, turquoise. Sometimes they seem like writing in my hand, hieroglyphics saying that the future may be all right and that I owe it to myself to live on and see. I feel sometimes as though I am swallowing my own funeral twice a day, since without these pills, I'd be long gone. I go to see my therapist once a week when I'm at home. I am sometimes bored by our sessions and sometimes interested in an entirely dissociative way and sometimes have a feeling of epiphany. In part, from the things this man said, I rebuilt myself enough to be able to keep swallowing my funeral instead of enacting it. A lot of talking was involved: I believe that words are strong, that they can overwhelm what we fear when fear seems more awful than life is good. I have turned, with an increasingly fine attention, to love. Love is the other way forward. They need to go together: by themselves pills are a weak poison, love a blunt knife, insight a rope that snaps under too much strain. With the lot of them, if you are lucky, you can save the tree from the vine.

I love this century. I would love to have the capacity for time travel because I would love to visit biblical Egypt, Renaissance Italy, Elizabethan England, to see the heyday of the Inca, to meet the inhabitants of Great Zimbabwe, to see what America was like when the indigenous peoples held the land. But there is no other time in which I would prefer to live. I love the comforts of modern life. I love the complexity of our philosophy. I love the sense of vast transformation that hangs on us at this new millennium, the feeling that we are at the brink of knowing more than people have ever known before. I like the relatively high level of social tolerance that exists in the countries where I live. I like being able to travel around the world over and over and over again. I like that people live longer than they have ever lived before, that time is a little more on our side than it was a thousand years ago.

We are, however, facing an unparalleled crisis in our physical environment. We are consuming the production of the earth at a frightening pace, sabotaging the land, sea, and sky. The rain forest is being destroyed; our oceans brim with industrial waste; the ozone layer is depleted. There are far more people in the world than there have ever been before, and next year there will be even more, and the year after that there will

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be many more again. We are creating problems that will trouble the next generation, and the next, and the next after that. Man has been changing the earth ever since the first flint knife was shaped from a stone and the first seed was sowed by an Anatolian farmer, but the pace of alteration is now getting severely out of hand. I am not an environmental alarmist. I do not believe that we are at the brink of apocalypse right now. But I am convinced that we must take steps to alter our current course if we are not to pilot ourselves into oblivion.

It is an indication of the resilience of humankind that we unearth new solutions to those problems. The world goes on and so does the species. Skin cancer is far more prevalent than it used to be because the atmosphere provides us far less protection from the sun. Summers, I wear lotions and creams with high SPF levels, and they help to keep me safe. I have from time to time gone to a dermatologist, who has snipped off an outsize freckle and sent it off to a lab to be checked. Children who once ran along the beach naked are now slathered in protective ointments. Men who once worked shirtless at noon now wear shirts and try to find the shade. We have the ability to cope with this aspect of this crisis. We invent new ways, which are well short of living in the dark. Sunblock or no sunblock, however, we must try not to destroy what's left. Right now, there's still a lot of ozone out there and it's still doing its job moderately well. It would be better for the environment if everyone stopped using cars, but that's not going to happen unless there's a tidal wave of utter crisis. Frankly, I think there will be men living on the moon before there will be a society free of automotive transport. Radical change is impossible and in many ways undesirable, but change is certainly required.

It appears that depression has been around as long as man has been capable of self-conscious thought. It may be that depression existed even before that time, that monkeys and rats and perhaps octopi were suffering the disease before those first humanoids found their way into their caves. Certainly the symptomatology of our time is more or less indistinguishable from what was described by Hippocrates some twenty-five hundred years ago. Neither depression nor skin cancer is a creation of the twenty-first century. Like skin cancer, depression is a bodily affliction that has escalated in recent times for fairly specific reasons. Let us not stand too long ignoring the clear message of burgeoning problems. Vulnerabilities that in a previous era would have remained undetectable now blossom into full-blown clinical illness. We must not only avail ourselves of the immediate solutions to our current problems, but also seek to contain those problems and to avoid their purloining all our minds. The climbing rates of depression are without question the consequence of modernity. The pace of life, the technological chaos of it, the alienation of

people from one another, the breakdown of traditional family structures, the loneliness that is endemic, the failure of systems of belief (religious, moral, political, social—anything that seemed once to give meaning and direction to life) have been catastrophic. Fortunately, we have developed systems for coping with the problem. We have medications that address the organic disturbances, and therapies that address the emotional upheavals of chronic disease. Depression is an increasing cost for our society, but it is not ruinous. We have the psychological equivalents of sunscreens and baseball hats and shade.

But do we have the equivalent of an environmental movement, a system to contain the damage we are doing to the social ozone layer? That there are treatments should not cause us to ignore the problem that is treated. We need to be terrified by the statistics. What is to be done? Sometimes it seems that the rate of illness and the number of cures are in a sort of competition to see which can outstrip the other. Few of us want to, or can, give up modernity of thought any more than we want to give up modernity of material existence. But we must start doing small things now to lower the level of socio-emotional pollution. We must look for faith (in anything: God or the self or other people or politics or beauty or just about anything else) and structure. We must help the disenfranchised whose suffering undermines so much of the world's joy—for the sake both of those huddled masses and of the privileged people who lack profound motivation in their own lives. We must practice the business of love, and we must teach it too. We must ameliorate the circumstances that conduce to our terrifyingly high levels of stress. We must hold out against violence, and perhaps against its representations. This is not a sentimental proposal; it is as urgent as the cry to save the rain forest.

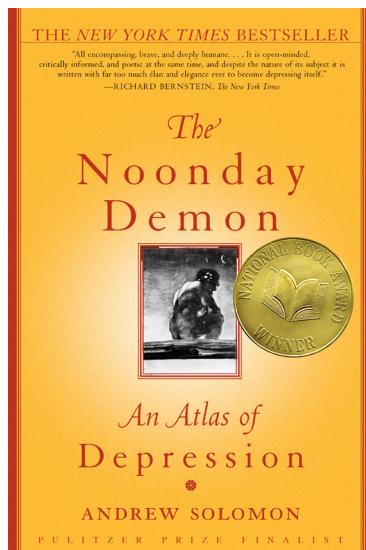
At some point, a point we have not quite reached but will, I think, reach soon, the level of damage will begin to be more terrible than the advances we buy with that damage. There will be no revolution, but there will be the advent, perhaps, of different kinds of schools, different models of family and community, different processes of information. If we are to continue on earth, we will have to do so. We will balance treating illness with changing the circumstances that cause it. We will look to prevention as much as to cure. In the maturity of the new millennium, we will, I hope, save this earth's rain forests, the ozone layer, the rivers and streams, the oceans; and we will also save, I hope, the minds and hearts of the people who live here. Then we will curb our escalating fear of the demons of the noon—our anxiety and depression.

The people of Cambodia live in the compass of immemorial tragedy. During the 1970s, the revolutionary Pol Pot established a Maoist dictatorship

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An Atlas of Depression

Andrew Solomon



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