

## Anatomy of melancholy

By Andrew Solomon  
January 12, 1998

*Depression afflicts millions of American each year, and many don't know where to turn when it strikes. The author recalls the greatest struggle of his life.*

I did not experience depression until I had pretty much solved my problems. I had come to terms with my mother's death three years earlier, was publishing my first novel, was getting along with my family, had emerged intact from a powerful two-year relationship, had bought a beautiful new house, was writing well. It was when life was finally in order that depression came slinking in and spoiled everything. I'd felt acutely that there was no excuse for it under the circumstances, despite perennial existential crises, the forgotten sorrows of a distant childhood, slight wrongs done to people now dead, the truth that I am not Tolstoy, the absence in this world of perfect love, and those impulses of greed and uncharitableness which lie too close to the heart — that sort of thing. But now, as I ran through this inventory, I believed that my depression was not only a rational state but also an incurable one. I kept redating the beginning of the depression: since my breakup with my girlfriend the past October, since my mother's death; since the beginning of her two-year illness; since puberty; since birth. Soon I couldn't remember what pleasurable moods had been like.

I was not surprised later when I came across research showing that the particular kind of depression I had undergone has a higher morbidity rate than heart disease or any cancer. According to a recent study by researchers at Harvard and the World Health Organization, only respiratory infections, diarrhea, and newborn infections cost more years of useful life than major depression. It is projected that by the year 2020 depression could claim more years than war and AIDS put together. And its incidence is rising fast. Between six and ten per cent of all Americans now living are battling some form of this illness; one study indicates that nearly fifty per cent have experienced at least one psychiatric disorder in their lifetime. Treatments are proliferating, but only twenty-eight per cent of all people who have a major depression seek help from a specialist; fifteen per cent of hospitalized patients succeed in killing themselves. Attempting to understand this strange malady, I plunged into intensive research shortly after my recovery. I started by attempting a coherent narrative of my own experience.

In June, 1994, I began to be constantly bored. My first novel had recently been published in England, and yet its favorable reception did little for me. I read the reviews indifferently and felt tired all the time. In July, back home in downtown New York, I found myself burdened by phone calls, social events, conversation. The subway proved intolerable. In August, I started to feel numb. I didn't care about work, family, or friends. My writing slowed, then stopped. My usually headstrong libido evaporated.

All this made me feel that I was losing my self. Scared, I tried to schedule pleasures. I went to parties and failed to have fun, saw friends and failed to connect; I bought things I had previously wanted and gained no satisfaction from them. I was overwhelmed by messages on my answering machine and ceased to return calls. When I drove at night, I constantly thought I was going to swerve into another car. Suddenly feeling I'd forgotten how to use the steering wheel, I would pull over in a sweat.

In September, I had agonizing kidney stones. After a brief hospitalization, I spent a vagabond week migrating from friend to friend. I would stay in the house all day; avoiding the street, and was careful never

to go far from the phone. When they came home, I would cry. Sleeping pills got me through the night, but morning began to seem increasingly difficult. From then on, the slippage was steady. I worked even less well, cancelled more plans. I began eating irregularly, seldom feeling hungry. A psychoanalyst I was seeing told me, as I sank lower, that avoiding medication was very courageous.

At about this time, night terrors began. My book was coming out in the United States, and a friend threw a party on October 11th. I was feeling too lacklustre to invite many people, was too tired to stand up much during the party, and sweated horribly all night. The event lives in my mind in ghostly outlines and washed-out colors. When I got home, terror seized me. I lay in bed, not sleeping and hugging my pillow for comfort. Two weeks later — the day before my thirty-first birthday — I left the house once, to buy groceries; petrified for no reason, I suddenly lost bowel control and soiled myself. I ran home, shaking, and went to bed, but I did not sleep, and could not get up the following day. I wanted to call people to cancel birthday plans, but I couldn't. I lay very still and thought about speaking, trying to figure out how. I moved my tongue, but there were no sounds. I had forgotten how to talk. Then I began to cry without tears. I was on my back. I wanted to turn over, but couldn't remember how to do that, either. I guessed that perhaps I'd had a stroke. At about three that afternoon, I managed to get up and go to the bathroom. I returned to bed shivering. Fortunately, my father, who lived uptown, called about then. "Cancel tonight," I said, struggling with the strange words. "What's wrong?" he kept asking, but I didn't know.

If you trip or slip, there is a moment, before your hand shoots out to break your fall, when you feel the earth rushing up at you and you cannot help yourself — a passing, fraction-of-a-second horror. I felt like that way hour after hour. Freud once described pleasure as the release of tension; I felt as though I had a physical need, of impossible urgency and discomfort, from which there was no release — as though I were constantly vomiting but had no mouth. My vision began to close. It was like trying to watch TV through terrible static, where you can't distinguish faces, where nothing has edges. The air, too, seemed thick and resistant, as though it were full of mushed-up bread.

My father came to my apartment with my brother, his fiancée, and a friend; fortunately, they had keys. I had had nothing to eat in almost two days, and they tried to give me smoked salmon. I ate a bite, then threw up all over myself. The next day, my father took me to my analyst's office. "I need medication," I said, diving deep for the words. "I'm sorry," she said, and she called a psychopharmacologist.

Dr. Alfred Wiener agreed to see me in an hour. He seems to have come out of some "Spellbound"-era shrink movie: he is in his late sixties, smokes cigars, has a European accent, and wears carpet slippers. He has elegant manners and a kindly smile. He asked me a string of specific questions. "Very classic indeed," he said calmly as I trotted out my atrocities. "Don't worry, we'll soon have you well." He wrote a prescription for Xanax, then handed me some Zoloft. "You'll come back tomorrow," he said. "The Zoloft will take some time. The Xanax will alleviate anxiety almost immediately. Don't worry, you have a very normal group of symptoms."

Once upon a time, depression was generally seen as a purely psychological disturbance. These days, people are likely to think of it as a tidy biological syndrome. In fact, it's hard to make sense of the distinction. Most depressive disorders are now thought to involve a mixture of reactive (so-called neurotic) factors and internal ("endogenous") factors; depression is a seldom a simple genetic disease or a simple response to external troubles. Resolving the biological and the psychological understanding of depression is as difficult as reconciling predestination and free will. If you remember the beginning of this paragraph well enough to make sense of the end of it, that is a chemical process; love, faith, and despair all have chemical manifestations, and chemistry can make you feel things. Treatments have to accommodate this binary structure — the interplay between vulnerability and external events.

Vulnerability need not be genetic. Ellen Frank, of the University of Pittsburgh, says, "Experiences in childhood can scar the brain and leave one vulnerable to depression." As with asthma, predisposition and environment conspire. Syndrome and symptom cause each other: loneliness is depressing, but depression also causes loneliness. "When patients recover from depression by means of psychotherapy," Frank says, "we see the same changes in, for example, sleep EEG as when they receive medication. A socially generated depression does not necessarily need psychosocial treatment, nor a biologically generated one a biological treatment.

The day after my birthday, I moved to my father's. I was hardly able to get up for the next week. The days were like this: I would wake up panicked. Xanax would relieve the panic if I took enough, but then I would collapse into thick, confusing, dream-heavy sleep. I wanted only to take enough to sleep forever. Whenever I woke up, I took more pills. Killing myself, like taking a shower, was too elaborate an agenda to entertain. All I wanted was for it to stop, but I could not say what "it" was. Words, with which I have always been intimate, seemed suddenly like complex metaphors, the use of which entailed much more energy than I had.

Little has been written about the fact that depression is ridiculous. I can remember lying frozen in bed, crying because I was too frightened to take a shower and at the same time knowing that showers are not scary. I ran through the individual steps in my mind: You sit up, turn and put your feet on the floor, stand, walk to the bathroom, open the bathroom door, go to the edge of the tub...I divided it into fourteen steps as onerous as the Stations of the Cross. I knew that for years I had taken a shower every day. Hoping that someone else could open the bathroom door, I would, with all the force in my body, sit up; turn and put my feet on the floor; and then feel so incapacitated and frightened that I would roll over and lie face down. I would cry again, weeping because the fact that I could not do it seemed so idiotic to me. At other times, I have enjoyed skydiving; it is easier to climb along a strut toward the tip of a plane's wing against an eight-mile-an-hour wind at five thousand feet than it was to get out of bed those days.

Evenings, I was able to rise. Most depression has a diurnal rhythm, improving over the course of the day and descending overnight. I could sit up for dinner with my father. I could speak by then. I tried to explain; my father implacably assure me that it would pass, and told me to eat. When I was defeated by the difficulty of getting a piece of lamb chop onto my fork, he would do it for me. He would say he remembered feeding me when I was a child, and would make me promise, jesting, to cut up his lamb chops when he was old and toothless. "I used to work twelve hours, go to four parties in an evening," I would say. He would assure me that I would be able to do it all again soon. He could just as well have told me that I would soon be able to build a helicopter of cookie dough and fly to Neptune, so clear was it to me that my real life was definitively over. After dinner, I would return some calls. It is embarrassing to admit to depression; to all but my closest friends I said that I'd developed an "obscure tropical virus."

When you are depressed, the past and the future are absorbed entirely by the present, as in the world of a three-year-old. You can neither remember feeling better nor imagine that you will feel better. Being upset, even profoundly upset, is a temporal experience, whereas depression is atemporal. Depression means that you have no point of view.

Since that first visit to Dr. Wiener, I have been playing the medicine game. I have been on, in various combination and doses, Zoloft, Xanax, Paxil, Navane, Valium, BuSpar, and Wellbutrin. This is a relatively short list. I do well with SSRIs ("selective serotonin-reuptake inhibitors," the growing family of drugs that includes Prozac, Zoloft, Paxil, and Luvox) and have good experiences with benzodiazepines (such as Xanax and Valium). I have never been on a tricyclic (which chiefly affects the neurotransmitters serotonin and norepinephrine) or on an MAO inhibitor (which influence serotonin, norepinephrine, and dopamine). I have never taken a mood stabilizer/anticonvulsant (such as lithium or Depakote), or had shock treatments

or psychosurgery. "Depression these days is curable," people told me. "You take antidepressants the way you take aspirin for a headache." Depression these days is treatable; you take antidepressants the way you take chemotherapy for cancer. They sometimes do miraculous things, but the treatment can be painful and difficult, and inconsistent in the results. Trying out different medications makes you feel like a dartboard. "If many remedies are prescribed for an illness" Chekhov wrote, "you may be certain that the illness has no cure."

Side effects arrive with the first pill and sometimes fade away with time. The real effects, at best, fade in with time. We cannot predict which medications will work for whom. Zoloft made me feel as though I'd had fifty-five cups of coffee. Paxil gave me diarrhea, but fortunately Xanax, though it made me exhausted, was also constipating. Paxil seemed better than Zoloft, and I soon adjusted to its making me feel as though I'd had eleven cups of coffee — which was definitely better than feeling as though I couldn't brush my own teeth. Only after a year did I discover Effexor, which made me appreciate that Paxil had been only partly effective for me. The side effects for which antidepressants are known (tension, irascibility, sexlessness, accompanied sometimes by headaches and indigestion), and so it was easy for me to conclude, two weeks after I began on Effexor, that I was probably having an adverse reaction to the drug. Dr. Wiener suggested that I might be having no reaction at all to the drug. He said, "Let's try doubling your dose. If you don't feel terrible, we'll keep going up. If you do, we'll come straight down." I'm now on triple the original dose.

The most constant side effect of the SSRIs is sexual dysfunction, and it is a serious side effect. It is damaging to your existing relationships and hell if you want to get into a new one. It doesn't matter how much when you're first recovering, when you have other things on your mind, but to get over unbearable pain at the cost of erotic pleasure is not a happy arrangement. Robert Boorstin, a senior adviser to the Secretary of the Treasury, is manic-depressive and is an outspoken advocate for the mentally ill, and he told me that during four years of Prozac he did not have an orgasm in intercourse — "which I considered a fairly major drawback."

Popular articles seem to suggest that the neurotransmitter serotonin is the key to happiness — that giving serotonin boosters to depressives is like giving iron to anemics, or insulin to diabetics. This is wrong. It appears that depressed people do not have low serotonin levels, which explains what would otherwise be a puzzling phenomenon. For three weeks, you're on Prozac, a drug that has an instant effect on your serotonin levels, and you feel as lousy as you did before. Then things improve. Why this delay? When the serotonin levels go up, the brain appears to reduce the number of receptors, or decreases the sensitivity of existing receptors, which suggests that the brain is seeking a balance between output and receptivity. Overall serotonin function is probably not very different from what it was before — and yet there are important subtle changes. Indeed, the most plausible explanation for the SSRIs is that they work indirectly. The human brain is stupefyingly plastic: cells respecialize and change; they "learn" new patterns of responding. When you raise serotonin levels, and cause some receptors to close up shop, other things happen elsewhere in the brain, and those other things are presumed to correct the imbalance that makes you feel bad.

Less is known about an herb called St. John's wort (*hypericum*), which has become popular among fans of alternative medicine. "These treatments can sound batty," Tom Wehr, at the National Institute of Mental Health, acknowledges. "But frankly, if you said to someone, 'I'd like to put wires in your head and run electricity through your brain to induce a seizure because I think that might help your depression,' and if that were not a well-established treatment, you might have a hard time getting it going."

But the precise mechanism of effect remains elusive even for the intensively studied mainstream pharmaceuticals. "It is in these subtle adaptations to nerve cells, these compensations meant to handle increased serotonin, that the actual healing process lies," Steve Hyman, the director of the N.I.M.H., says of the SSRIs, "just as a pearl results from the adaptation of an oyster to the irritation caused by a grain of

sand." Bill Porter, who until recently headed a research group in clinical psychopharmacology at the N.I.M.H., says, "Drugs that work by very different mechanisms produce antidepressant effects. It is possible for drugs with acutely different spectrums of biochemical activity to produce very similar long-term effects. It's like a weather system. Something changes wind speeds or humidity, and you get a completely different kind of weather a hundred miles away, but even the best meteorologists can't calculate all the variables." There is an ongoing quest for drugs that affect the brain with greater specificity. "The existing medications are just too indirect for us to fully understand how they are working," Potter says.

It was amazing" Sarah Gold, a young editor, said of her first months on Wellbutrin, a drug that affects the neurotransmitters dopamine and norepinephrine but not serotonin. "I could pick up the phone and make calls — my life was no longer governed by fear. It was like my first experience of sunlight." But she was one of those people for whom medication is effective for only a limited time. She got a lift again from Effexor, but that, too, wore off after a year or so. "One of my roommates told me I had a black aura and she couldn't stand to be in the house when I was up in my room," she recalled. Gold went through other combinations of medications, only to end up taking Wellbutrin again, along with Zoloft and small doses of Risperdal. Sometimes, especially when she is dancing — and she is a wonderful dancer — she reaches the unsustainable height of normal feelings. Having lived them, she says, "I have them to aspire to."

One woman who works in the mental health field and takes a panoply of SSRIs and mood stabilizers told me, "I have two children who also suffer from this disease, and I don't want them to think it's a reason for not having a good life. I get up every single day and make breakfast for my kids. Some days I can keep going, and some days I have to go back to bed afterward. I come into this office at some point every day. Sometimes I miss a few hours, but I've never missed a whole day from depression." We were in a cubicle at the hospital where she works. Her eyes were wide as she held forth. Her hands, folded in her lap, trembled from all the medicines she was on at the time. She soon had tears rolling down her face but went right on speaking. "One day last week, I woke up and it was really bad. I managed to get out of bed, to walk to the kitchen, counting every step, to open the refrigerator. And then all the breakfast things were near the back of the refrigerator, and I just couldn't reach that far. When my kids came in, I was just standing there, staring into the refrigerator."

Two separate but inseparable matters come into play here: depression and personality. Some people are disabled by levels of depression that others can handle, and some contrive to function despite serious symptoms. Antidepressants help those who help themselves. To take medications as part of the battle is to battle fiercely, and to refuse them is as ludicrous as entering a modern war on horseback. "It may be a sign of character, not of weakness, to know when you have to ask for help," says Martha Manning, whose book, "Undercurrents," chronicles her depression.

Two years before my first severe episode, a friend with an apparently terrific life, a regular old Richard Cory, committed suicide. It was no cry for help: he slit his wrists crosswise, and then went up to the roof of his building and jumped off. Suicide is a seductress, and those who have sailed near it stay alive only when they stop up their ears and flee from its Siren song. Even with chemical assistance, it's a fight against the wind and the tide to stay off the rocks. I don't believe that this friend's life had become more intolerable than Manning's, or mine. His life was not, however, strong enough in him to defy annihilation, and our lives, so far, are.

It is possible to keep yourself alive without modern technologies, but the price can be high. At a cocktail party in London, I saw an acquaintance and mentioned to her that I was writing this article. "I had terrible depression," she said. I asked her what she had done about it. "I didn't like the idea of medication," she said. "My problem was stress related. So I decided to eliminate all the stresses in my life." She counted off on her fingers. "I quit my job," she said. "I broke up with my boyfriend and never really looked for another

one. I gave up my roommate and moved to a smaller place. I stopped going to parties that run late. I dropped most of my friends. I gave up, pretty much, on makeup and clothes." I was looking at her in bewilderment. "It sounds bad, but I'm much less afraid than before," she went on, and she looked proud. "I'm in perfect health, really, and I did it without pills.'

Someone who was standing in our group grabbed her by the arm. "That's completely crazy. That's the craziest thing I've ever heard. You must be crazy to be doing that to your life," he said. Is it crazy to avoid the behaviors that make you crazy?

Inconveniently, I had a reading tour to do after that birthday, and antidepressants usually take about a month to kick in. Still, I was determined to get through it, because I believed that, meds or no meds, if I started giving up on things I would give up on everything and die. Before the first reading, in New York, I spent four hours taking a bath, and then a friend helped me take a cold shower, and then I went and read. I felt as though I had baby powder in my mouth, and I couldn't hear very well, and I kept thinking I might faint, but I did it. Then I went to bed for three days. Though I could keep the tension under control if I took enough Xanax, I still found mundane activities nearly impossible. I woke up every day in a panic, early, and needed a few hours to conquer my fear before getting out of bed. But I could force myself out in public for an hour or two in the evening.

I had thought I could not possibly go to California for a reading the next week. My father took me there: he got me on and off the plane and to the hotel. So drugged up that I was almost asleep, I could manage these changes, which would have been inconceivable a week earlier. I knew that the more I managed to do, the less I would want to die. During my first dinner in San Francisco, I suddenly felt my depression lift. I chose my own food. I had been spending days on end with my father, but I had no idea what had been happening in his life, except me; depression is a disease of self-obsession. We talked that night as though we were catching up after months apart. When I finally went to bed, I was almost ecstatic. I had some chocolates from my mini-bar, wrote a letter. I felt ready for the world.

The next morning, I felt just as bad as I had ever felt. My father helped me get out of bed and turned on the shower. He tried to get me to eat, but I was too frightened to chew. I managed to drink some milk. These days, a quarter of a milligram of Xanax put me to sleep for eight hours. That day, I took seven milligrams of Xanax and was still so tense I couldn't sit still. Dr. Wiener had by then started me on Navane, an antipsychotic drug that we hoped would allow me to take the Xanax less often. (I was then taking it every forty-five minutes or so, and in higher doses at bedtime.) The perpetual sensation of tension was completely exhausting, and the cumulative sedative effects of the Xanax and the Navane began to overwhelm me.

The third week of my tour, I lost the ability to remain upright for very long. I would walk for a few minutes and then I would have to lie down. I could no more control that need than I could the need to breathe. At my readings, I would cling to the podium. I would start skipping paragraphs to get through. When I was done, I would sit in a chair and hold on to the seat. As soon as I could leave the room, on any excuse, I would lie down again, often on a bathroom floor. I remember going for a walk with a friend outside Berkeley, hoping that nature might do me good. I had not left my bed for the previous fifty-eight hours; because I'd reduced my Xanax substantially, I was beginning to experience high anxiety again. We got out of my friend's car and walked for almost fifteen minutes, and then I couldn't go any farther. I lay down, fully dressed in nice clothes, in the mud. "Please let me stay here," I said, and I didn't care about standing up ever again. For an hour I lay in that mud, feeling the water seep through, and then my friend pretty much carried me back to the car. Those same nerves that had been scraped raw now seemed to be wrapped in lead. During my reading tour, I took a lot of cold showers, which got me through the necessary hours. As soon as I could drag myself out of bed, I'd do exercises or, if I could manage it, I'd go to a gym. I felt as

though the exercise filtered the depression out of my blood, helped me to get cleaner. "Most people feel that," Norman Rosenthal, at the N.I.M.H., says, "It's very strong anecdotally." In the end, I canceled only one reading. Between November 1st and December 15th, I visited eleven cities. Doing those readings was the most difficult endeavor of my life. My publisher's publicist, who had organized my reading tour, came with me for more than half of it, cheering me through; my father came with me the rest of the time, and when we were apart he called me every few hours. I was never alone for long. The knowledge that I was loved was not in itself a cure, but without it I would not have been able to complete the tour. I would have found a place to lie down in the woods and I would have stayed there until I froze and died. Recovery depends enormously on support. The depressives I've met who have done the best were cushioned with love. Nothing taught me more about the love of my father and my friends than my own depression.

After Thanksgiving, I felt better earlier in the day, and for longer, and more often. My great-aunt Beatrice is remarkable because she's ninety-seven and lives alone; gets up and gets dressed every day, will walk as much as sixteen blocks. Emerging from a depression, you get up and get dressed every day, but this triumph no more implies that you're leading your regular life than Aunt Bea's ability to dress up for lunch implies that she is the all-night dancer she was at seventeen.

The terror lifted in mid-December. Whether that was because the Paxil had really kicked in or because the reading tour was over, I do not know. The poet Jane Kenyon, who suffered from devastating depressions, wrote, "With the wonder and bitterness of someone pardoned for a crime she did not commit I come back to marriage and friends...to my desk, books, and chair." So in mid-December I walked into a Christmas party on the Upper West Side and I had an O.K. time. I took hope not from the O.K. time I was having but from the fact that I was having it. I had lost eighteen pounds, and now I was putting on weight. My father and my friends congratulated me on my progress. I thanked them. Privately, however, I was convinced that only the worst symptoms were gone. I was back to about where I had been in September, except that now I understood how bad it could get. I was determined never again to go through such a thing.

Accuracy of perception is not an evolutionary priority. Too optimistic a world view results in foolish risk-taking, but moderate optimism gives you a strong selective advantage. "Normal human thought and perception," Shelley Taylor writes in her 199 book, "Positive Illusions," "is marked not by accuracy but by positive self-enhancing illusions about the self, the world, and the future. Moreover...these illusions are not merely characteristic of human thought; they appear actually to be adaptive." As she notes, "The mildly depressed appear to have more accurate views of themselves, the world, and the future than normal people. [They] clearly lack the illusions that in normal people promote mental health and buffer them against setbacks."

The phrase of depressive realism that I entered after Christmas is the dangerous time. During the worst of my depression, when I could hardly eat, I could not have done myself real harm. In this emerging period, I was feeling well enough for suicide. I could push myself to do pretty much all of what I had always been able to do, but I was unable to experience pleasure. Now I had the energy to wonder why I was pushing myself, and I could find no good reasons. One February evening, an acquaintance persuaded me to attend a party. I went to prove my own gaiety, and for several hours kept up every appearance of sharing in the fun that others were having. When I came home, I felt a return of panic, and a sadness that felt almost menacing. In the bathroom, I threw up repeatedly, as though my acute understanding of my own loneliness were a toxin; and when I tried to catch my breath I inhaled my own bile. I lay on the bathroom floor for about twenty minutes, and then I crawled out and lay down on my bed. It was clear to me that I was going crazy again, and the awareness tired me further; but I knew that it was bad to let the craziness run wild. I needed to hear another voice, which could penetrate my fearful isolation. I didn't want to call my father, because I knew he would worry. I picked up the phone and, shaking, dialed one of my oldest friends. It was about three-thirty in the morning. "Hello?" she said.

"Hi," I said, and paused.

"Has something happened?" she asked.

It was immediately clear that I could not explain. "I've got to go," I said, and hung up.

Later, I climbed laboriously up to my roof and wrapped myself around a pipe. As the sun came up I realized that you live in New York there was no point in attempting suicide from the top of a six-story building. Drenched with sweat and developing what would soon become a raging fever, I returned to my bedroom. I knew that the voice of reason was the voice of reason; that depression was ludicrous; and that it would be sad for my father to have worked so hard at saving me and not have succeeded. I had promised to cut up lamb chops for him someday; and that, finally, led me downstairs. When I called my old friend, the next day, to apologize, she demanded an explanation. I could not explain. She told me I had gone too far, and did not speak to me for two years.

It is hard to talk to friends about depression during depression, so there's solace to be found in strangers. In recent years, support groups have proliferated. Mood Disorders Support Group, Inc. (MDSG), is the largest such organization in the United States, with more than a hundred support-group meetings annually. I never went to one when I was ill, but in researching this piece I went to MDSG/New York meeting at Beth Israel medical Center for eight weeks at seven-thirty on Friday night, which is when depressed people are not having dates. Members pay four dollars, get a sticky label bearing their first names only (to further protect privacy, I've changed those names), and go into a room with about a dozen others and a facilitator.

This crowd looks as run-down as it felt, especially in the hospital light. At one meeting, Jaime talked first. Forced to resign from his job with "a government agency" after missing too many days, Jaime had been on disability leave for three years. People wouldn't understand. He pretended to have his old job — didn't answer the phone during the day. "If I couldn't keep up appearances," he said, "I'd kill myself." Maggie, who was too depressed to talk, pulled her knees up under her chin.

John, who came often and spoke seldom, had been stroking his coat all evening. At forty, he had never had a full-time job. Two weeks ago, he'd announced that he was about to take one, be like a normal person. We'd told him to go for it, but tonight he said that it was just too frightening. Maggie asked whether his moods improved on vacation. "I've never had a vacation," he said. He shuffled his feet. "I'm sorry. I mean, I guess I've never really had anything to take a vacation from."

Anne said, "I hear people talking about cycling, and I feel really jealous. For me, it's never been like that. I was a morbid, unhappy, anxious child. What's the point?" She was on Nardil, and had found that Catapres-TTS in microdoses saved her from heavy sweating, a side effect. She had originally been on lithium but had gained about fifteen pounds a month, and stopped. Someone thought she should try Depakote, which can be helpful with Nardil, even though the Physicians' Desk Reference discourages the combination. No one could tell her "the point."

A longtime MDSG member, Polly, asked the group, "Do you have friends outside?" Only one other person and I said that we did. Polly said, "I try to make new friends, but I know how it works. I took Prozac, and it worked for a year, and then it stopped. I think I did more that year, but I lost it." She was sad and sweet-natured and intelligent — clearly a lovely person, as someone told her encouragingly. "How do you meet people, besides here?" she wanted to know. Before I could answer, she added, "And, once you've met them, what do you talk about?"

And then it was Howie's turn. He looked around, but you could tell that he wasn't seeing any of us. His wife had brought him here, hoping it would help, and she was waiting outside. "I feel," he said, in a flat voice sounding like a slowed-down old record-player, "as though I died a few weeks ago but my body hasn't found out yet."

The basic feeling at the support group — I have my mind today, do you have yours? — was as familiar as a native language, and, almost in spite of myself, I began to relax into it. There is so much that cannot be said during depression, that can be intuited only by others who know about it. "If I were on crutches, they wouldn't ask me to dance," one woman said about her family's relentless efforts to get her out. We all held each other up with what we said.

Talk is not cheap, medication is not cheap, and often even the two together are not enough. Only one person at MDSG had tried electroconvulsive therapy, or ECT, and the others were mostly too upset by the thought of it even to discuss it. Most people I met elsewhere who had done ECT, however, were enthusiasts. "I didn't want to die because I hated myself — I wanted to die because I loved myself enough to want this pain to end," Martha Manning says of the day she found the address of a gun shop. "I listened to my daughter singing in the shower and knew that if I killed myself I would stop that song. The next day, I checked myself in for ECT." Antidepressants are effective about seventy per cent of the time. Among people who are severely depressed, ECT seems to work about seventy-five per cent of the time or more. It is used as a recourse for people who have not had success with medications. Patients normally get six to twelve treatments over about a month. ECT often works much more rapidly than medication; its effects can be sustained with meds.

After some routine exams and blood work, a cardiogram, often a chest X-ray for older patients, and some neuroanesthesia-related tests in a hospital, a patient judged suitable for ECT signs elaborate consent forms. The patient is taken to the ECT suite, usually in the morning. After he has been hooked up to monitors, nurses put an electrolyte jelly on his temples, and then electrodes are attached. A short-acting general anesthetic, which puts the patient out completely for about ten minutes, is administered, along with a muscle relaxant to prevent physical spasms. (The only movement during treatment is a slight wiggling of the fingers and toes.) The patient is connected to EEG and EKG monitors. The electrical stimulus usually lasts no more than several seconds. It causes a seizure in the brain which usually lasts about fifty seconds — long enough to change brain chemistry, not long enough to create trouble. Why ECT works is unclear, but it seems to have a strong enhancing effect on the major neurotransmitters. Within ten minutes, the patient wakes up in the recovery room. Once he's awake, he's give breakfast and taken to his room — "feeling hung over, knowing it's going to be a Tylenol day," Manning says. The session lasts about thirty minutes, from start to finish; afterward, there is real disorientation for about twenty minutes, and some minor memory loss, which is usually recovered during the day. In fact, the only lasting memory loss is usually of the ECT period itself; patients are often blurry about the whole treatment period.

ECT is considered easier and safer — especially in elderly patients — than antidepressants, and it is now sometimes done on an outpatient basis. But ECT is still the most stigma-loaded of the popular treatments. "You do feel like Frankenstein on the table there," Manning says. "And people don't want to hear about it. Nobody brings you casseroles when you're in for ECT. It's very isolating." But it can be miraculously effective. "Before, I was aware of every swallow of water, that it was just too much work," she goes on. "Afterward, I thought, Do regular people feel this way all the time? It's like you've been not in on a great joke for the whole of your life." The effects start quickly. "Vegetative symptoms got better fast, although mood took longer, then my body felt lighter; then I really wanted a Big Mac," Manning says. "I felt like I'd been hit by a truck, but that was, comparatively speaking, not so bad. And researchers have begun imagining a possible new-generation device that would accomplish the effects of ECT without the trauma. Robert Post, chief of biological psychiatry at the N.I.M.H., has been working on repeated transcranial

magnetic stimulation, or T.T.M.S., which uses fluxes in magnetic fields to stimulate the brain without producing seizures. While electric current has to be turned up quite high to get through the scalp and the skull, magnetic fluxes travel through easily. Since R.T.M.S. avoids the brain seizure, it appears that there are no memory-loss side effects, and that alone makes it an attractive alternative.

Like all illnesses, depression is a great equalizer, but I met no one who seemed a less likely candidate for it than Ted Winstead — thirty, a Northwestern graduate, soft-spoken, polite, good-natured, and good-looking. "So you want inside my head?" he wrote in a notebook once. "Welcome...Not exactly what you expected? It's not what I expected either." Six months after he graduated from college, his first depression hit him. In the seven years since, he has been hospitalized more than thirty times. He puts his hands up and presses hard on his forehead and the back of his head, the just above his ears. "It's like my head's in a vise, squeezing together. All I can do is obsess on the negative, and the pain is petrifying and physical. It's like I'm in a locked room and I can't get out and the walls are closing in and in and I'm being compressed and destroyed under the pressure."

His first episode came on abruptly: "I'd been to a movie, and on the way home I realized I might drive into a tree. I felt a weight pushing my foot down, someone pulling my hands around. I know I couldn't drive home because there were too many trees, so I headed for the hospital." In the following years, Winstead went through every medication in the book and got nowhere. In the hospital, he tried to strangle himself. He finally had ECT, which made him briefly manic. "I attacked another patient and had to go into the quiet room for a while," he recalls. For the last five years, Winstead has been getting booster ECT whenever his depression hits — usually about every six weeks. When we met, he was also taking lithium, Wellbutrin, Adapin, Cytomel, and Synthroid. "ECT is totally safe and I would recommend it, but they're putting electricity into your head, and that's scary," he says. "I hate the memory problems. It gives me a headache. I keep journals so I can remember what happened. Otherwise, I'd never know."

Winstead was unable to work from late 1994 to the middle of 1996, but before this he researched and wrote part of a history book. "The people I've worked with and for have been really supportive, and have made allowances," he says. "Everyone was great: parents, friends, doctors. The attention has gotten me through."

First, you might try talking, then you might try pills, then ECT; at some point, you try the experimental odds and ends; then you try surgery. In the late nineteen-forties and fifties, patients diagnosed with severe neuropsychiatric disorders were prime candidates for having their prefrontal lobes severed. In the heyday of lobotomies, about five thousand were performed annually in the United States, causing between two hundred and fifty and five hundred deaths a year. Psychosurgery lies under this shadow. When I first met Winstead, he just got back from having a cingulotomy. In that procedure, the scalp is frozen locally and the surgeon drills a small hole in the front of the skull. He then puts an electrode directly into the brain to destroy areas of tissue, usually measuring about eight by eighteen millimeters. The leading place for this surgery is Massachusetts General Hospital, and that is where Winstead was operated on by the neurosurgeon Rees Cosgrove. "About sixty to seventy per cent of patients have at least some response," Cosgrove told me. "Thirty per cent show marked improvement. This procedure is for people whose illness has failed to respond to everything thrown at it, so those are encouraging statistics." It is difficult to get into the cingulotomy protocol; Mass. General, the most active center, does only fifteen or twenty of the procedures a year. The surgery usually has a delayed effect, often showing benefits only several weeks, or even months, later. Like ECT, such surgery probably causes disruption of brain function, but how, exactly, this trauma causes a change for the better is not clear. "We don't understand the pathophysiology," Cosgrove says. "But the effect on other parts of the brain is indirect, whatever it is."

"I have real hopes for the cingulotomy," Winstead told me when we met. He was having a pretty good day, laughing from time to time in gentle self-deprecation. He pushed back his red hair to show me the scar near

the front of his scalp, centered over his eyes. "I heard the drill going into my skull, like when you're at the dentist's office. I thought, This is creepy, and I asked to be put further under. So they did before they started burning my brain. I hope it works. If it doesn't, I have a plan for how to end it all, because I just can't keep going like this."

The spring of 1995, I stopped taking drugs cold turkey. I knew that this was dumb, but I wanted desperately to find out again who I "really" was. At first, all I was conscious of was the awful withdrawal symptoms from the Xanax. I couldn't sleep for four days, and my eyes and stomach hurt, and my sense of balance was off. Unrelenting nightmares seemed to penetrate my wakefulness, and I kept sitting up abruptly with my heart pounding. Dr. Wiener had told me that when I was ready to go off the drugs I should do it gradually, but I was afraid that if I went slowly I'd never really make it.

It was a bad mistake. If you stimulate seizures in an animal every day, the seizures become automatic: the animal will go on having them even if you withdraw the stimulation. Similarly, a brain that has gone into depression several times may return to depression. Brain-imaging scans have indicated that depression changes both the structure and the biochemistry of the brain. Medication-responsive patients may cease to respond over the long term if they cycle on and off the medications; with each episode, there is a ten percent increase in the risk that the depression will become chronic. "It's analogous to a primary cancer that's very drug-responsive but once it transforms itself and metastasizes is less responsive," Bob Post explains. "People worry about side effects from staying on medication for a lifetime, but these effects seem in substantial compared with the lethality of undertreated depression. It would be like asking someone to go off his digitalis, seeing if he has another heart attack, and re-starting medication when his heart is too flabby to recuperate."

At this point, I entered what is commonly called "agitated depression." I developed in rapid succession all the typical symptoms — hatred, anguish, guilt, self-loathing. I stopped speaking to at least six people. I took to slamming down the phone when someone said something I didn't like. I criticized everyone. It was hard to sleep, because my mind was racing with tiny injustices from my past: irritability kept me awake every night, and the lack of sleep made me more irritable still.

It is not unusual for really depressed people to have no deep sleep at all. Does one sleep oddly just because of depression or does one sink into depression in part because of sleeping oddly? Many people occasionally wake up too early with a sensation of ominous dread; that momentary fearful, despairing state may be the closest that healthy people come to depression. "By not letting someone go to sleep, you extend the diurnal improvement," Tom Wehr, who heads sleep research at the N.I.M.H., says. "Though depressed people seek the oblivion of sleep, it is in sleep that the depression is maintained and intensified." There has been limited research in this area (because it is non-patentable and hence unprofitable), but studies suggest that manipulating the timing of sleep can be a way to treat depression.

In my agitated state, with my sleep disrupted and my time in the daylight altogether irregular, I found that I couldn't really concentrate on anything. I started doing my laundry every night, to keep busy. When I got a mosquito bite, I scratched it until it bled, then picked off the scab; I bit my nails so far down that my fingers were always bleeding. I had open wounds and scratches everywhere, though I never actually cut myself with a knife. Yet, being free of the vegetative symptoms of my breakdown, I did not imagine that I might still be depressed.

In retrospect, this seems odd, since I had developed the ultimate hallmark of depression, which is an obsession with suicide. I had had more than enough of life, and wanted to figure out how to end it with the least damage to those who loved me. I decided that a fatal disease would be a valid excuse for suicide. I knew that it would be devastating for my family and sad for my friends, but felt that they would

understand, whereas I knew that if I did something while I was "healthy" they would not. I couldn't figure out how to give myself cancer or M.S., but I knew just how to get AIDS. The particular behavior I chose was related to my own neuroses, but the decision to behave in so systematic a way, with such a sustained hunger to die, was typical of agitated depression. After my first episode of unsafe sex, I had a burst of fear and called a good friend and told him what I had done. He talked me through it, and I went to bed. When I woke up in the morning, I felt much as I had felt on the first day of college or summer camp or a new job. This was to be the next phase of my life. There was something I genuinely wanted, and the end was at hand. Over the next three months, I took ever more direct risks. I was sorry to have no pleasure from encounters some of which I knew I would have once enjoyed. Casual with life, I also walked through Central Park at night, crossed highways against the traffic, and drank myself into unconsciousness.

In early October of 1995, after a bout of unpleasant unsafe sex, I realized that I might be infecting others. Dismayed at how numb I had become to their vulnerability, I again withdrew into physical isolation. I'd had four months to get infected; I had a total of about eighteen encounters; and knowing I would die had, ironically, diminished the urgency of my wish to die. I put that period of my life behind me, became gentler again. On my thirty-second birthday, I looked at the many friends who had come to celebrate it, and was able to smile, knowing I would never have a birthday again. The celebrations were tiring; the gifts I left in their wrappings.

When major depression with high-level anxiety — in the argot of the clinicians — started coming around the second time, I recognized it. I didn't want to go back on meds, and tried to ride it out. I knew about three days ahead of the total crash that I was going all the way down. I started taking Paxil. I called Dr. Wiener. I warned my father. I addressed the practicalities: losing your mind, like losing your keys, is a hassle. Out of the terror I heard my voice holding on tight when friends called. "I'll have to cancel Wednesday," I said. "I'm afraid of lamb chops again." The symptoms came fast. In about a month, I lost a fifth of my body weight — some thirty pounds. I had just moved into the new house I'd been restoring for five years. I stayed there three nights, then had to move in with my father again. There was a lot of talk about hospitalization, which terrified me further. I believed that once I went into Payne Whitney I'd never return, and I didn't want to die slowly in a padded room.

Dr. Wiener started me on Effexor, and also added BuSpar, an anti-anxiety medication. Anxiety is not paranoia; people with anxiety disorders assess their own position in the world much as people without them do. What changes in anxiety is how one feels about that assessment. It's possible to distinguish between anxiety and depression, but, according to Jim Ballenger, a leading expert on anxiety, "they're fraternal twins." George Brown, of the University of London, has said succinctly, "Depression is usually a response to a current loss. Anxiety is a response to a threat of future loss." About half the patients with anxiety or panic disorders develop major depression within five years. The diseases appear to have overlapping genotypes.

Depression exacerbated by anxiety has a much higher suicide rate than depression alone, and is much harder to recover from. "If you're having panic every day," Ballenger says, "it's gonna bring Hannibal to his knees". "One in ten Americans has a panic attack of some kind every year. Because the locus coeruleus in the brain, which controls much of norepinephrine production, has a strong influence on lower-bowel function, almost half of panic-disorder patients have irritable-bowel symptoms as well. "Two out of three times, life events are implicated in the onset of panic disorder, and it's always a loss of personal security," Ballenger says.

Xanax is, in my view, a lifesaver. There is popular prejudice against the benzodiazepines, partly because they have often been given without proper patient evaluation. They can be addictive, so withdrawing from them abruptly can be an enormous problem; some can affect short-term memory. Despite these drawbacks,

the rapid relief they provide is extraordinary, and for people who are not inclined toward abuse they save lives. "Nonsense, nonsense," Dr. Wiener said when I dithered about Xanax. "Take it as I tell you and we'll deal with these problems when your symptoms have lifted."

When I have heading for my second breakdown, everyone, including Dr. Wiener, told me firmly that I should find a new shrink for talking therapy. Finding a new shrink when you are feeling up and communicative is burdensome, but doing it when you are in the throes of a major depression is beyond the pale. Nonetheless, I was lucky that I could afford to follow the advice. Most managed-care companies are keen on medication, which is, comparatively speaking, cheap, and are not very keen on talking therapies or hospitalizations.

"I spend more and more time on the phone with managed-care companies trying to justify patients' need to stay in the hospital," Sylvia Simpson, a physician at Johns Hopkins, says. "Frequently, when a patient is still very, very ill and unable to function — if he's not acutely suicidal that day, authorization for coverage of further in-patient stay is denied." Depressed people are usually in no condition to argue their own cases with insurers — and depression is one expensive illness. My first breakdown cost me five months of work, five thousand dollars' worth of visits to the psychopharmacologist, twelve thousand dollars of talking therapy, thirty five hundred dollars for medications. My guess is that I've used up about seventy thousand dollars on this disease so far.

The result of treatment dictated by cost-economizing managed-care companies is that more and more people are taking medication with little context. "Medicines treat depression," said the therapist I now see. "I treat depressives." More people are treated for depression now because it is more acceptable and medicines are available, and, over all, public health may be going up in consequence, but the idea that the option of psychotherapy can go on a back burner is "lunacy," according to Kay Jamison, the author of "An Unquiet Mind" and an authority on manic depression; she believes that she would be dead without psychotherapy. Therapy helps someone to make sense of the new self attained on meds and accept the loss of self that occurs during a breakdown. Antidepressants are not amnesiac drugs. If real experience has triggered your descent into depression, you have a human yen to understand it even when you have overcome acute symptoms. Dr. Robert Klitzman, of Columbia University, says, "Pills should not obviate insight; they should enable insight."

The week of my H.I.V. test, I was taking between twelve and eighteen milligrams of Xanax every day, so that I could sleep most of the time. On Thursday of that week, I woke up at four in the afternoon and checked my messages. The nurse from my doctor's office: "Your cholesterol is down, cardiogram is normal, and your H.I.V. test turned out fine." I had to call her the next morning to make sure that that hadn't been another Xanax dream.

I knew then that I wanted to live, and I was grateful for the news. But I went right on feeling terrible for two more months. Gritting my teeth against what is quaintly termed "suicidal ideation," I decided I was sufficiently well to go to Turkey to do research, but I went feeling infinitely burdened by the work I had there. The, in the perfect Turkish sunshine, the depression finally evaporated. That was the last I heard from it.

In a poem entitled "Back" Jane Kenyon writes, "Suddenly I fall into my life again, like a vole picked up by a storm then dropped three valleys and two mountains away from home. I can find my way back. I know I will recognize the store where I used to buy milk and gas. I remember the house and barn, the rake, the blue cups and plates, the Russian novels I loved so much, and the black silk nightgown that he once thrust into the tow of my Christmas stocking." And so it was for me: everything seemed strange, then became abruptly familiar, and I realized that the deep melancholy that had started when my mother got ill, had worsened

when she died, had build beyond grief into despair, and had disabled me was not disabling me anymore. I was still sad about he sad things, but I was myself again.

"Pharmaceutical wonders are at work," Kenyon writes in another poem, "but I believe only in this moment of well-being. Unholy ghost, you are certain to come again...and turn me into someone who can't take the trouble to speak; someone who can't sleep, or who does nothing but sleep; can't read, or call for an appointment for help. There is nothing I can do against your coming. " You are never the same once you have acquired breakdown knowledge. We are told to learn self-reliance, but it's tricky if you have no self on which to rely. Friends, doctors, and my father have helped me, and some chemistry has wrought a readjustment, and I feel O.K. for the moment, but the recurring nightmares are no longer about the things that will happen to me, from outside, but about the thing that happen in me. What if tomorrow I wake up as a manure beetle? Every morning starts with a check for cancers, a momentary anxiety about which nightmares might be true. It's as if my self, like the friend that I called late that night in 1995, had said, "Don't push it, don't count on me for much, I have problems of my own to take care of."

I hope not to have to go off my medications. I'm not addicted, because addicts are prone to symptoms caused by the removal of the drug, but I am dependent, because without the drug I would probably develop symptoms. I have some side effects, which may eventually become intolerable. I get terrible hives, which seem to be getting worse, and have to apply cortisone creams and ointments every six hours; I also have to take antihistamines several times a day and am therefore perpetually groggy. The way that SSRIs undermine your capacity for sustained sexual fantasy means that you can only climax when you're in the presence of someone to whom you're strongly attracted. I gain weight more easily that I used to. I sweat more. My memory, which was never good, is impaired: I frequently forget in the middle of a sentence what I am saying. I get headaches often, and occasional muscular cramps. It's not ideal, but it seems to have put a real wall between me and depression.

Slowly, I catch up. When two friends died recently, both in freak accidents, I felt sad, but to feel just grief was almost (this sounds terrible, but it is true) a kind of joy. "Will you become depressed doing your depression piece?" everyone has asked me. I have not. I have felt blue sometimes, and on some days I have chosen not to work on this difficult subject, but I feel far away from the reality described here, and were it not for notes I wrote when I was ill, I would have been unable to describe it fully.

Once you stop being depressed, you can notice in isolation those sensations which were previously blurred. What is it like to feel tired? To be frightened by something frightening? To be hungry, annoyed, hung over, bored? You learn them all over again. And what is it like to hope? Hope is the belief in a future without loss; it defends against its oblique cousin dread - the dread of recurrence. "I am overcome by ordinary contentment," Jane Kenyon has written. "What hurt me so terribly all my life until this moment? How I love the small, swiftly beating heart of the bird singing in the great maples; its bright unequivocal eye."

I wonder constantly whether these experiences have served any purpose. Is depression a mood state that nature or God willed us to have for some reason? Is it useful? "Organisms have a selective advantage if they have different states that give them the upper hand in particular circumstances," Randolph Nesse, of the University of Michigan, says. Is depression one of those states? Is it merely a derangement, like cancer, or can it be defensive, like nausea? Some people argue that it's best seen as a mixture of maladaptive or pathological withdrawal and so-called conversation withdrawal, which may be useful in some circumstances: hibernating, avoiding danger, saving energy.

This is an idea that has been elaborated in Emmy Gut's book "Productive and Unproductive Depression," which proposes that the long pause brought about by a depression causes people to change their lives in useful ways, especially after a loss. It can draw people away from unproductive pursuits and relationships.

For her, the question is which depressions should be normalized and which should be left untouched. There are probably people who don't have enough anxiety and sadness to keep them out of trouble, and it seems likely that they don't do well. Leprosy is a disease in which you do not feel enough physical pain: lepers become deformed and then die because crucial warnings do not get through to them. I suspect that the most important function of grief is in the formation of attachment. If you do not fear loss, you cannot love intensely. Homesickness showed how much I loved my parents; losing my mother not only depressed me but also intensified my love for her and for people still alive.

We now identify as pathology many things that were previously accepted as personality. The supermodel has damaged our images of ourselves by setting unrealistic expectations, and the psychological supermodel is even more dangerous than the physical one. People are constantly examining their own minds and rejecting their own moods. The use of antidepressants is going up as people seek to normalize what used to be deemed normal. Thirty million people worldwide have been on Prozac, and millions more on the other SSRIs—not to mention a substantial number on non-SSRI antidepressants. SSRIs are now prescribed for homesickness, eating disorders, PMS, household pets who scratch too much, chronic joint pain, and ordinary grief. They are prescribed not only by psychiatrists but also by G.P.s and gynecologists, someone I met had been put on Prozac by his podiatrist. When TWA Flight 800 went down, families waiting for news of their loved ones were offered drugs with the same palliative expression with which they might have been offered extra pillows or blankets.

Is the grand-scale social experiment of eliminating a state from the human mood spectrum dangerous? George Brown says, "Social systems can play a powerful role in generating both psychiatric and physical disorder. For example, in the U.K., the rate of major depression among single mothers is double that of women raising children with a partner. I have nothing against Prozac, but there needs to be a recognition that what may well be a rising tide of depression is related to the fact that basic social and psychological needs are not being met." More generally, modernity has wrought changes to which we are not yet adequately adapted; depression appears to increase even more rapidly in technological cultures than in others. "The investment to achieve modern life goals, the number of opportunities we have, is probably beyond the range our mind was designed to handle," Randolph Nesse says.

The question of what functions depression serves is not the same as the question of what functions antidepressants are coming to serve. Are they restoring the normal self or are they changing the self? It's said that everyone has the virtues of his faults. If one eliminates the faults, do the virtues go as well? "We are only at the dawn of pharmacological exuberance," Nesse says. "New medications that are being developed may likely make it quick, easy, cheap, and safe to block many unwanted emotions. We should be there within the next generation. And I predict we'll go for it, because if people can make themselves feel better they usually do. I could imagine the world in a few decades being a pharmacological utopia, controlling viciousness, fear, and pain. I can equally imagine people so mellowed out that they neglected all their social and personal responsibilities." Robert Klitzman says, "Not since Copernicus have we faced so dramatic a transformation. In centuries to come, there may be new societies that look back at us as creatures that were slaves to and crippled by uncontrolled emotions."

The survivors stay on pills, waiting. "I'm reconciled to a lifetime of medicine," Martha Manning says, suddenly fervent. "And I'm thankful. Sometimes I look at those pills and wonder, Is this all that stands between Hell and me? You don't defeat depression, you learn to manage it. When you come so close to taking your life, if you get it back you'd better claim it."

Striving to claim it, we hold on to the idea of productive depression, something not only normal but vital. "I lost a great innocence when I understood that I and my mind were not going to be on good terms for the rest of my life," Kay Jamison says, with a shrug. "I can't tell you how tired I am of character-building

experiences. But I treasure this part of me. Whoever loves me loves me with this in it."

"My wife has never seen me severely depressed," Robert Boorstin says. "I've walked her through it, and other people have talked to her about what it's like. I've done my best to prepare her, because doubtless I'll have another depression. Sometime in the next forty years, I'm going to be crawling across the room again. And it scares me a lot, because the thought of being without your mind is a lot scarier than being without anything else. I mean, if somebody said to me, "I'll take away your mental illness if you cut me off your leg," I don't know whether I'd make the exchange. And yet, before I was ill, I was intolerant beyond comparison, arrogant beyond belief, with no understanding of frailties. I'm a better person as a result of having been through all this, but I would not recommend the experience.'

"If I had it to do over, I wouldn't do it this way," Ted Winstead said the last time I saw him. I had spent the afternoon with him and his parents and his psychiatrist, and we were discussing the grim reality: that his first cingulotomy still hadn't worked, that he'd been hospitalized three times in the months after it, and that he might have to have a second surgery. In his gently courageous way, he was making plans to be up and running in six months. "I have this experience with my doctor that's been very good," he said gamely. "There really are upsides to depression. It's just hard to see them when you're in it." On the happy day when we lose depression, we will lose a great deal with it. As the sun seems brighter and clearer, when it comes on a rare day of English summer after ten months of gray skies than it can ever seem in the tropics, so recent happiness feels enormous and embracing and beyond anything I have ever imagined. In the course of my depression, I reached a strange point at which I could not see the line between my own tendency to theatricality and the reality of my illness. The line is still not clear, but there is someone or something here writing these words, a unionist me that held on until the rebel chemicals had been brought back- into line. Some ropy fibre holds fast even when most of the self has been stripped from it, we know what chemistry is and how deep it runs, and yet anyone who lives through this knows that the shifting self reaches beyond serotonin and dopamine. I'm more confident, in some odd way, than I've ever imagined being. I do not think that I will ever again try to kill myself, nor do I think that I would give my life up readily if my plane crashed in a desert. I would struggle tooth and nail to survive. The opposite of depression is not happiness but vitality, and *my life*, as I write this, is vital, even when it's sad. I may wake up sometime next year without my mind again. But I knoll what is left of me when my mind is gone and my body is going. I was not brought up religious, and think that when you die you're dead, yet I have also discovered what I guess I would have to call a soul — something I had never imagined until one day, two and a half years ago, when Hell came to pay me a surprise visit. It's a precious discovery. This week, on a chilly night when I was overtired, I felt a momentary flash of hopelessness, and wondered, as I so often do, whether I was slipping, for a petrifying instant, a lightning-quick flash, I wanted a car to run me over, and I had to clench my teeth to stay on the sidewalk until the light turned green. Nevertheless, I cannot find it in me to regret entirely the course my life took.