Preface

> Anybody know what's the lethal dose of lorazepam? Will alcohol lower the threshold?
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> How do you handle telling people about your illness? I am an open person in general, and it's hard not to be able to talk to my friends about something that naturally occupies a fair bit of my mental time. On the other hand, once you tell someone, you can't untell them, and I don't want to lose my credibility, and I don't want people to think I'm 'crazy', or even worse in my opinion 'emotionally unstable'.
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> —Anonymous Postings to Internet Depression Newsgroups

On the 10th of July 1996 Etienne Mureinik, a prominent South African legal academic aged 44, booked a room in a Johannesburg hotel. He specifically requested one on the top floor, as it happened the 23rd. A few hours later he jumped from the window to his death. The media noted with a kind of wistful puzzlement his accomplishments and apparently bright future, and remarked that he had been under treatment for 'clinical depression'. There was virtually no further discussion; depression did not become an issue in the media, and nobody—at least in public—even raised the possibility that his suicide might have been a natural and reasonable response to his condition.

My reaction was quite different. I felt empathy, envy, and irritation at the lack of public understanding of what had happened, or willingness to confront it. Here was a man with the nerve to go and do it— what I had been wanting to do on and off since I was a teenager, more intensely as the years progressed.

The common view is that suicide is 'cowardly', a cop-out or betrayal of responsibility to self and others. In practice it may often be the latter; but anyone who thinks it either cowardly or self-betraying is seeing darkly through the glass of conventional religion or morality, has never experienced major depression, or both. The moral stigma usually attached to suicide in the depressed can be due only to a lack of understanding of what the overused word 'depression', in its proper medical and experiential sense, really means. Not that this lack of understanding is in itself blameworthy, as things are; some states of mind are simply unthinkable to those who have not experienced them, and because of this (literally) unspeakable.

I wrote this book under a kind of compulsion. It arose from my growing interest in the destructive and mysterious illness I was (and still am) caught up in, and from an attempt to understand it and myself. But another, perhaps 'altruistic' motivation seems to have crept in: to help give some more public prominence to serious depressive illness, clarify what it is and what it is like to have it, and try defusing the stigma that so often attaches to it. Why shouldn't depressives come out of the closet? Why should we lack the courage that homosexuals once needed, and often still do? Why do we so characteristically brood about death and ways of achieving it? I do not counsel suicide, though I certainly defend it as an appropriate response to certain conditions of living. But I think it important, both for the families and friends of depressives, and for depressives themselves, many of whom are mired in a slough of incomprehension,

to communicate something of what it is like to suffer from this potentially lethal disease. Or this terminal disease, since virtually all of us who have it will die with it, if not of it. And to make it clear why so many of us periodically desire nothing in the world more than death, and why some insist on achieving it.

I make no pretense at pioneering: many well-known victims, like Art Buchwald, Patty Duke, Kay Jamison, Joshua Logan, Spike Milligan, William Styron, Stuart Sutherland, Mike Wallace and Lewis Wolpert have 'come out', and there are already a number of excellent and accessible books, all with quite different emphases, different degrees of sophistication, aimed at different audiences. But mood disorders are peculiarly personal and idiosyncratic illnesses. Our brains (what Samuel Beckett aptly called 'the seat of all the shit and misery') are after all the most individual part of us. In fact they *are* us; and despite the common features, everyone's story is different, and the more stories known the better. Mine for instance differs from the others I have read, and most I have come across in person, in that I managed without two things that have apparently been vital to many others. Whatever success I achieved in staying alive and functional, and in the end getting considerably better, was managed entirely without psychotherapy or counselling of any kind, and religious belief or practice. I made it entirely through very sporadic advice from fine doctors, the support of my wife and a few select friends, reading and thinking, and medication. My formal treatment was deliberately drugs only, so I have some personal knowledge of the advantages and limitations of this approach.

I and countless others have survived largely through the at least partial pharmacological repair of shattered selves, assisted by family and friends and good doctors. But as Kay Jamison notes in perhaps the finest nontechnical book on one variety of this illness (*An unquiet mind: a memoir of moods and madness*, 1995), 'the road from suicide to life is cold and colder and colder still'. Many make it, many do not; the world is full of seemingly 'cured' depressives who lovingly hoard their suicide stash ... just in case.

In the end survival is often a matter of hanging on, even in the worst moments, to the possibility of remission. Chronic depression, like advanced cancer, is usually not cured but only held at bay. You somehow have to fight the bleakness and fatigue that come from repeated and terrifying mood-swings and the accompanying feeling of disintegration. And, paradoxically, you have to combine into some coherent and supporting vision two clear facts: (a) when you feel bad you're going to feel OK again; and (b) when you feel OK you're going to crash again. Perhaps the most debilitating thing is that the constant knowledge of (a) often does very little to counteract the equally certain knowledge of (b). It sometimes boils down to a simple question: how long can I bear this? For many the answer is first 'not much longer', and finally 'no more'.

This is in part a rather grim book, about a common and often fatal affliction. The bulk of the available literature suggests that the lifetime incidence of major depression (at least one episode) worldwide is a little over 5% of the population; this is almost certainly low, due to rampant underdiagnosis and the number of depressed people who do not get medical assistance (some studies have reported up to 15% incidence). The lower figure may look rather insignificant at first until one considers that 5% of the world's population is 300,000,000.That's a lot of sufferers from depression. The WHO has recently predicted that within 20 years depression will

be the world's major health problem. The lifetime attempted suicide rate for the US population at large is about 1%, compared to 18% for chronic unipolar depressives, and 24% for manic depressives. Baldly, if you suffer from a serious depressive disorder you are between 18 and 24 times more likely at least to attempt suicide than if you don't. And some 70-90% of suicides in the US and UK appear to be associated with depression. A grim book yes, but not at all hopeless: I am still here after all, writing it, uncured but changed, and for the moment at least in incomparably better shape than when I began it.

My altruistic aim is to encourage understanding and perhaps empathy for other sufferers through a description of my own experience. This may also help some victims to understand just what it is they have, to realize they are more typical and less crazy than they may think, and that they are not uniquely damned—idiosyncratic and original as their disease may seem. This often can be comforting; I was certainly heartened by reading about the experiences of three depressives who went public: Spike Milligan, in his collaboration with the late Irish psychiatrist Anthony Clare (*Depression and how to survive it*, 1994), the American psychologist Kay Redfield Jamison (*An unquiet mind*), and the novelist William Styron (*Darkness visible*, 1991). Reading these books I looked dimly into a mirror and found I was not the only one there. And I number among my friends in the strange freemasonry of the seriously depressed more than a few who seem to have been helped by knowing what I have gone through, and who have helped me by telling me their stories. Perhaps another report, out of the same depths but from a different kind of narrator, with a different story and course of illness, will be useful both to victims and those who have to face the harrowing and often uphill battle of living with them. To others it may be at least of clinical and philosophical interest. But this is not a self-help manual, and the altruistic intent is only a small part of what I eventually found myself doing.

This book is a hybrid—autobiography surrounding and sometimes intertwined with a core of science and philosophy. Chapters 1-2 and 6, 7, 9 are primarily about my experience, or more generally the life of the disordered mind as perceived by itself and others. Chapters 3-5 are the intellectual rather than experiential centre, and more technical than the others, because their subject matter is. Chapter 8 stands alone, as an extended philosophical and moral consideration of suicide. This has resulted in the book falling into three genres, perhaps not completely unified. But the subject matter seems to have dictated this structure: depression is singularly opaque without detailed description of what goes on in the depressive's mind, and incomprehensible (in terms of cause and treatment) without some elementary neuroscience and medicine. And because the problem of suicide is so overwhelming a part of the experience for many, this issue must be dealt with honestly. I have tried to keep the technical parts as accessible as possible, at times perhaps to the point of oversimplification, but I hope not inaccuracy. That is always a risk when a non-professional (I am not a medical person but an 'educated layman') seeks to write about a medical topic in detail.

The writing of this book took me nearly 15 years; or rather I wrote it once starting in about 1994, and except for a good deal of the purely autobiographical material rewrote it extensively in 2008, and added one chapter (6) dealing with what happened to me at the end of

that period. Because of this, there is sometimes a kind of chronological uncertainty: there are passages which may not represent the present me, but an earlier (and who knows, perhaps subsequent) one. The intertwinedness of the disease/person relationship is an important point: it is possible to *become* one's depression in a peculiarly intimate way, without realising it, or realising it but not caring. There may then be a certain lack of unity, an overlapping and intercutting of 'voices' in this book; as there seems in general to be in a life, though not necessarily this dramatic. There is also (I hope) a third voice, a 'neutral' and expository one, in the places where it is appropriate.

There are also some polemical threads running through this structure. Aside from the stigmatisation of psychiatric illness, there are other harmful attitudes I will have a good deal to say about. One is the New Age idiocy of condemning the 'medicalisation' of psychiatry. It is as if it were supposed to be magic, instead of simply doctoring—like any other kind, but unfortunately concerned with disorders of the least understood bodily system. Related to this is the common and nearly hysterical mistrust of drugs in treating mental disorders. This frequently accompanies a 'pharmacological Calvinism', a moralistic dislike or fear of medication in general. There is a general public anxiety (usually misplaced) about 'addiction', 'dependence', 'loss of autonomy', and a misguided view that illnesses of the mind should be treated by 'mental' means only. Drugs are seen to be at best only 'crutches'; taking them undermines the search for insight and understanding that alone can really 'cure' these diseases successfully. This is dangerous; as Kay Jamison has said, to treat depression without drugs 'verges on malpractice'. (Of course it is possible to overmedicate or choose medications unwisely, and especially in the case of children and adolescents there can be dangers in drug treatment—though perhaps not as serious as some of the more alarmist journalism would have it. Almost nothing is.)

It will be clear from the above that I subscribe entirely to the often criticised 'medical model' of depression. I do not subscribe to the paranoid belief that depression and similar illnesses are simply the results of dysfunctional living or society, turned into (fake) disease by the pharmaceutical companies so they can make money selling drugs. Depression is a cluster of *physical* brain diseases, as discrete and unmystical as cancer, and therefore its treatment is a medical matter. Whatever the role of friends and therapists, the central figure in the attack on depression should be the psychiatrist, in my estimation anyhow preferably the psychopharmacologist

Another matter that arises from time to time, though it does not have a chapter to itself, is the strange and complex relation between depressive illness, particularly bipolar disorder (or to use its older and better name 'manic depression'), and artistic and intellectual creativity. As a professional academic and writer, I have found that my own experience of manic depression has clarified some very strange things about living with my brain. It has allowed me to understand why we often feel a kind of perverse affection for our disease, and are unwilling to be as fully treated as we could be. In some circumstances cure may be worse than death.

But perhaps the key theme is dissolving the distinction between the 'physical' and the 'mental', between 'mental illness' and 'brain disease'. People seem to have a primitive fear of

'mental illness'; someone 'on antidepressants', or more euphemistically, 'on medication', is at best suspect, not fully trustworthy, probably intellectually compromised, likely to do who knows what. And since depression does not usually present with obvious physical signs, there is a widespread tendency (philistinism based on ignorance) to treat it as a moral defect, a failure of character. How many depressives have been told 'pull your socks up' or 'snap out of it'? This is as fatuous as telling a diabetic to stop being a wimp and put his pancreas in order. As William Styron notes in *Darkness visible* (62-3), the seriously depressed are 'walking wounded':

> [...] in virtually any other serious sickness, a patient who felt a similar devastation would be lying flat in bed, possibly sedated and hooked up to the tubes and wires of life-support systems, but at the very least in a posture of repose and an isolated setting. His invalidism would be necessary, unquestioned and honourably attained. However, the sufferer from depression has no such option and therefore finds himself, like a walking casualty of war, thrust into the most intolerable social and family situations. There he must, despite the anguish devouring his brain, present a face approximating the one that is associated with ordinary events and companionship [...] But it is a fierce trial attempting to speak a few simple words.

The stigma that grows out of the attitude Styron deprecates even at times affects doctors, and produces a strange and unprofessional pussyfooting. I have known several people who presented to their GPs with obvious signs of depression, and were told that what they had was a 'chemical imbalance' (of course they did) which could be treated easily; the word 'depression' was never mentioned, and the doctors then wrote scripts for the patients without saying that the drug prescribed was an antidepressant. The patient could of course find out by reading the package insert, but few do, and it rarely if ever says on the box what a drug is for.

The public lack of understanding also shows itself in the puzzlement that suicides like Mureinik's evoke. He seems to have a bright future, no obvious sources of unhappiness: what does he have to be depressed *about*? And that is precisely the wrong question. Most often depression is not 'about' anything at all, and it is this very lack of aboutness that makes it so disabling. As a sufferer, nearly a connoisseur, of depressive states, I am almost tempted to say snobbishly that the finest, purest depression is what it is precisely because of this lack of object. It is no more about anything (at least anything current) than cancer or flu are about something. It just *is*. As Virginia Woolf wrote in her diary (28 September 1926),

> Intense depression: I have to confess that this has overcome me several times since September 6th (or thereabouts). It does not come from something definite, but from nothing.

Chronic depressive disorder, as opposed to so-called 'reactive' depressions triggered by bereavement or other stressors, may once have been about something; but by the time it reaches crisis level it usually no longer is. Even when it does seem to be about something, the aboutness is curiously abstract and unconvincing.

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> I use my friends rather as giglamps: there's another field I see; by your light. Over there's a hill. I widen my landscape.
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> —Virginia Woolf, *Diaries* (2 September 1930)

This book is dedicated to the memory of my late wife and best friend Jaime, who lived through and carefully read and commented on the first draft, but died several years before this revision. It is also dedicated to my doctor Jeff Peimer, who is partly responsible for my being alive to write it; to Meg Laing, who maintained an unshakeable faith in me and this project over many years, and spent far too much of her time and energy tearing it and me apart and trying to make us both better; and to Kirsten Morreira for being a depressed and brilliant and unembarrassable friend and listener and commentator.

I could not have written this without medical help—and not just in the trivial sense of being kept alive to do it. A number of imaginative and patient doctors and psychotherapists have devoted time and energy to discussing things with me, and some have read at least parts of this book in one of its innumerable drafts. Special thanks then to François Daubenton, Dave Kibel, Bruce Lakie, Jeff Peimer, Roger Melvill and Bob Werman for being encouraging and pouncing on errors. And to Ian Laing, Dion Opperman, Hein Pierneef, Felix Potocnik, Esther Sapire and James Temlett for telling me things you can't find in textbooks, freely discussing technical, clinical and ethical matters, and at least trying to save me from one or another medical *faux pas*. Ian Laing, combative bugger that he is, was especially helpful (perhaps unknowingly) on a couple of gloriously tipsy Edinburgh evenings. In several fits of polemic induced as I recall by copious amounts of The Macallan (10-year old) I learned a great deal about how laymen should talk—and more important, argue—with doctors, without sounding too much like idiots.

Thanks also to a legion of fellow-victims, some of whom I've exposed to an indecorous amount of self-description, and who have done the same to me. And to many friends, depressive and not, who have coped with me in my less pleasing moods; and have done more than they know by just being good friends, saying or writing the right things at the right time, and shutting up when appropriate. So diffuse but no less sincere gratitude to my (sometimes unsuspecting) support-crew: Debra Aarons, Sylvia Adamson, Judith Ayling, Kate Brett, Claire Cowie, Christiane Dalton-Puffer, Lara Davison, Ana Deumert, Lyn Holness, Meg Laing, Kirsten Morreira, Vaunda Parsonage and Lisa Treffry-Goatley.

Though I began by setting down what I thought was my story and reflections, some of this crew seem to have got in as well. At times I felt I was writing something more like a novel, dialoguing with a set of reflective, enlightening and often critical voices. Some of them indeed became actual characters; they are interwoven for the reader in footnote and quotation, and for me in perpetual subliminal conversation. I thank those initials scattered through my text for allowing themselves to be quoted and weaving their stories into mine.

While I was trying to find out what the audience for this book was, whether it made sense at all, should be finished and was worth exposing to the world, I was helped and encouraged by

friends who took the time to discuss and comment on it while it was in progress, often at heroic length: especially Debra Aarons, Ana Deumert, Meg Laing, Lisa Treffry-Goatley and Roly Sussex. Meg Laing in particular was (and is) my indestructible support, stylistic conscience, copy-editor and fiercest of critics. I also owe an immense intellectual debt to my colleague Peter du Preez, whose profound and deliciously readable *A science of mind: the quest for psychological reality* (1991) opened me to new ways of thinking about selves and persons, in particular as rhetorical and social constructs, and not just as brains and diseases.

Special thanks as well to Sue King and GlaxoWellcome for inviting me to speak at their Neurology Weekends in 1999 and 2000, treating me to superb food, wine and conversation, and a chance to continue my education. And to April McMahon and Selwyn College, for arranging a week or so of irresponsibility and relative solitude in the glorious surroundings of Cambridge and its bookshops. This mini-sabbatical gave me the leisure to walk endlessly, read at will, talk to almost nobody, and let my mind free-wheel and try to make some sense of its eternally looming chaos. Much of the overall structure of this book seemed to come to me effortlessly among the Buddleias, watching the peacefully belching cattle in the water-meadows by my favourite pub, *The Granta*, or in Selwyn's expansive gardens.

And finally my endless gratitude to the late Jaime Lass for tolerating my moods far beyond the call of duty for over four decades, for close, sympathetic and critical reading, and for a firm and stylish editorial hand and a sharp sense of what's over the top and what isn't. My worst breaches of decorum, my worst self-indulgent one-liners, can be blamed only on my not doing as I was told. I suppose I don't have to add but will that all errors and infelicities are mine alone.

Diep River, 2009