Chapter 1

“The Illness that Dare Not Speak Its Name”: An Auto-Ethnographic Approach to Understanding Adult Learning in and on Clinical Depression

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ABSTRACT

Depression is something variously estimated to afflict between 5 and 10% of the North American adult population at any particular time. As such, it represents a major community health issue. This chapter uses an auto-ethnographic approach to analyze the adult learning tasks associated with dealing with depression. After situating his own experience as a person who suffers from depression, the author uses his narrative to analyze four learning tasks: learning to overcome shame, learning to engage in ideological detoxification, learning to normalize despair, and learning to calibrate treatment. Central to each of these tasks is the act of public disclosure. The chapter ends by suggesting directions for future research in this neglected area of adult education.

INTRODUCTION

The US government’s National Institute of Mental Health (NIMH) estimates that in any given year 14.8 million American adults (about 6.7% of the adult population) suffer from clinical depression, or major depressive disorder as it is sometimes called (NIMH, 2010). The NIMH also classifies clinical depression as the leading form of disability for Americans aged 15-44. A recent Centers for Disease Control and Prevention report placed the overall figure higher at 9.1%, with 4.1% suffering major clinical depression (Centers for Disease Control and Prevention, 2013). In Canada, a recent study projected the estimate of sufferers much higher than had previously been imagined, calculating that 19.7% of adults suffer from clinical depression sometime during their lifetime (Boughton, 2009).

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By any calculation then depression is a major social problem that takes up an enormous number of resources and affects a staggering number of people. Yet the stigma surrounding this illness is still very strong. For example, as someone who suffers from this condition I did not know of a single male colleague or friend who admitted to being affected by this until I began to disclose my own struggles. It seemed that other men would only own up to this in conversation with me after I had publicly spoken about my own situation. Somehow, patriarchy has decreed any public admission by men of mental health problems as evidence of personal weakness.

Those who suffer from depression often blame themselves for their perceived character flaw and feel ashamed from their inability to ‘snap out of it.’ Those who live with the depressed soon become exhausted by their inability to make sufferers feel better and often feel helpless to know how to respond. By any measure depression must therefore be considered a major community health problem. In this chapter I will draw on my own experience of depression to explore the interconnections between various strands of adult learning theorizing and the analysis of depression and I will propose some future directions for research in this area.

DEFINING DEPRESSION

Depression is not just feeling sad at the loss of a loved one, being devastated by a marriage break-up or experiencing a loss of identity after being fired. Neither is it feeling trapped by winter in Northern climes with the resultant lack of natural light or sun. All these things are traumatic and distressing, and any of them may trigger a depressive episode, but all are traceable to a specific root cause. In this chapter I am defining depression as the persistent feeling of complete worthlessness and hopelessness, often accompanied by the overwhelming anxiety that this hour, this day, or this week, will be your last on earth. This kind of depression has no clearly identifiable social cause such as death, divorce, or economic crisis; instead it settles on you uninvited and often completely unexpected and permeates your soul, flesh and bone.

Winston Churchill described his own depression as the black dog that prowled constantly on the edge of his consciousness. He never knew when the black dog would appear, but it became an almost constant companion – just as the presence of a dog that is a family pet is woven into the fabric of your daily life. Clinical depression is like that – quotidian, everyday, the first thing you’re aware of as you open your eyes, and the last thing you think about as you drift off to sleep (if you’re lucky enough to be able to sleep). Its very familiarity and its relentless presence is itself terrifying suggesting that it will always dog you (pun intended). I can speak with experiential authority about this as someone who suffers from depression and who has spent over a decade experimenting with how to function with this condition as part of my everyday life.

Everyone reading these words has probably either suffered from depression or knows someone who has. Yet the stigma surrounding mental illness means that it is rare to hear people admit to this. It is easier to hide and disguise depression than it is to hide physical disability or severe mental disorders such as schizophrenia or a bi-polar condition. You can pretend to be overworked, needing more sleep, stressed, fed up, worried about your job, having difficulties in your relationship, or lonely – and people will see these as part of the ups and downs of everyday life. In my own case, I spent many years hiding depression from every human being I interacted with (including my children) other than my wife and my brothers. I did so partly because I felt ashamed of my condition. I did not want my children or my friends to think of me as pitifully unable to control my life. And partly I hid this condition as best I could because I feared that public knowledge that I suffered from this would do irreparable harm to my career. In my mind I calculated that no one would trust me