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Severe Depression: A Patient's Thoughts

E. GEORGE GRAY

Summary: A research neuroscientist in his fifties, who has recovered from endogenous depression after several years, describes the experience and makes some comments on treatment and management. He found electroconvulsive therapy, mianserin, lithium carbonate and diazepam acceptable. He considers that occupational therapy and conventional psychotherapy were counter-therapeutic. He stresses how physically ill he felt when depressed, and compares this with prolonged influenza. He hypothesises that the underlying psychological disorder in endogenous depression is the learned extinction of optimistic thoughts, and suggests that any psychotherapy used should be aimed at restoring these.

The first draft of this paper was made several months ago. Since then I have made two lecture tours abroad, and my sense of well-being and creative drive have returned. The immediacy of the past lessens, but I can write more clearly and, in the context of books and journals on depression read recently (see below), more objectively.

I write about severe (not manic) depression. My breakdown started when I began to feel irreversibly ill, and during the following six years I spent two months in one hospital, returned to work prematurely for a year and then finally disintegrated mentally into deep depression and entered another hospital for five months, so that I can compare two courses of hospital treatment.

In retrospect, I see that since the age of 14, or before, I have suffered bouts of depression of greater or less severity, with one minor breakdown in 1948 after returning from war service. Since I was not aware that I was suffering from depression, I suffered literally in silence, often for months on end. I suspect that many people have similar experiences, and I wonder whether studies have been made on populations to detect them.

I went to my general practitioner some years ago. He rightly diagnosed depression, and prescribed a tricyclic antidepressant. The side effects turned out to be so disturbing that I never returned to him. The point is that 'depression' was then just a word to me, when I should have been warned that untreated depression could lead to an extremely serious breakdown (as in fact it did). Thus GPs, when first diagnosing depression, should have a cast-iron regime to ensure return of the patient for observation at least once a month. The GP cannot assess the seriousness of the depression from a brief interview. I remember, just before the crisis, bouncing on to the psychiatrist's couch and putting on a brave front. A few probing questions, and I found myself reduced to tears and wanting to die. Only then did I realise how seriously ill I was. My major breakdown had been coming on for the previous three years.

I should like to consider certain aspects of the subsequent hospital treatment. Over seven months, in two hospitals, this included drugs, electroconvulsive therapy, psychotherapy and occupational therapy.

1. *Electroconvulsive therapy*

Much has been written about this. What controlled trials on humans there have been do not give great encouragement (see Johnstone *et al*, 1980). However, I find no obvious deficits in my memory, although at first many past incidents were beyond recall. (This could well have resulted from the illness, of course). One suggestion I should like to make is that patients should not be kept so much in the dark about the procedure. Some, for example, wonder how on earth an electric shock to the brain can help if they are anaesthetised and don't feel it. It could well be explained in lay terms that the brain in fact undergoes a full seizure and that they are not missing anything when unconscious. It might also be helpful to explain that natural epileptic fits benefit depression (as has long been known), that electric shocks to the brain are not harmful or painful and that the anaesthetic is given only to a prevent awareness of muscle paralysis. Another suggestion is that ECT candidates might be given a strong (intravenous) anxiolytic before the first session. This is a dreaded time—like going to the gallows, or should it be the electric chair? After the first session, the experience is known to be painless (or even pleasant, see below) so that the subsequent sessions hold no fears, and anxiolytics are not required.

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2. *Drug therapy*

The tricyclic amitriptyline produced, in me, intolerable side effects. I was for a long time on 60 mgs daily of the tetracyclic antidepessant mianserin, but am now stabilised on 40 mgs. I have also, during and since my breakdown, been taking 750 mgs of lithium carbonate daily. My weight is 12 stones.

For comments on non-specific drugs in depression, please see under *convalescence*.

3. *Occupational therapy*

This is a very dubious form of treatment. In deep depression, the patient feels terribly *physically ill*. In the initial stages of recovery, I feel it is of vital importance for him to sit in the corner and do nothing, safe on three sides from approach. This gives him complete mental rest and is a normal response to his sick feelings. Only when he really wants to participate in extra-armchair activities, clearly of his own free will, should he be encouraged to do so. Occupational therapy may well have all sorts of adverse effects. I was often pressed into playing Scrabble, and each game ground me more and more down into the ground, for my intelligence clearly couldn't match that of the least eloquent of the probationary nurses. What clearer evidence could I have been given that my brain had seized up for ever? The moral clearly is that OT should be avoided, or else carefully tailored to the patient so that is engenders a positive and not a negative mood. The results of his first session should be carefully assessed. If it makes him feel worse rather than better, further sessions should be suspended. The person with bad 'flu curls up in bed and can do nothing mentally and physically, and the GP doesn't come along and say, "Up my man, go down to the hospital OT unit and plane a piece of wood, paint a picture or weave a basket"!

4. *Talk psychotherapy*

Having endured this myself, read Beck *et al* (1979; see below) and participated in group therapy, I write with the licence of a patient that talk therapy can become so much mumbo-jumbo.

The psychotherapist sets out with the (maybe unconscious) assertion that he knows better than the patient in which way the patient's thoughts should be directed. He is thus invetitably condescending. But the depressed patient is not lacking in intelligence; rather, his ability to exercise it is dramatically impaired. I repeat, and no doubt will again repeat below, the deeply depressed patient feels physically ill (headache, nausea, lassitude, insomnia, impaired bowel and urinary function, trembling limbs, etc.) and the psychotherapist talking to, say, a person in the throes of violent 'flu and hidden behind a screen could well arrive at a diagnosis of deep depression. Let the patient, in his early stages of depressive breakdown, continue with the well-known manifestation of 'sitting quietly in the corner' for as long as he wants (i.e. needs) to. This is the best way he knows of tolerating his physical illness.

From a perusal of the psychotherapeutic literature (e.g. on psychoanalysis, talk-therapy and OT) one observes two classes of psychiatrists. One group give and publish accounts of long sessions of the therapy (full of subjective judgements, apparently, in spite of long 'scientific' training), oblivious to the fact that controls are essential for any meaningful assessment of the progress or otherwise of a given patient. Beck *et al* (1979), for example, give numerous accounts of talk therapy sessions and draw endless subjective conclusions about the efficacy of this or that 'cognitive' approach, completely ignoring the absence of controls, and it might well be that 50 per cent of their patients would have got better quicker without their 'cognitive' talk therapy! The second kind are much more scientific, in that they try to use controls. Most are aware of the almost infinite problems of obtaining carefully matched controls, but, having a statistical bent, they attempt to overcome this by using as large a sample as possible. To this second group, I am, of course, merely stating the obvious. The amazing thing is that the first group, in this day and age of refined statistics, can continue oblivious to this fact. Present day appraisals of Freud not only underline his lack of the (statistical) scientific approach, but give clear evidence that long courses of psychoanalysis are followed as likely as not by a worsening of the patient's condition (I do not fall into the trap of saying 'make the patient worse'). Freud, Jung and Adler, as pioneers and innovators, were great in spite of, rather than because of, their techniques.

My convalescence

Recovering and back to work, on lithium and mianserin, but still with bouts of headache, nausea, insomnia, hand trembling, stuttering and so on, I found diazepam (Valium) of inestimable value during this phase. Particularly traumatic were times when I had to chair a staff meeting or conduct a seminar; on such occasions 2 mg diazepam (*chewed* and swallowed for rapid absorption) 20 minutes beforehand usually saved the situation. There are two ways to take diazepam, by mouth and by eye. The first I have just mentioned, and its efficacy over the months became clearly established. Then comes the time when one is beginning to feel physically better, and the second method is used. A transparent tube containing one yellow 5 mg tablet of diazepam is kept in the pocket and when a critical event approaches, the tube is taken

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out of the pocket, gazed upon the knowledge that the pill is there if needed, *and returned to the pocket*. Thus diazepam is taken by eye. Now I chair a meeting often forgetting even to carry the tube.

Early morning wakening with anxiety and depression (which result from feeling physically ill) seems to be the most intractable of depressive symptoms. A whole gamut of sleeping pills proved unsatisfactory for various reasons. I still tend to suffer from this, though for the past two years I have usually felt well by mid-morning and, during the rest of the day, an uplift occurs. I still use 5 mg of diazepam when I awake between four and five a.m. The radio helps, and for a long time I had a thermos of warm, sweet coffee to hand (especially helpful at four a.m. during my recent lecture tours of the States and Portugal). Coffee may well prove more efficacious than has been thought, for there is recent evidence that it contains an active substance that blocks opiate receptors (Iversen, 1983). This substance is not caffeine and is equally active in decaffeinated coffee.

Some reading

Two books on depression I found particularly fruitless. Sutherland's (1976) thickish volume on his own breakdown devotes only a short beginning to this topic: most is potted Freud, Jung and Adler with accounts of antidepressant drugs, ECT, psychotherapy, etc. Since Sutherland is not medically qualified, his accounts are second or third hand and that's the way they read. His breakdown is really not valid as an example of typical deep depression. He takes pains to point out that most of his life he was happy; that the breakdown was specifically related to an exogenous event, i.e. marital infidelity. He could obviously have not been deeply depressed, for throughout his stay in hospital he was able not only to read *The Times* but even to do the crossword! He was able to talk with, and later recall discussions with, the various patients. Each day he optimistically looked forward to his night's sleep and so on—all these are way beyond the repertoire of the really deeply depressed patient. Considering he is a professor in experimental psychology, the absence of any original suggestions on how to treat depression make his book singularly disappointing.

As for the four hundred odd pages of Beck *et al* (1979) devoted largely to talk psychotherapy, I take the layman's prerogative by suggesting that apart from a few flashes of (overlooked) light, the therapeutic approach (see above) is based on a complete misunderstanding of the patient's illness. Statements and conclusions on nearly every page are highly subjective, because of the absence of controls; e.g. that patient X, when sent to OT, showed an improvement, with no consideration of the possibility that X might have shown an even more marked improvement had he *not* been sent to OT. Suitable controls are, of course, the bug-bear of treating humans—but that is no excuse for not attempting control situations. Numerous accounts of the dialogue between psychotherapist and patient are given; almost invariably the psychotherapist assumes that he knows better than the patient. When the patient says he feels (physically) ill, he means it, and no amount of cognitive talk-orientation of the patient's thinking will make him feel otherwise.

"Optimism therapy"

At this point, let me draw on my own introspection. In retrospect I realise an initial clue came when I was undergoing ECT. Shocks were spaced at precise intervals, two a week, so that I knew that for the ensuing eight weeks precisely at 10 a.m. on Tuesdays and Thursdays I would receive a pre-shock general anaesthetic of intravenous quick-acting barbiturate. From complete consciousness to unconsciousness a period of maybe three seconds elapsed, when I had the profoundly satisfying experience of escaping from myself and the endless and unbearable feeling of illness. But it is neither this pleasure nor the possible efficacy of a brief spell of unconciousness (for the shock, see above) that here concerns me; no, it is the fact that I was having, what was then completely novel, thoughts which were optimistic, i.e. was looking ahead to events in the future that would occur with certainty. And when these inevitable events took place, my *optimism* was confirmed.

From this observation, my introspection (months later) increased. Spend a day jotting down your thoughts, and you will see that a large percentage of them involve contemplation of future events (partly in order to avoid the potentially unpleasant ones). Daily contemplation of future pleasant events is the lot of the happy, undepressed person: this may perhaps be termed *'mental self-grooming'*. It is no doubt related to drive and is part of the mechanisms of pleasure-seeking, pain-avoidance and goal-seeking, terms familiar to the psychologist.

Now consider a patient undergoing deep depression. In the early stages he begins to feel physically ill, and as the days pass his mental self-grooming decreases. At the start his optimism prevails. "I feel ill now and unable to cope, but tomorrow I'll feel better". When tomorrow arrives, however, and he feels slightly worse, he learns that his optimism of the previous day was unjustified. This gradual unlearning of optimism continues on for hundreds, even thousands of days, all optimistic thoughts abolished—for the patient has learned (correctly) that the future holds nothing but terrible suffering. Mental self-grooming has ceased

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and day after day a thousand and one events confirm previous pessimistic thoughts and a complete breakdown results. Consider a person with acute 'flu symptoms—if the symptoms continued day after day, week after week, year after year, that person, I predict, would come as near as makes no odds to a severe depressive breakdown.

Where then do we go from here? Once we understood not only that the depressed patient feels extremely physically ill, but that his mental self-grooming has been obliterated by hundreds or thousands of days of experience that it is his lot forever to feel ill and hence incapable—i.e. that he has become orientated towards pessimism rather than towards optimism—then we can perhaps reorientate our thinking about the talk-therapy aspect of treatment for depression. As the physical illness is removed, with lithium, antidepressants and ECT, in parallel the patient must be taught optimism, i.e. slowly to unlearn the deeply ingrained pessimism learning of the past. Thus the psychotherapist's main duty would be to ascertain from the patient, when he was beginning to venture from his 'chair in the corner', what sort of events he could look forward to with enjoyment; e.g. Mozart every Monday morning at 10 a.m., television every evening from 6–9 p.m., a couple of pints of beer every Thursday at 11 a.m., a 'girlie' magazine every Friday morning (if his tastes lay in that direction) and so on: the point being that it is not so much that the brief pleasures derived from these things are efficacious, rather that they occur again and again at specific points in time. In this way, optimistic thoughts are engendered and reinforced by repetition, and soon the optimistic self-grooming will start up again.

The initial phase of sitting inert, day after day, I consider vital. Not only is the depressed patient removed from the pain of having to mingle with the world of normal people outside, but, more important, he becomes aware that tomorrow, and the next day, and the day after that he will be able to do the same. Thus the first spark of optimism is kindled in his thoughts, and recovery has commenced!

Conclusion

Let me summarise: the person entering a deep depression lasting months or years (probably as a result of genetic disposition coupled with prolonged environmental adversities) undergoes a profound trauma to the CNS—probably involving, at least in part, the brain monoaminergic circuits (transmitters, receptors, axonal transport, etc). He feels (with increasing severity) desperately ill and suffers from insomnia with early morning wakening and anxiety, muscular aches, trembling, sluggishness, nausea, bladder and gut malfunction, headaches (or 'tight bands around the head'), loss of appetite and sex drive, confused thinking and so on. *NB. he feels depressed because he is ill and does not feel ill because he is depressed.* The profound feeling of illness, in itself, differs little from that felt, say, in severe influenza. The main difference, however, is that the 'flu patient, having been happy all his life, is not in a state of deep depression, for he knows he will be back to his happy state in a few days. In a few days his optimism is confirmed, i.e. reinforced, and he will face his next bout of 'flu with optimism.

The depressed patient has lost completely all experience of daily optimistic thoughts, numerous in the well person. He no longer has the capacity for 'mental self-grooming'. It is the duty of the talk-therapist to re-establish this capacity.

Curiously, there are no drugs that can give satisfactory short-term alleviation of the deep feeling of illness in depression in the way that a few aspirins can often give temporary relief to, say, severe toothache or 'flu. Alcohol and opiates may have an effect, but for obvious reasons they are out of the question. Long-term treatment with lithium, tri- and tetracyclic antidepressants, ECT, and the carefully thought-out talk psychotherapy mentioned above are the major tools at present, and may be for a long time, till we are able more precisely to understand and manipulate, for example, brain transmitter turnover mechanisms of the monoamine and other pathways and the receptors that they agonise or antagonise.

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References

BECK, A. T., RUSH, A. J. & SHAW, B. S. (1979) *Cognitive Theory of Depression.* Chichester: John Wiley.

IVERSEN, W. L. (1983) Another cup of coffee? *Nature,* **301,** 195.

JOHNSTONE, E. C., DEAKIN, J. F. W., FRITH, D. C., STEVENS, M., LAWLOR, P., MCPHERSON, K. & CROW, T. J. (1980) The Northwick Park ECT trial. *Lancet, ii,* 1311–12.

SUTHERLAND, S. (1976) *Breakdown: A Personal Crisis and a Medical Dilemma.* London: Wiedenfeld and Nicolson.

E. George Gray, PH.D., F.R.S., *Head of Laboratory for Biological Ultrastructure, Medical Research Council, National Institute for Medical Research, The Ridgeway, Mill Hill, London NW7 1AA*

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