I’m a Psychiatrist—and I Live With Depression

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By Linda Gask, MB, ChB, MSc, PhD [3]

A personal account by a psychiatrist who has battled depression.

I am a psychiatrist, and I have experienced recurrent severe major depression for most of my adult life. My problems first appeared during adolescence when I began to suffer from anxiety. I experienced my first episode of significantly low mood in my last year of medical school. Nevertheless, I decided to go ahead and train in psychiatry, as it was clear to me this was the specialty that I showed the most talent for as a student. I had a further episode of depression during my training when I failed a professional examination. After that, I began to attend sessions of psychotherapy. Since then, I have undergone both psychodynamic and cognitive behavioral therapy with some benefit—although not enough to prevent further more serious episodes over the past 25 years. My illness has necessitated some long periods off work.

I've tried most antidepressants and have now taken medication continually for 2 decades. I've never been hospitalized, although I once refused admission, and my current psychiatrist thinks I could well have been an inpatient in recent years if I had not stayed on antidepressants. I had mixed feelings about medication at first. I trained in psychodynamic therapy and found it hard initially to accept that tablets would help. The tricyclic I was first treated with caused adverse effects, which I struggled to cope with. SSRIs were an improvement but were insufficient to keep me well. I've been on lithium and now take another combination of drugs, which keeps my mood fairly stable. I still have occasional relapses though, usually in response to life events.

I am certain that both having depression and being a patient have had a significant impact on my career. I understand what it is to experience severe depression—to feel worthless, hopeless, and even paranoid—and I have had persistent suicidal ideas, although I have never attempted to harm myself. I too have felt the ambivalence about accepting help from professionals that my patients have sometimes expressed about receiving from me. I think all this has caused me to be a more empathic doctor, although I am not suggesting that you have to have experienced these things to help people who are depressed. I am simply saying that I think it can help. I do understand what it is like to visit a psychiatrist, to wait in the waiting room, and to be asked the questions that are so familiar to you in your everyday work. As someone who takes the tablets but who would much rather not have to do so, I've learned a great deal about the need to negotiate treatment, to answer questions truthfully, and above all to listen to my patients' worries and concerns.

I have been perhaps more concerned with the importance of the depressed patient getting access to care (hence my interest in primary care) and the need to really engage people who are depressed. I know how hard it is to commit to attending a session regularly if you have difficulty even getting out of bed and putting your clothes on and you have to tell your manager you need to take every Monday afternoon off. Yet too often the onus for beginning therapy is placed solely on the patient, who has to be “motivated.” I know my first therapist did not always find it easy to persuade me to engage in working with him, but he made a considerable effort to do so, and he succeeded in reaching out to me.
I am now retired from clinical practice, and I’ve written about my experience of depression in a book, which was published in the United Kingdom this year. Quite a few people have told me how brave I am to “come out” and admit that I’ve suffered from mental illness. Yet if I had written about having diabetes or some other physical condition, no one would have described my illness in such terms. Why should it be such a surprise that a person who worked as a psychiatrist for over 30 years and who has spent her life researching and teaching about depression might have first-hand experience of it herself? Probably because, in the health professions, the last thing we usually want anyone (particularly our colleagues) to know is that we too are vulnerable to exactly the same stresses and problems as our patients.

During my clinical career, I treated many doctors and nurses, including mental health professionals, for depression. I recognized the pressures they faced in wanting to provide excellent care for their patients while at the same time having to learn how to deal with the impact that this drive to “be the best” could have on them and their families. I know that as physicians we like to see ourselves as strong. Indeed, maintaining our position on the career ladder often seems to depend on this perception. There is still a stigma related to having depression in health care—even though mental health professionals profess that they are always “fighting it.” I have experienced negative attitudes during my career from one or two people in managerial positions who, despite working in mental health, chose to interpret my behavior when I was becoming unwell as “difficult” or “unreasonable” rather than related to my illness, even though they were well aware of it. Depression is something that others suffer from, not us."When people came to see me, the focus was rightly on their problems—not mine.'

-Linda Gask, MB, ChB, MSc, PhD

It is exactly this “us” and “them” attitude that I set out to challenge in my book. It started off as a straightforward memoir. As I began to write, however, the close parallels between my own experiences and those of the people I had tried to help throughout my professional life became increasingly obvious to me. There certainly wasn’t a clear difference between the problems in my life and those of my former patients. We all had complex lives—experienced loss, grieved for those who had gone from our lives, felt lonely, wanted to be loved, and sometimes felt compelled to self-medicate with alcohol to ease our distress. Some of us made the same mistakes in our relationships over and over again. Many of us wanted or even tried to end our lives. The stories I tell in the book alongside my own are taken from my work as a psychiatrist but have been extensively altered and merged to create people who are true to life, but are not real case histories. However, my own story is very real indeed. I waited until retirement before seeking a publisher because it wouldn’t have been appropriate to be so open when I was still practicing. When people came to see me, the focus was rightly on their problems—not mine.

I’ve never tried to hide my illness from colleagues. This isn’t easy to do when you have to take time away from work, and my health has been a regular topic at my annual appraisal. I’ve just never been quite so public about it before. I have become more vocal now because I’m determined to challenge the stigma that still exists within our profession. How can we deal with the stigma in society if we cannot face up to our own tendency to stigmatize both our colleagues and, even now, our patients? I have listened to junior staff members describe people with depression who are not actively suicidal or psychotic as the “worried well.” I’ve been told that depression is not a “severe” mental illness that warrants more investment of psychiatric and mental health nursing resources. I’ve read articles written by my colleagues that describe improving treatment for depression in our society as “medicalizing misery.” Only people who have never experienced the pain, despair, and hopelessness could talk about depression in such terms. I’ve spent my career challenging such attitudes.

Before I applied to train in psychiatry, I contacted the psychiatrist who had treated me when I was unwell at medical school. I asked him if he thought it would still be appropriate to be so open when I was still practicing. When people came to see me, the focus was rightly on their problems—not mine.

Disclosures:
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