If I Had . . .

Chronic depressive illness

JOHN SCOTT PRICE

The Chinese have it that an unlucky doctor treats the head of the disease and a lucky doctor its tail. Starting this article back to front I will say that if I had a depressive illness with a long tail refractory to all other treatment I would like to have a leucotomy, whereas I am very reluctant to advise leucotomy for my patients. Having said that, I may leave the tail to a more appropriate place in my argument.

Like venereal afflictions and physical deformities, depressive illness is associated with *stigma*, as Irving Goffman so clearly described in his book with that title. The shame that is to stigma as strain is to stress is compounded in depressive illness because shame itself is one of the symptoms of depression. The doctor, and particularly the psychiatrist, who develops a depressive illness is well advised to make only one decision about his treatment, and that is who he would like to treat him. He should make that decision before he gets depressed, and tell his wife or a close friend who will insist that he goes for treatment before he starts treating himself—a thing that most doctors do and, being reasonably normal, I should probably want to do too. The shame of being depressed makes a doctor reluctant to approach a colleague; he is likely to see his depression as a failure to cope with life and, moreover, he will be reluctant to expose to a colleague the shameful secrets which may be either causes or symptoms of his depression. Most doctors are conservative and suspicious of new drugs and so treat their depressions with alcohol, hiding from themselves their knowledge that "he who physics himself poisons a fool."

I will not give a fictional case history because depression is too serious and painful a condition to turn into fiction, unless one is a master of the art like Thackeray in *Vanity Fair* or Racine in *Phèdre*. Those who cannot get the feel of depression from fiction or textbooks may turn to biographies of men like Francis Galton, Julian Huxley, and Bertrand Russell.

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Conventional treatment

For me, and I suppose for most psychiatrists, there is not likely to be much difference between precept and practice over conventional treatments of depression. The most important measure is to prevent the patient harming himself, and, if the depression is severe, he may not want to co-operate in this part of his treatment. Next, I would sort out the various factors that may be causing or perpetuating the depression, and this requires an almost surgical intrusion into the patient's private life, into the secrets of the bedroom and the counting house, the shameful memories of the past, the incompatible actions of the present, the unrealistic aspirations for the future. The results of these explorations may lead to various forms of social and psychological manipulation, including marital therapy, that are likely to be painful but which I hope I would submit to with good grace as I expect my patients to.

Any lasting depression deserves a trial with both the tricyclic and monoamine oxidase inhibiting drugs, regardless of where it lies on the endogenous/reactive continuum. There is a lot of breast beating about electric convulsion therapy in cranky circles, but there is strong "bedside" evidence and increasing scientific evidence that ECT is effective for certain categories of depression, and I imagine that most psychiatrists would want to have this treatment if their psychiatrist advised it. If necessary, I should want ECT given against my will, provided my next of kin, my general practitioner, and enough psychiatrists thought that I should have it. In my experience the need to give ECT against a patient's will is *extremely* rare.

I sometimes give, and would accept, whatever fashionable and relatively harmless remedy is in vogue, like tryptophan and acupuncture. If consultant psychiatrists were better paid I would try several weeks at a health farm under the care of a good osteopath. I would take a long sea voyage. I would like to keep hope alive by seeing the arrival of new remedies reasonably often, and I would like to be reminded every day of the biochemists who might at any moment produce a drug that suited my particular case.

Failure of conventional treatment

What if my depressive illness did not remit with time or respond to these excellent treatments? I have seen spontaneous remission of 20 years' continuous depressive illness, and relapsing depressions that have stopped relapsing after a similar time. Let us assume that the depression has lasted for two years and has failed to respond to conventional treatment. It may remit next week, or it may last for another 18 years. There is no way of predicting when spontaneous remission is likely to come. It is in managing this condition—probably more common than is generally realised—that the guidelines are

least clear, and practice is likely to be variable, personal factors are likely to intrude more into decision-making, and the choice for oneself as a patient is likely to diverge most from the choice for someone else.

For those readers who are not psychiatrists let me emphasise the existential position of the severely depressed patient. Firstly, it is very unpleasant: depressive illness is probably more unpleasant than any disease except rabies. There is constant mental pain and often psychogenic physical pain too. If one tries to get such a patient to titrate other pains against the pain of his depression one tends to end up with a description that would raise eyebrows even in a mediaeval torture chamber. Naturally, many of these patients commit suicide. They may not hope to get to heaven but they know they are leaving hell. Secondly, the patient is isolated from family and friends, because the depression itself reduces his affection for others and he may well have ideas that he is unworthy of their love or even that his friendship may harm them. Thirdly, he is rejected by others because they cannot stand the sight of his suffering. There is a limit to sympathy. Even psychiatrists have protective mechanisms for dealing with such cases: the consultant may refer the patient to the registrar's follow-up clinic; he may allow too brief a consultation to elicit the extent of the patient's suffering; he may, on the grounds that the depression has not responded to treatment, alter his diagnosis to one of personality disorder—comforting, because of the strange but widespread belief that patients with personality disorders do not suffer. Fourthly, and finally, the patient tends to do a great cover-up. Because of his outward depression he is socially unacceptable, and because of his inward depression he feels even more socially unacceptable than he really is. He does not, therefore, tell others how bad he feels. Most depressives, even severe ones, can cope with routine work—initiative and leadership are what they lack. Nevertheless, many of them can continue working, functioning at a fairly low level, and their deficiencies are often covered up by colleagues. Provided some minimal degree of social and vocational functioning is present, the world leaves the depressive alone and he battles on for the sake of his god or his children, or for some reason which makes his personal torment preferable to death.

Radical treatment

Psychotherapy, particularly group therapy, may help a patient to survive his depression until spontaneous remission, or, one hopes, it might even cure the depression; I should be less inclined to accept this for myself than to recommend it for patients. Radical social change is a course of action about which I have mixed feelings. To a patient who consistently recovers in hospital and relapses on discharge I might conceivably say, "your depression may be entirely biochemical in nature; on the other hand, it may be a result of your way of life, even though we have not been able to find any obvious causal connection. Change your job, leave your wife, abandon your children, reject your god, and start again afresh; since your life is a misery

and you wish you were dead you have nothing to lose; things may be just as bad, but they cannot be much worse and you might be lucky and avoid another 10 years of depression." I should like to feel that I could take this step if a psychiatrist gave me such advice but I doubt that I would have the courage.

If I ever found myself in this sorry state I would like to have a leucotomy. I would have a stereotactic subcaudate tractotomy at the Brook Hospital, or a stereotactic limbic leucotomy at Atkinson Morley's Hospital, or I might even go abroad to Finland or some other country where they have experience of the new stereotactic psychosurgical procedures. These operations are quite unlike the old leucotomies, which rightly went out of fashion in the 'fifties. Deaths from the new operations are negligible and morbidity is low. There have been no controlled trials but I have read the case histories and the statistical analyses and the optimistic conclusions which have been drawn from them. I have a "gut" feeling that the operations are effective. On the other hand, I am most reluctant to advise such an operation for a patient. Many informed people consider leucotomy in any form to be a barbaric procedure, and in some countries such as the Soviet Union it is banned by law. The idea of destroying irreversibly part of a normal brain is repugnant to many people, and, in the absence of satisfactory clinical evidence from controlled trials that the procedure is effective, I would therefore not feel justified in advising it for a patient, and I certainly could not justify such advice in any rational terms to a colleague.

On mature reflection, Chinese style, I would realise that the psychosurgical teams are the lucky doctors treating the tail of the disease. Moreover, although I would give ECT to a patient without informed consent, I would find it much more difficult to refer a patient for psychosurgery without being sure that he really understood the implications and wanted to have the operation. And, if a patient feels like destroying himself including his brain, how can he be in a fit state to give informed consideration to destroying a tiny portion of his frontal lobes?

Epilogue

I was asked to write a personal article, so I will end on a personal note and thank the editor for giving me an unusual privilege. In the event of my developing a chronic depressive illness I would like to have a leucotomy, but if my psychiatrist held views like my own he would deny me the operation on the grounds that during a depressive illness I could not give informed consent. Let this manuscript, therefore, be evidence of my informed consent.

I also give informed consent to being included in a prospective controlled trial of leucotomy, in which case I would not wish to be told I was in a trial, and if I was allocated to the control group I would like to have a dummy brain operation in the hope that I would pick up any placebo effect that was going. But I hope the biochemists get there first.

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