

## PRACTICE

## A PATIENT'S JOURNEY

## Psychotic depression

This patient works as a psychiatrist in the hospital where she is treated, and has been admitted, for depressive disorder. She tells her story, and describes her feelings about other health professionals' attitudes towards her

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This is one of a series of occasional articles by patients about their experiences that offer lessons to doctors. The *BMJ* welcomes contributions to the series. Please contact Peter Lapsley (plapsley@bmj.com) for guidance

I had an easy early life. My family was a combination of conservative and intellectual, and throughout medical school I fitted in. There were, perhaps, a number of warning signs of what was to come—a long period of blackness after a relationship ended, and one of poorly controlled mood before final exams—but hardly different from many others. I was unaware at that time of family history.

I coped well with the stress of house jobs followed by a number of senior house officer jobs and a period of travelling. I then decided, for romantic and literary reasons, to do my GP training year in Cornwall. It was hard work, but all went well until, after my marriage, I found myself rather unexpectedly—though not unhappily—pregnant. Quite suddenly my life fell apart. I don't remember feeling depressed, but I became terrified of everything, afraid to eat, and convinced the baby would die. I saw a psychiatrist, who dispensed with note taking as it might apparently affect my career, and ended up briefly in a psychiatric hospital before being looked after by one of my fellow GPs, my husband, and my mother-in-law. I had no idea what was wrong with me.

When I was around five months pregnant, we moved back to Edinburgh and went to our GP, who immediately referred me to a psychiatrist, who sent me straight to the local hospital. I had last been there as a medical student, several of my friends and colleagues worked there, and my previous life as a doctor was instantly shattered. I had hoped to train as a psychiatrist myself, and I thought that possibility was now extinguished, that anyone who had been a psychiatric inpatient would never be accepted as a colleague.

I don't really know how I felt—bleak and exhausted, but also sad and angry, especially when I saw other doctors apparently confident and successful. I had a series of admissions, both before and after my baby was born.

What was my diagnosis? How to classify the feelings of fear, terrible fatigue, anxiety, and blackness? Depression was what I was told, but I formed an unshakeable conviction that everyone thought I had a personality disorder. Looking back, I still think my personality was sorely tested by my experiences. I did improve with electroconvulsive therapy and medication, but hated taking them.

Finally, after a period of relative stability, I managed to return to work, to a junior hospital post. I hadn't worked for two and a half years, and felt incompetent and inadequate. I subsequently finished my GP training, but realised I would be unlikely to get a job given my medical history. When I look back now, I wonder how I had the courage, or the cheek, to apply for a psychiatric training scheme. One of my psychiatrists advised me not to, and I am generally very reluctant to do things others disapprove of, but I think I knew I would always regret not doing it.

I had a long commute, as I, and others, felt I could not work locally. I loved the work and think I was good at it, but I can't pretend it wasn't emotionally draining. I have always felt like two people—the psychiatrist and the psychiatric patient—and it is very difficult when they overlap. I even use two names, as do many female doctors, but I think my reasons are slightly different.

My training proceeded well, and I was lucky to experience no problems with exams. Life was not straightforward, though. I had an early stillbirth, and, perhaps inevitably, a relapse followed. But I picked myself up, and staggered through another pregnancy as well as my training. Looking back, I think I was very anxious for some years after this, but relatively well otherwise, at least partly due to my always supportive husband.

I think I took medication for much of the time, but certainly had some lucky periods where I didn't.

My husband has always found the switch from spouse to carer and back rather difficult, particularly during periods of recovery, and especially given that I don't really appreciate what I'm like when ill. He also finds my occasional non-compliance with medication understandably infuriating. But I admit I worry more about the potential effect on my three daughters. Any illness in a parent is both frightening and annoying for children, and mine isn't an easy one to understand, or indeed to explain to friends or teachers. Worse, I've not always been there for them, and one of them has experienced emotional difficulties. I can't prove that my illness caused this, but I'm pretty sure it contributed, and I shall always bear the guilt.

Six years ago I gained a consultant post in addiction psychiatry in the local hospital where I had been a patient. I had been a trainee with my colleagues, and, for the first time, had not divulged my history. In fact, I thought they knew and was rather mortified when I subsequently discovered this was not the case. But I couldn't quite believe it—a job near my home in the specialty of my choice. Initially, I found that walking past wards where I had been a patient was troubling, but I gradually stopped thinking of myself as a patient.

Unfortunately I have since had episodes of illness, one necessitating an admission out of area and another resulting in a series of electroconvulsive therapy as a day patient in the hospital where I work. I still find the experience of illness troubling and confusing—in many ways it makes me feel like a different person. When I read a textbook description of psychotic depression, my diagnosis, I can't marry it with how I feel. I do feel low, but also agitated and frightened, and simply very ill. I still fear that others think I have a personality disorder. And this, for me, is one of the harder aspects. I work in a hospital where I've had some significant admissions and

treatment. I find it hard when I speak with doctors who have treated me. But what is far worse is the uncertainty as to whether others—doctors and nurses—have seen me as a patient, or have listened to the inevitable hospital gossip, and formed opinions.

My memories of my periods of illness are very muddled, and I simply don't know who knows or who has treated me. My close colleagues are hugely supportive, but I've heard talk about psychiatric patients, including about healthcare professionals, and it's not all kind. It's difficult to sit in a ward round talking with a nurse I suspect may have seen me in much unhappier circumstances, and I can't help wondering whether people think I shouldn't work here. My current plan is to be more open and to tell people, but that's not easy either. Often they're very embarrassed, and I don't want my patient status to become the most important thing that people know about me.

Some day I hope my two selves will become less separate, and my working life will become more comfortable. Until then I will try to comply with my psychiatrist's advice, try to remain well, and to make sure the psychiatrist remembers what the patient experiences.

All authors declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, no other relationships or activities that could appear to have influenced the submitted work."

Provenance and peer review: Not commissioned; not externally peer reviewed.

Patient consent: Not required; the patient is one of the authors.

**Accepted:** 04 July 2012

Cite this as: *BMJ* 2012;345:e6994

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### A clinician's perspective

Rebecca meets the diagnostic criteria for recurrent depressive disorder (ICD-10 code F33), and during an episode she often has psychotic symptoms. At her most ill, Rebecca is convinced that she is a terrible doctor, about to be referred to the General Medical Council, and a burden on others. Her view that she has a personality disorder rather than depression, which I do not agree with, also comes to the fore. Reassurance, rational challenge, and cognitive therapy do not cut much mustard at these times.

Depression that may benefit from treatment is so common—affecting about 5% of the population at any one time, about 20% each year, and 50% over the average lifetime—that it is part of most lives in some way. Psychotic depression is, however, rare, with a lifetime risk of only 0.35%. In other words, less than one in 100 people with depression will have psychotic symptoms. There is much debate about how to manage “everyday” depression, but psychotic depression needs treatment to avoid the risks of dehydration, starvation, and suicide. Electroconvulsive therapy is the evidence based treatment of choice and can be lifesaving.

It took almost two years of drug treatment, including two courses of electroconvulsive therapy, before Rebecca recovered from her first episode 20 years ago. She completed her training under the cloud of her illness but had good spells, sometimes without treatment. About four years ago, another course of electroconvulsive therapy, in another health district, was followed by a return to maintenance treatment with lithium and fluoxetine. Towards the end of last year, we avoided hospital admission with quetiapine augmentation, but some combination of Rebecca stopping that drug, going back to full time work, and perhaps a naturally worsening episode underneath it all led to a relapse earlier this year.

Reinstating and then maximising the dose of quetiapine helped a bit, affording some respite from insomnia but bringing weight gain. Rebecca and her husband suggested electroconvulsive therapy, done locally to reduce disruption to the family but as an outpatient to minimise the chances of bumping into colleagues. All the medical and nursing staff involved went out of their way to make it go successfully with a minimum of fuss. We have recently added tri-iodothyronine hormone augmentation, with apparent success, so that quetiapine can be reduced. Once Rebecca has been well for 6-12 months, we could phase out medication.

Rebecca is now back to her usual self—an excellent clinician and active in educating students, mentoring trainees, audit, and research. Her abilities make her a highly valued member of the team, and a dry and often self deprecatory wit contribute to her popularity around the hospital and beyond.

I admire Rebecca for having the courage of her convictions and publishing this piece. It is brave to do so, but I doubt that anyone will think less of her for having depression, and most will applaud her in being so open about it. As she says, it will allow her to know that everyone knows, or at least could know, rather than having to deal with the uncertainty of not knowing and people being unable to talk about it. This will not, of course, preclude insensitive remarks, even if they are made in the guise of empathy or with the best of intentions. What we really need to reduce and ultimately defeat the stigmatisation of psychiatric disorders, and to allow people to practise talking about them with some sophistication, is capable people like Rebecca saying how it is: that one can have severe psychiatric disorders, respond to treatment, and get back to a productive, happy life at work and with family.

What are the learning points from all of this? For starters, that careers advice is best left out of doctor-patient consultations. That the vicissitudes of life as a clinician or academic are as nothing compared with accepting and managing a major illness and the treatment for it. That it is difficult for people to share their innermost thoughts with a doctor, especially if he or she is a colleague. I am reminded of the primacy of patient experience, the power clinicians have, and the trust required in and of them. It may not be straightforward having a doctor as a patient, but it is a lot easier than it is for a doctor to be a patient. Being a doctor is almost always easier than being a patient. Having a colleague as a patient helps one to appreciate the inevitable but necessary power imbalance in the doctor-patient relationship. Perhaps that is why I was so pleased that Rebecca told me, at our most recent appointment, that it was the first time she hadn't been nervous about seeing me.

Preparing this text has crystallised these thoughts for me. I hope the article contributes to de-stigmatising depression among doctors and others, and helps Rebecca and those around her manage her illness as best we all can.

Stephen M Lawrie

### Useful resources for patients and health professionals

- Doctors Support Network ([www.dsn.org.uk](http://www.dsn.org.uk))—A confidential self help group for doctors
- Depression Alliance ([www.depressionalliance.org](http://www.depressionalliance.org))—Provides information and support services in the UK
- Royal College of Psychiatrists ([www.rcpsych.ac.uk](http://www.rcpsych.ac.uk))—UK professional and educational body for psychiatrists; provides educational material and information for psychiatrists and general public
- Samaritans ([www.samaritans.org](http://www.samaritans.org))—National charity providing confidential emotional support
- Befrienders Worldwide with Samaritans ([www.befrienders.org](http://www.befrienders.org))—Worldwide confidential emotional support
- National Institute of Mental Health ([www.nimh.nih.gov](http://www.nimh.nih.gov))—Provides mental health information and education in the US
- Beyondblue ([www.beyondblue.org.au](http://www.beyondblue.org.au))—National, independent, not for profit organisation working to address issues associated with depression, anxiety, and related disorders in Australia