

Chapter 1

Experiencing depression

Lewis Wolpert

Depression varies from low mood to clinical depression. Severe depression is disabling and difficult to describe. Other symptoms such as local pain, feeling faint, and not being able to sleep are common. I describe my own experience.

If you can describe your severe depression you probably have not had one. It is indescribable and one enters a world with little relation to the real one. It was the worst experience in my life, even worse than the death of my wife from cancer. It is shameful to admit this but that was my experience (Wolpert, 2001). While she was dying I could do things to help her and I mourned afterwards. But with my depression there was nothing I felt I could do and I believed I would never get better. My mental state bore no resemblance to anything I had experienced before. I had had periods of feeling low but they were nothing like my depressed state. I was totally self-involved and negative and thought about suicide all the time. I just wanted to be left alone and remain curled up in my bed all day. I could not ride my bicycle and had panic attacks if left alone too long.

I also had numerous physical symptoms – my whole skin would seem to be on fire and I would on occasion twitch uncontrollably. Each new physical sign caused extreme anxiety. Sleep was very difficult and sleeping pills only seemed to work for a few hours. The future seemed hopeless and I was convinced that I would never recover and would probably end up completely mad.

Everyone has some story to tell as to why they get depressed. My own, I believe came from the difficulties I had in controlling my episodes of atrial fibrillation. The drug I had taken for several years no longer was as effective. My cardiologist changed my medication to flecainide and this gave me morning sickness and severe stomach cramps. I do believe it was this drug that precipitated my depression but the evidence is poor. I am a well-known hypochondriac and feared having a stroke. I also had a trip planned to South Africa, my country of origin, concerned with science and was terrified I would go into fibrillation far from medical help.

I persuaded a colleague at my medical school to give me an X-ray but all was in order. My doctor encouraged me to go and I cancelled the trip. I was distressed at letting my colleagues down and this increased my anxiety. I began to feel even more weird, and I was unable to sleep at all. I was clearly rather ill and called a psychiatrist friend from my medical school to visit me. He told me that I was severely depressed and put me on a tricyclic antidepressant. I read about its side effects and it became increasingly difficult for me to urinate. I ended up begging a urologist to hospitalize me. He did not but I came off the tricyclic antidepressant.

I spent most of my time at home thinking about death. It was weird that I should have been in this condition as I was generally very stable, happily married and with a fine job at the university. Then one night I had a dream about devils and woke up with a compulsion to kill myself. My wife and family got me into the Royal Free hospital by lunchtime and I was curiously relieved to be there. I was in the psychogeriatric ward and it was peaceful and I was well looked after. My psychiatrist put me on Seroxat® and assured me that I would recover – I did not believe her. I spent most of the time in bed for the first few days doing relaxation exercises, and then they let me go for little walks with

a companion. They tried to give me cognitive therapy but it made no sense at that stage. I accepted that all my views were negative but this seemed perfectly natural considering the condition I was in. I thought of suicide all the time but did not know how to do it. As I was too scared of heights, jumping from my window which was high up was ruled out. I kept asking for electro-convulsive therapy which involves giving the brain electric shocks as I thought the drug would not work.

Nothing gave me pleasure and every decision, no matter how small, increased my anxiety. I had no emotions and was unable to cry but I did retain a macabre sense of humour. Sleep was very difficult but the staff gave me pills which left me doopey the next day. I got a bit better during the day and by evening could read and watch TV, but next morning I was back in the original bad state – a diurnal change classical for depression I was told. My hypochondria continued and I had Parkinson's disease as my hand trembled, and my foot flapped which they diagnosed as muscle weakness. My memory seemed to be failing and I was frightened that I was going insane. I also wondered what I was doing in a ward of old sick people, but at the same time was probably the sickest.

Over a period of three weeks I improved a bit and cognitive therapy began in the last week to make some sense. I returned home but remained indoors most of the time. My wife was angry that I was thinking of suicide and made a bargain with me. If I was no better in a year she would help me to die. I believed her and it reduced my suicidal thoughts.

I had cognitive therapy once a week and began to consider going back to work but was frightened I would not be able to cope. There was a meeting that I considered attending but was frightened I would panic and walk out. My therapist did a scenario with me about the meeting in which I walked out but the others did not mind. This enabled me to go and I survived and this was an important step in my recovery. I gradually got better and felt like Lazarus risen from the dead.

My wife was embarrassed about my depression. She had not told anyone about it as she thought it would be bad for my career – stigma is ever present. She just told them that I had a minor heart condition. For many the stigma of depression is a serious problem and I have been told by other depressives that they would not confide their condition to their bother or sister even though they had attempted suicide. Others were concerned that if their condition were known they would lose their job. One lady told me how she disguised her condition by appearing cheerful in public. I have to confess that prior to my illness I had a temporary technician in the department who had a severe depression that was so disruptive for those working with her, that I did not reappoint her. Carers of depressives all too often get depressed themselves.

But my recovery from my severe depression was not the end. I had read that only 10% of patients with a severe depression do not have a relapse and I believed that I would be in that group. Four years later, though I was working and travelling a lot, some of the symptoms of depression came back for no obvious reason. I tried St. Johns Wort but that did not help. I returned to my cognitive therapist who thought I was anxious about my impending retirement. I even visited her on the morning of my 70th birthday. Things got worse and my psychiatrist put me back on Seroxat® (paroxetine) and my decline continued. There were panic attacks and a cold tingling feeling would spread over my skin. I tried exercise which usually made me feel better but this made me exhausted and I entered a half-sleep state when I no longer had control of my thoughts. I felt I was going insane. I cancelled many of the meetings at which I was supposed to talk.

My new partner, my wife had died, found my condition very hard to deal with and she persuaded me against my will to consult a psychoanalyst. She had to drive me there and pick me up as I could not travel on my own. I refused to lie on the couch and found the interaction unfriendly, quite unlike my relationship with my cognitive therapist. Also I think psychoanalysis is without any scientific foundation. Fortunately after several weeks he took a long winter break and I got much better and did not go back. Since then there have been further episodes, but none really severe and I was prescribed Effexor® (venlafaxine) which I am still on. Exercise also works well for me.

Depression has a confusing number of different meanings and there is a lumpy continuum from feeling low to severe depression. Considering how many people have a severe depression it is surprising that there are virtually no good descriptions of depression in English novels. But writers have done well with their own depression. An outstanding example is William Styron's book *Darkness Visible*. He points out early on that 'the pain of severe depression is quite unimaginable to those who have suffered it, and it kills in many instances as it cannot be borne.'

Hamlet was clearly depressed:

'I have of late (but where fore I know not) lost all my mirth, foregone all custom of exercises . . . the earth seems to me a sterile promontory . . . it appears no other thing to me than a foul and pestilent congregation of vapours.'

John Stuart Mill (1962) wrote that Coleridge's poem, 'Dejection', was an accurate description of his state.

A grief without a pang, void, dark and drear,
A drowsy, stifled, unimpassioned grief,
Which, finds no natural outlet or relief
In word, or sigh, or tear.

Manley Hopkins poem is also excellent.

No worst, there is none. Pitched past pitch of grief,
More pangs will, schooled at forepangs, wilder wring.
Comforter, where is your comforting?

Shelley described his suicidal feelings thus:

Then would I stretch my languid frame
Beneath the wild wood's gloomiest shade,
And try to quench the ceaseless flame,
That on my withered vitals preyed;

The poet John Clare was in an asylum for many years:

I am! yet what I am none cares or knows,
My friends forsake me like memory lost;
I am the self-consumer of my woes,

And Tolstoy wrote that life had no meaning for him. Anne Sexton (1999) had manic depression and committed suicide:

God went out of me
as if the sea had dried up like sandpaper,
as if the sun became a latrine.
God went out of my fingers.
They became stone.
My body became a side of mutton
and despair roamed the slaughterhouse.

All these descriptions are essentially based in terms of Western culture. To what extent is the experience of depression similar in other cultures? There are claims that in some cultures there is no word for depression. An important feature of depression is somatization which results in bodily symptoms similar to that of neurasthenia. In the 1980s, Arthur Kleinman (Kleinman, 1988) found that in China most cases of patients with neurasthenia were suffering from severe depression which was not an acceptable concept in China at that time. In India typical comments

by depressed patients were that they could not tell anyone how they felt as it would lead to ill-treatment and people thinking lowly of the person (Raguram et al. 1996).

Since depression is common and disabling, particularly so as suicide is all too common, and since there is a strong genetic component involved, it is surprising that evolution has not reduced the incidence (Wolpert, 2008). It is hard for many to believe that so common a state does not have some advantage for the individual. I must confess that I can see no advantage to me that having a severe depression may have brought, other than having a better understanding of the condition. This debate is accurately described in Chapter 3 of this book.

There is no doubt that sadness is an adaptive emotion, but it is severe sadness, severe depression, that raises problems. Several hypotheses have been proposed to show that depression can have an advantage for the individual. One of the first was the social competition hypothesis (Price et al. 1994). This sees depression as an adaptation whose function is to inhibit aggression by rivals and superiors when one's status is low. It is a means of yielding when there is social competition and thus reduces the efforts by the aggressor. It is hard to see how this could actually function in any current human society, and why depression should be so physically and psychologically debilitating. In terms of these ideas, just giving in would be sufficient. It also is completely at variance with women having twice the incidence of depression as men, depression in children, and the increased chance of a depression in adulthood if a child is abused or neglected – all these argue against depression being used to yield to social competition, and being adaptive in this way.

Another hypothesis is that the function of depression, and of low mood, is to make people accept unobtainable goals and so change those goals (Klinger, 1975). This may make sense for low mood, but not for severe depression. Another view, particularly in relation to postpartum depression, is that it is essentially a plea for help to the woman's partner in looking after the newborn child (Hagen, 1999). The social navigation hypothesis is that low mood and depression focuses resources and motivates partners to help (Watson and Andrews, 2002). Yet another approach is that varied situations can cause non-severe depression and that the symptoms serve related but distinguishable functions (Keller and Nesse, 2006). For example, sadness would result from loss, whereas crying may be a social signal, and fatigue reflects physical or mental weariness. But all these really deal with sadness at a low to moderately high level, and offer no evolutionary explanation for clinical and disabling depression (Nettle, 2004).

A different approach to depression is to view it as sadness having become excessive and out of control, in other words, malignant. Cancer is an example of a normal healthy process, cell multiplication, going wrong and becoming malignant. Cancer has its origin in a single cell with a small defect, which then goes through a series of stages that lead to malignancy. The same may be true for depression in the sense that there is a normal process that has become disordered. It may be that because sadness is a complex emotion it may increase to a malignant state due to loss of normal controls. The complexity of the processes involved may have prevented the evolution of adequate preventive mechanisms. Severe depression may result from the interaction of natural biological sadness and negative cognition – malignant sadness (Wolpert, 2001). There may be a positive feedback loop between the biological basis of sadness and the psychological basis that leads to severe depression. There is also a contribution by other factors, such as genetic disposition and cytokines produced by the immune system.

References

- Hagen, E.H. (1999). The function of postpartum depression. *Evolution and Human Behavior*, **20**, 325–359.
- Keller, M.C. and Nesse, R.M. (2006). The evolutionary significance of depressive symptoms: different adverse situations lead to different depressive symptom patterns. *Journal of Personality and Social Psychology*, **91**, 316–330.

- Kleinman, A. (1988) *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York, Free Press.
- Klinger, E. (1975). Consequences of commitment to and disengagement from incentives. *Psychological Review*, **82**, 1–25.
- Mill, J.S. (1962). *On Bentham and Coleridge*. Smith Peter.
- Nettle, D. (2004). Evolutionary origins of depression: a review and reformulation. *Journal of Affective Disorders*, **81**, 91–102.
- Price, J., Sloman, L., Gardner, R., Gilbert, P., and Rohde, P. (1994). The social competition hypothesis of depression. *The British Journal of Psychiatry*, **164**, 309–315.
- Raguram, R. et al. (1996). Stigma, depression, and somatization in South India. *The American Journal of Psychiatry*, **153**, 1043–1049.
- Sexton, A. and Kumin, M. (1999). *The Complete Poems*. Anne Sexton, Mariner.
- Styron, W. (1991). *Darkness visible*. Picador.
- Watson, P.J. and Andrews, P.W. (2002). Toward a revised evolutionary adaptationist analysis of depression: the social navigation hypothesis. *Journal of Affective Disorders*, **72**, 1–14.
- Wolpert, L. (2001). *Malignant Sadness: The Anatomy of Depression*. London, Faber & Faber.
- Wolpert, L. (2008). Depression in an evolutionary context. *Philosophy, Ethics, and Humanities in Medicine*, **3**, 8.

