University of Oxford Disability lecture 26 May 2016 Transcript

Vice Chancellor, Professor Louise Richardson: Introduction

Good evening everyone, I'm delighted to welcome you to this brand spanking new lecture theatre and I'll bet that for many of you it must be your first time here – it is quite glorious – but I'm especially delighted to welcome you all here to our second lecture on the theme of disability.

Now the notion of parity of esteem - where mental health is valued equally with physical health - is now enshrined in English law but I think many of us believe there is much to be done if the country is to stand a good chance of actually achieving this parity. The British Medical Association has said that what we lack is a clear range of actions to help ensure not just 'parity of esteem' but 'parity of outcome'. Being open, confronting the stigma that has been perpetuated for generations, and encouraging frank discussion are all important elements of the response and few are better qualified to inform this discussion than our distinguished visiting lecturer this evening.

Professor Linda Gask is Emerita Professor of Primary Care Psychiatry at the University of Manchester, and is one of the world's most eminent specialists in the treatment and understanding of mental illness. After reading Medicine at the University of Edinburgh, Linda then undertook her specialist training in Psychiatry in the North West of England.
Much of her clinical research has taken place in Greater Manchester, but the impact of this work has been truly international. In 2000 to 2001, she was a Harkness Fellow in Health Care Policy, based at the Centre for Health Studies in Seattle. She has also worked as a Consultant for the World Health Organisation, and as a regional representative of the World Psychiatric Association.

Today she is one of the academy's most respected and compelling voices on Mental Health. She has a long list of publications, her most recent being 'The Other Side of Silence: A Psychiatrist's Memoir of Depression'. Among her earlier work was the 'ABC of Anxiety and Depression', 'A Short Introduction to Anxiety', the widely adopted 'Teaching Psychiatry: Putting Theory into Practice', which offers a globally relevant perspective, and provides practical advice on all aspects of teaching psychiatry. Other works include 'Medical and Psychiatric Issues for Counsellors', and 'Psychiatry in Medical Practice'.

Over her career as a researcher and clinician Linda Gask has accrued deep expertise in researching mental health policy and practice, with a particular focus on primary care mental health. Her most recent research projects have been concerned with improving the quality of care for those with depression, and the management of people who are at risk of self-harm. In this field, Linda helped to found the STORM suicide prevention initiative. STORM – which stands for Skills Training On Risk Management – is a package designed for all front-line health and social care staff, for those who work within the criminal justice system, and for staff in voluntary agencies - particularly those working with people at risk of suicide.

But a fundamental component of her life's work has been her experience of life itself. Throughout her academic and medical career Linda has spoken openly and fearlessly about her own personal experience of both pharmacological and psychological treatment for depression and anxiety.

Her most recent book is in part a memoir and has been described by Professor Dame Susan Bailey, as a 'first' in bringing together the intricate web and weave of being simultaneously a doctor, a patient and an academic.

Ladies and Gentlemen, please join me in welcoming Professor Linda Gask to deliver the Second Annual Oxford Lecture on Disability.

Professor Linda Gask: A Psychiatrist's Experience of Depression

Thank you very much. I'm honoured to be invited to speak here – and in such a beautiful building as well. I'm going to speak to you without a Powerpoint. I want to really try and speak to you very much from my heart rather than reading through things on slides. I have some notes. First of all I want to tell you a bit more about who I am. You've heard about my career, but perhaps a little bit more about me. I was a clinical psychiatrist for thirty-three years. I went straight into psychiatry, a from medical school and I was a consultant for the last twenty-three years of that and I worked in the north of England – I think the furthest south I've ever worked was Sheffield, which gives you some idea – I'm a northerner. You probably can tell that from my accent anyway. But my interest … I worked in Barnsley, I worked in Preston and most recently I worked in Salford … and Barnsley and Preston are two of the most deprived areas in England.

I've always had an interest in people with *common* mental health problems – with depression, anxiety, eating problems – rather than more severe mental health problems such as schizophrenia. My interest has been in the people who don't or do get help in primary care. Only about 10% or less of people with mental health problems are treated in the mental health services, although many of my younger colleagues find it very hard to believe that GPS treat the majority of people with mental health problems. So that's been my interest and I taught medical students, I taught junior doctors, all of the things that one would expect, but as well as that I've been a patient and I've been a patient in terms of my mental health ever since I was in medical school.

My problems with anxiety began in my mid-teens and I had really awful anxiety about my A-levels. I've always had a great fear of failing. I'm sure that's something that is quite a common experience – I'm in Oxford where people are high achievers – and I was a high achiever in my school and when I went to Edinburgh I was suddenly in a complete lecture theatre full of other high achievers, so it was very competitive.

I have had several episodes of depression, some of them quite severe, throughout my working life. My first episode - more severe episode - was when I was a medical student. As you might imagine given that my problems began around my A levels, I had problems with my finals. And at that time I rang up the consultant afterwards – I got through them and I rang up the consultant who had taken care of me and I said "I wonder what you think about me going into psychiatry?" because psychiatry had actually been the subject that I was best at at university. I somehow seemed to be able to understand how people felt. And he did pause for a moment – there was a perceptible pause – then he said "I think it would be a good idea". And that really did change my life because although I'd done very well in psychiatry I really thought that because I'd had mental health problems as a student I couldn't possibly go and do it. My experience follows on from that. I'm now retired – I retired from the University of Manchester two years ago, and I kind of hoped that once I'd retired I wouldn't have any more episodes – everything would be fine – and then a year ago I got quite ill again. So it's been a lifelong thing.

What I want to talk to you about is a bit more about the subject of depression and about treatment, but before I go on to that I just want to remind us … I've been writing a paper recently about an intervention we did training people in universities to be better at helping people in acute distress and it is hard to find data from the UK but the *US National College Health Assessment 2013* reported

31.3% undergraduates had felt so depressed at any time in the last twelve months that it was difficult to function. 5.9% had intentionally cut, burned, bruised or otherwise injured themselves. 7.4% seriously considered suicide in the previous twelve months and 1.5% had attempted suicide. A review of the epidemiology of college student suicide noted that the age at which you go to university is a period of great transition on many different levels: social, socially, academically, psychologically, existentially – it is a period of great change. It was certainly that for me because I came from a working-class background in the east of Lincolnshire and it was quite a shell-shock for me going to university. I was the first person in my family to do that.

I want to say a bit about what depression is, and then relate that to my personal experience. I'll say a bit first about what it is supposed to be. I say that because if my academic colleagues were here I'm sure that's how they would start off. Then I'll talk about how it's experienced and then I'll talk a bit more about my own beliefs about that.

If a psychiatrist were here giving a lecture to you about depression they would start off by telling you that there is something called major depression. To have this you have to have depression, low mood, and/or loss of interest and pleasure for at least two weeks and you have to have at least four of the following symptoms: change in sleep (that's sleeping too much or not sleeping enough); change in appetite; loss of energy or motivation; poor concentration; guilt, self-reproach; retardation (being slowed up) or being agitated and suicidal thoughts or hopelessness. That comes straight out of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, which is currently in its fifth version.

They would be telling you about all the biological models of depression: anyone who follows the discussion on the web, particularly on Twitter, will know that there is a constant argument about the monoamine theory of depression and psychologists sometimes say that psychiatrists are still holding onto this, and psychiatrists will say no, we stopped believing in that years ago. But we don't really know. There are many different theories about the biological causes of depression. Genes certainly play a part (and I'll say a bit more about that in relation to my own family in a moment). The latest theory is it's all about inflammation – so you just have to say the word inflammation – that's the latest theory (theories for most things actually). And then physical things can cause depression: alcohol and drugs – you can be depressed because you are drinking and you can get depressed because you stop drinking. They both play a part. Physical illness, chronic illness, cancer, having an underactive thyroid, the tablets that you are taking …

But the theories that most people know about are the psychological theories and almost everyone knows about.. . I mean Freud has passed into common parlance – people have heard about some of his ideas. He very much believed ... the psychodynamic understanding of depression is that past relationships have an influence on our lives in the present. So your relationship with your parents will have an influence on how you relate to other people now and that might result in you getting depressed.

Psychological models also include cognitive models which are really fashionable: it is quite hard in many places to get any other kind of therapy but cognitive therapy. That very much comes from the theory that if we think negative thoughts that can not only cause us to become depressed but can keep us depressed. There are also behavioural ideas that when we get depressed we stop doing the things that we enjoy doing, we stop doing the things we have to do and we retreat, and that we can actually recover by starting to do things again – the idea of acting better will actually help you feel better. And there are social models as well. What we certainly know is that people who have had trauma and early abuse in their lives are more likely to get depression; people who have had chronic

lack of social support; and in the areas I've worked in England I guess there are four things that come up over and over again. I call them the four Ds: Debt, Disease, Divorce and Deprivation.

So how do we experience it? Well there's a lot of memoirs written about depression – I've written my own – but there are many others. I've often encouraged my students to go away and read about people's experience rather than starting from the nine symptoms. Go away and find out how people actually feel when they are depressed. Let's start from there. There are some well=known ones. There's a very, very good book called *Darkness Visible*, which was written by William Styron. He was the author who wrote *Sophie's Choice*. A more modern one, which I found particularly affecting, was by Tim Lott, the journalist and writer, who wrote a book called *The Scent of Dried Roses* and that was about getting depressed following the suicide, the unexpected suicide of his mother. He talked very much in that book about how depression can affect our sense of who we are. But I would say that they are all different because I think that people's experiences of depression are different: one person may relate to a memoir and another person may find it very difficult to.

So what do people experience? What did I experience? Well for me it is much more than sadness. There are a great many people who think that depression is just unhappiness. It is much more than that: it is a loss of vitality, it is a loss of joy, a sense of utter despair and when I get depressed I can't think clearly. My brain seems to shut down. I'll give you a small quote here from something I wrote about when I was very depressed, when I was having major problems at work, and I think it gives you some idea of the cognitive experience:

'My mind seemed at last to disintegrate into small, sharp-edged monochrome pieces. I was unable to think with any clarity. I sank down in front of the sofa. I sat down on the sofa in front of the fire and wept. I just couldn't think.'

The other thing is that is a very physical experience and that again is something that is not unhappiness. You don't feel like physically exhausted and like there's a weight pressing down on your chest when you're unhappy. That's what I felt. At the same time, the same episode I wrote:

' … the terrible weight pressing down on my chest, which became lighter when I cried or talked, but only for a while. When it returned it was if an invisible demon had loaded ten more pounds on each side of a bar. I was unable to push it off my chest. Maybe this is where the expression getting it off your chest comes from, only I couldn't. The talking didn't work anymore.'

For me, there was a point where talking therapy stopped working, and I'll say more about that later.

So I've not only thought about my own experiences, I've done some research, interviewing people about the experience of depression and what's clear to me is that it is a bio-psycho-social experience. People experience what is going on in their life as the cause and most of the time it is, but they experience emotional and physical symptoms. Depression has social consequences. Living with someone who is depressed is very difficult. Keeping your job when you're depressed is difficult. Just functioning in a relationship is very difficult. So there is a secondary loss: there's not just the loss that caused you to become depressed in the first place, there is the impact on your life.

I don't think there's a nice, simple, single depression like DSM would have us believe. I think there are many different types of depression and I think some of them are more caused by physical causes, some of them have more psychological and social causes. People have very common experiences in terms of symptoms, but they all have a different story and my patients over the years have told me many different stories: they've told me about being very frightened, they've told me

about loss, they've told me about trauma in their lives - particularly sexual trauma, need to be loved (everyone needs someone), feeling very lonely, difficulty in trusting others and a common experience for me is unresolved grief (and that is a very personal one for me). I don't think there is a single cause. What I've learned over the years, and I guess I learned this partly from working very much in primary care but working with Professor Sir David Goldberg, who was my supervisor in my PhD … I use the vulnerability and stress model and I'll say more about that in a moment and I'll talk about it in relation to my own life. Genes are important but they aren't the whole story: it is the interaction between the genes and the environment which is important. Temperament is important: I think temperament is partly inherited. But your life is also absolutely crucial: your early life experience of conflict, trauma and neglect. I would meet mothers when I worked in Salford who had five year old children and those children had been exposed to the most awful lives and I knew even by that point that a great deal of damage had been done. It was almost too late but not too late.

Physical health is really important: if we get chronical physical illnesses, and I've recently been diagnosed… for the last two years I've been diagnosed with chronic kidney disease. About 50% people with chronic kidney disease get depressed. Age is important: the older we get the more susceptible we are. Social deprivation is obviously very important. But the stress that triggers it off are life events and they are commonly loss. So for me that begins to explain why not everybody gets depressed when something awful happens to them: it depends on your vulnerability. Some people are remarkably resilient in the face of those life events because they have had a different experience of life, they have different genes, they have different health. Some of us are not as resilient. I guess that's one of the reasons why I don't find resilience a terribly helpful concept because I'm not sure I could undergo four hours of resilience training. I actually think a great deal of my resilience depends on what happened to me early in life. What I could undergo is some training in some coping skills and actually rethinking how I cope with stress.

I've mentioned loss and grief and grief is a remarkably common experience and it's not just about death. I wrote in my book 'We can grieve for the loss of a person we love, a job which means a great deal to us and for the loss of our health when we become chronically ill.' When I was given a diagnosis of polycystic kidney disease I did grieve for my health. 'We grieve for the loss of our dreams for the future and the lost opportunities we'll never have.' Darian Leader, the psychoanalyst who has written about depression (I don't agree with all of his views by any means but I think he's written some very interesting ideas about depression and grief) cites the ideas of Freud that 'in mourning we grieve the dead but in melancholia we seem to die with them'. That's how it feels: it feels like a part of you … that you have also died … that you have taken in the dead person and you are dying as well. I say that with a great deal of feeling because one of the big problems in my life was an inability to grieve.

So how can I fit that to my own experience? Well I come from a family which had mental health problems (still does have mental health problems). My mother had chronic anxiety. My father, I'm fairly sure, had episodes of depression for which he would never dream of asking for treatment. He was certainly extremely socially anxious: my mother had to … he wouldn't go into shops . My mother had to bring things home for him, which was the sort of thing that you could do in a small town but I can't imagine in Oxford you going into a shop and asking if you could take all the clothes home for your husband to try on! But that was how he was. He would only go around shops at

night, when there was no one around. My brother had, and still has, severe OCD. Now that started at the age of seven, so I find it hard to believe that biological factors don't play a part: it was very early. He's never had really effective treatment. Mental health services tried all sorts of things, which so unimpressed my father that I'm sometimes relieved he didn't find out I became a psychiatrist, because he did used to refer to them as 'trick cyclists'. He really has nothing but contempt for the people who'd tried to help because they really got nowhere. I think a lot of that was to do with the fact that effective treatments for OCD hadn't yet been described, but by the time my brother got effective treatment in his twenties it was really too late.

So I grew up in an extremely tense and anxious household and when my father lost his temper he would hit and I was physically hit on occasions. But I was also aware that I was pretty good at getting him angry because we were remarkably similar in terms of temperament. I got on well with him when I was younger but not when I was a teenager: he didn't know how to cope with me. So my early life experience wasn't easy, but I went to university and you would have hoped that things would have improved, but that vulnerability left me very open to particular stresses. I had a tremendous desire to please my father, because he always wanted me to do well and to go … to do well at school. He was one of those people for whom 99% just wasn't good enough. So I got very anxious around the time of exams. I was always, I think, still trying to please him. I sometimes wasn't entirely sure who was it who decided that I should be going to higher education – him or me? So stresses have played a big part and the stress that causes most damage is the stress that seems to fit into you like a key going into a lock. So you can imagine when I failed my membership examination of the Royal College of Psychiatrists, not only had I failed in my chosen career that I thought was right for me, but I had failed, I thought, completely and that was a terrible blow. It was around that time that I really started to seriously think that something major was wrong with me. That was after the problems at medical school.

So I've experienced vulnerability and stress.

Now how do we approach helping someone with depression? Well if you go and see your GP he will have the guidelines from NICE (National Institute for Health and Care Excellence) and he will start off by following those and they suggest that severity is a great pointer in terms of how we should treat someone. So there is a whole spectrum of depression from unhappiness through to suicidal depression. So severity is very important, but I think one of the things I've learned as a clinician, from being a person consulting doctors, and I've had the (I think disconcerting – perhaps sometimes more for the doctors than for me) [experience] of consulting doctors who know me) and that's quite interesting, but what I'm aware of is that within my own profession there is a disturbing tendency to think about people as 'it'. So there's I/it encounters – you know, 'I'm going to look at this person and try and decide what diagnosis they have and where I can fit them into my system', rather than actually thinking of you as another person, that is remarkably similar to you. That was one of the reasons why I started to write my book really, because throughout my career I had realised that the lives of my patients really weren't; so terribly different from mine, except that awful things had happened to them, or they came from families where life was difficult or they came from families with a history of severe mental illness, but there were parallels: their stories were very similar to my stories. I had periods of unhappiness because I failed in things. I had periods of unhappiness and depression because of failed relationships: so did they. So I think it helped me to be a more understanding doctor. I did have times when my patients would say to me 'Hmm, you've been

asking these questions. Have you suffered from this as well?' and I would say 'Well yes I have, but this time is for you, not for me.'

What's really important, I think, is how well we engage with the people who are helping us, and those of you here who are therapists (and there may be some of you), but people who are in a supporting role will know that, that sometimes you have to make a real extra effort to engage emotionally with someone and that's probably the most important thing in recovering. It's probably more important than whatever model of therapy you have: you have to find someone that you can click with. The therapeutic alliance has to be strong. I've had four periods of psychotherapy in my life, three of them on the NHS and one privately … no two of them on the NHS (I've lost track now, I'll remember in a moment) but on one occasion I did go and see a therapist and I simply did not click with him at all. I've known patients that stayed with people they didn't click with, feeling that it is somehow their fault, when it isn't necessarily, it's that the two of you just don't gel. I think that's really important that a first effort at getting help shouldn't be – although it often feels like it - very important. I'll just tell you I saw that man for three months and during that time he would sit with sit hands like this [palms together gesture]. He was very psychoanalytic in his model and I was actually doing quite a lot of therapy training at the time and the first ten years of my career I did psychotherapy under supervision. I finally, after three months, summoned up the courage to say I didn't want to see him anymore. I've written 'It wasn't his qualifications and curriculum vitae I wanted to purchase from him: first and foremost I wanted to feel that he cared whether I lived or died. In the absence of this basic humanity, my visits to him had begun to feel like a kind of chore at best, and at the very least rather poor value for money. The emotion he had evoked in me most was anger at a wasted opportunity. We never really reached any deeper than this, but then I'd experienced as strange and rather paradoxical sense of pity for him, so I let him off lightly. I said "It's me, not you; I'm not ready"'.

I think one of the things I've learned about talking to people who are really in severe distress is the importance of really trying to get in to understanding what's going on for them. Too often people in life try to reassure us – they try to reassure us by saying 'but you've got everything going for you, you know, you're doing well, you've got a nice husband, you've got a great home' – that has nothing to do with it. It's how you feel inside that is important. And when someone feels that suicide is the only way, you have to try to understand why that is because they've got a peculiar kind of logic that you've actually got to try and work out, rather than saying 'it's not the only way, there are other ways to cope.'

I'm going to talk a bit now about coming to terms with depression and I think that if you're interested in this topic of finding out about people's experience the sociologists have written a lot about it, but the one in particular that I find very impressive is David Karp, who is an American, who experienced depression and wrote an entire book where he interviewed people with depression and what he described was first of all, a feeling of distress, inchoate feeling, can't put a name to it. And then coming to terms that something is really wrong and I can remember that feeling very powerfully when I was a medical student. I knew that something was wrong, but I couldn't work out what to do about it. I went along to see one of the student counsellors, and I didn't gel with her, and it carried on. I didn't know what was going on with me. I was very, very afraid that I was going to develop the kind of mental health problems my brother had, and I did in fact become quite obsessional. And then there's a crisis. And that's the point where you just kind of feel you've got to

do something and it was at that point that I went along to see the GP at the student health centre and he referred me to see someone for my mental health. I've seen many people when they've been in crisis and I just want to read you something which I think for me is... reflects how people often imagine they can plan their career out and plan their life and I suspect that will resonate with some of you here because I was a high-achieving student at my school, I went to university, I thought I had my life mapped out, and it wasn't.

'I've seen many people in my career who almost believe its's really possible to magically plan how your life will turn out and they try to plan their children's lives too. Sometimes it seems as though they can because nothing terrible has ever happened in their lives thus far – everything has gone as expected – then they experience a loss and the closer this loss relates to their sense of who they are and where they see their lives going, the greater the difficulty will be in coming to terms with it.

In failing the examination I'd temporarily lost the plot. I thought I'd safely sketched out for the story of the rest of my life. No-one else created this plan: I was quite sure it was mine. I disregarded any thought that I might have been still trying to please my father in some way, even though my father was dead and gone. I realise now that I was effectively papering over the cracks which had threatened to appear after my father's death. At the time it merely seemed as though I'd temporarily lost my way and found it again, but I failed to understand that coming off the pre-ordained track of my life might have been what I really needed.

I've learned that sometimes those moments of chaos when life careers off the rails hold important messages about things we need to change in our existence and the rigid expectations that we and others have of us that we need to challenge before it's too late. If we address these we can start to move forward once more towards achieving our own goals. If we choose the goals ourselves we have a better chance of success.'

My father died when I was half way though my house jobs – the one year I did after qualifying as a doctor – and we had become quite estranged after a very difficult adolescence when I'd been very close to him as child. I didn't grieve. I was doing a 2-in 3 on-call in surgery: that worked out as one night first on-call, one night second on-call when you couldn't leave the building and one night off when we usually just went to the pub next door. That was my life, and that was a really good way of avoiding having to deal with the loss. I went to the funeral. I even remember telling myself that it was easier that he'd gone because he was so difficult.

It was five years before I actually started to grieve for him and that was after my first psychotherapy. I started to grieve for him, strangely enough, when a relationship I'd had broke down. I was crying and then I realised I wasn't really crying about losing that man, I was crying about losing my father. I thought my life was planned out: that I would go to university and I'd become a doctor. And then I thought I'd found my place in psychiatry and then I made a mess of that. But I did manage to pass the exams and I did manage to carry on. I guess I've come to terms with having what David Karp calls 'an illness identity': I know that I have episodes of depression. But that's really hard for a lot of people. Some people don't have repeated episodes: some people only have one episode and they want to be absolutely normal again afterwards, and that's fine. But I have had recurrent episodes.

What I've tried to do is always to not let that define who I am. Yes, I get depressed, but that's only one part of me. The rest of the time I can function reasonably well. There are just times when I don't function very well and I have to rely on my husband and when I was at work my colleagues to tell me when things were going astray, because they would usually notice the signs. I would be repeating the same questions over and over in an attempt to reassure myself. I would find it very hard to get out of bed in the morning. I'd start to lose weight. I think I'm at the point now of defining my depression as a condition that I can get past.

I've talked a bit about my experience of therapy: I've had psychodynamic psychotherapy looking at my relationship with my father and also my rather difficult relationship with my mother, which was part of the reason why my father and I became estranged because I think my mother came between us in many ways. Then later, when I was having difficulty at work, I had some cognitive behaviour therapy, so I've had both types of therapy and they were helpful at different times, for different things. Because I found that CBT actually helped me cope with the everyday stresses of work: I learned how to manage my constantly repetitive thoughts, and that was really helpful. I worked with a therapist that was an expert in anxious ruminations and he was enormously helpful, but it was an entirely different experience from my first experience of therapy: he wasn't interested in me talking all about my life. We had to just get down and talk about now, and that was completely different and I don't think that would have been right for me when I was trying to grieve.

I've also taken a great deal of medication. I know that there are a lot of people who are antagonistic to the idea of anti-depressants. I know there are some people who think they don't work. I know there are some people who think they are dangerous: I have colleagues who have written about that. I can only say that for depression at the severer end of the spectrum, which mine is, they can be helpful. I've now been on anti-depressants continuously for the last twenty-two years and I don't think they've done me any lasting harm, although you may think otherwise, I don't know! But, you know, they've kept me alive. I've had to have them changed from time to time: when I've gone down to one I've had to go up to two again. I've had a whole range of different substances. At the moment I'm on a combination that seems to suit me, and they've kept me really very well for the last eighteen months and I hope that's going to carry on. But a lot depends on what's happening in my life and how much stress I put myself under. And that's part of the problem: if you're an ambitious person, as I have been, but you also are vulnerable, then there's always going to be difficulties. You've really got to plan your life out so that there are safety nets. I have those safety nets in place, I hope.

I've talked about a psychological therapy that didn't work and I would say that for me the most important thing in psychological therapy is that you can trust the person that you're talking to. One of the concerns I have about the NHS at the moment is its sheer inflexibility. It's not about finding what's right for the patient, it's about finding where the patient fits in and 'do you fit into my particular niche, and if you don't well I can't help you.' That's always made me very angry because I had therapists that went out of their way, I know, in order to provide what I needed at the time. It's really, really important when you're looking for therapy to make sure that you find people who are properly registered, properly supervised - there are ways to check that out – but there are always risks of harm. And psychological therapies – we've talked about the side effects of medication (of which I've experienced most of them) but psychological therapies have risks too. So I think it's important to be realistic. It's hard work and it requires quite a lot of participation. It isn't something

that people do to you. You have to work, and it can be very painful, and sometimes just getting from week to week can be painful.

I've had a lot of side effects from anti-depressants, which was one of the reasons why I didn't originally want to take them. But I had an episode when, as I said, the talking stopped being effective. What people tell me is they're worried about being dependent on them, they're worried about the side effects, what to tell other people? I've often made a point of getting my tablets out at breakfast when I've been in the company of other psychiatrists, and seen how they react. And there are some who look away in embarrassment, which I find really amusing because you would really expect wouldn't be the case. But I can tell you psychiatrists are as aware of stigma as everyone else.

Do they have long term effects? Who is the real me? Is this the real me on medication or if I stop the tablets would that be the real me? Well it would be another version of me, and my husband says he remembers that other version of me and it was a bit up and down. There's two problems you have to go through when you take tablets. Alice Malpass, in Bristol, wrote a very nice paper about this: she talked about the moral career of experiencing treatment. That what the doctors tell you is you have a duty to be well, that when you take the tablet and get well then you won't be stigmatised, you'll be better and then you can get back to work and then you can get on with your life. But what you're experiencing inside is you're experiencing the stigma of seeking help and then there's a double stigma when you actually have to take treatment. And then you start to say 'well is this the real me?' And then you worry about being dependent on them. Those are the kind of questions that go round in people's heads.

I haven't mentioned much more about social factors either, and I think that, particularly for students, that's a big factor: financial problems, housing problems. I think one of the first times I … well, when I first went to see the counsellor at university it was because I was late applying to Edinburgh because I had not met the requirements and I didn't expect to get an offer from them., but they gave me .. . they took me anyway. So I didn't get into halls of residence and I found myself sharing a room in digs with an extraordinary woman who was the yard-of-ale competition drinking champion [laughter] and had an entirely different approach to socialising and relationships to me. And I had to share a room with her. I was desperate to get away from her because I was lying on my bed trying to revise anatomy while she was socialising. Loneliness is a big factor; homesickness.

So I'm just going to say a bit more about how we get into therapy. How do you get into treatment? I've done quite a bit of research on that myself with groups of people who find it hard to get into treatment. I'll reflect on my own experience of that in a moment. First of all you've got to actually recognise that you need it, and that's a big issue. Then you've got to find your way there, so that means there's got to be sufficient information around the university to get you there. Then you've got to physically get there and talk to someone about things that are very personal to you. And then they've got to make a decision about whether they can help you or whether someone else needs to. All of those steps are difficult. I would always encourage any of you who are in that position as therapists to really think 'how does this person come to be in the room with me? How much do they understand about what you need to do to feel better?'

I don't think we pay enough attention to how ambivalent people are, and ambivalence for me is one of the core feelings. I've experienced it with my patients: I've seen people who say 'I don't want to live but I'm afraid of dying'. There's a very wonderful little book on ambivalence, that some of you

may have seen, by Kenneth Weisebrode, and I'm just going to quote something from it on ambivalence, which describes this for me really powerfully:

'Ambivalence lies at the core of who we are: it's something more subtle and more devastating than human frailty. Weaknesses can be remedied. Ambivalence comes rather from too much ambition. Desire begets dissatisfaction and vice versa. Optimisation becomes a fetish. Wanting the best means that we must have both or all, and are reluctant to give up any option lest we pull up the roots of our desire. That's why ambivalence is so hard to confront, understand or master and why it can be so disastrous. Most of us know this, yet we continue to deny it.'

Many people who are seeking help are experiencing that powerful ambivalence and unless we acknowledge that it can be very hard to deal with. I, as a doctor… doctors are supposed to be strong, so I'm not supposed to have emotional problems, even in psychiatry. So that is fighting against my desire to get help. So I want to be me, but I want to get help. I want both. But I have to give up something in order to go and get help. I have to risk that people will see me in the waiting room. One of my psychiatrists used to say 'you can come and sit in here if you want', and I actually said to her on one occasion 'no, I make my patients sit in this room, I'm going to sit here. I'll sit here watching property programmes with the sound turned down, just like everyone else does in the waiting room.' [Laughter] About the worst possible thing you can watch, actually, if you're poor is property porn on the television.

But people often get told that they are not motivated, and I think there's all sorts of things about being motivated. You might find it hard to attend regularly because you've got to tell someone that you've got to miss a lecture, you've got to tell someone that you've got to miss workshops. You might not understand what therapy is all about because no-one's really explained it. You might find it really hard to go to therapy because your life is in complete turmoil: you don't really know whether you are going to be sober tomorrow morning after you've had another argument and drank a lot the night before. And you might feel so hopeless and lacking in energy that you can't get out of bed to go. So when I hear that people have been offered something and then they've been discharged because they haven't turned up, it always make me want to say 'well, how hard have you tried to get them there?' That has been my experience of treating doctors and other people in health professions, and also students as well.

I'm going to come to an end now, and I want to just say a few things. What I've learned from experiencing depression, and also being a psychiatrist, is that there's no single answer. There are all those self-help books that people have on their shelves, and they've each got a single answer, and you might find the one that suits you, but none of them actually say there's no single answer, because that doesn't make for good sales. So for each person, on each occasion, the parts played by the different dimensions of biology, psychology and life circumstances will be important to a differing degree. That's true at different points in my life. As I'm getting older it feels like biology is playing a bigger part. My brain isn't as hot as it used to be, and I've also now got chronic kidney disease, which is inherited, but fortunately I didn't know that I had it until I had just retired.

The help and support and treatment required may be different at different times in a person's life, so when we have things where everyone is offered CBT, that's just not right, because you need different things at different points in your life. Sometimes you just need someone to talk to: you

don't need someone who's going to immediately give you an exercise book and say 'go and do these exercises'.

My life has been profoundly affected by my experiences of mental ill-health: it hasn't turned out how I thought it would turn out. When I was at school I think one of the reasons I went to medical school was that at my grammar school, in the east coast of Lincolnshire, if you did well in A levels you seemed to end up as a teacher and come back and teach. So I was determined that wasn't going to be me: I was going to get away, and I was going to have a job where I would have … I was going to do a degree where I would have a job and be able to be financially independent. And I have managed those things, but it's just not quite worked out … quite the way sometimes. I was never going to get married and I managed to do that twice, you know [laughter].

Life never does work out the way you expect. But I believe it's made me a more capable and empathic doctor. I know what it's like to sit in the other chair. I know what's going through people's minds. I know what it's like to have those questions asked of you. I sometimes think if some of my colleagues knew how much time people spend thinking about what they're going to say in response to those questions, they wouldn't take it all for granted that this was just the truth, because it's very easy to lie in a consultation. It's also helped me to be a more enlightened teacher as well, because I've been able to work out, I think, what people needed. And it's certainly made me a better researcher because I've found something that suited me, which was about trying to improve the quality of care for people with mental health problems out there in the community – the people that don't get help.

So, a couple of last quotes that I'm going to read you:

'Depression is a profoundly personal illness: it burrows into the soul and damages our sense of who we are and our reason for living in the way a worm makes its way to the core of a ripening apple.'

' We all have to find our own ways of managing the damage it causes but I know from my own experience that it can be done. Despite what some people may say, asking for and receiving help is really nothing to be ashamed of.'

Thank you very much.

Catherine Walter

I'd like to invite Dan Holloway to give the vote of thanks. Dan is a member of staff, a mental health activist and a performance poet.

Dan Holloway: Vote of thanks

Linda [indistinct], Vice-Chancellor, Catherine, Caroline and everyone from the Disability Advisory Service, members of the Disability Advisory Group, everyone at the Blavatnik and throughout the university who has made this event happen, questioners, gentlefolk, thank you.

Stigma is the thing with branches,
the miserly larch that will not shed its spines in winter,
the hollow hinterland that marches to horizons
where the eyes of reason and compassion cannot follow.

Thank you
...For lighting a path into the wilderness
That bewildered mess of passions dressed in dust,
Fashioned from half-started lives now carcasses of rust,
Ashes from the lists of everything we thought we'd be
…For caressing from the shards of carbon
Filaments of empathy
From which
Tomorrow builds her nest.

See, I can fly but sometimes I need you to give me wings
My heart is full of song
But I sometimes need your love to amp me when I sing
Sometimes people reel off lists of things I've done
Jobs done, medals won
Ultramarathons run
Poems told and stories spun
And I feel like I'm in a minority of one
When I say, "mate, the hardest thing I've ever done
Was get out of bed,
Put down the pills
Pick up some clothes
And face the sun."
And all you can say is
"the least you can do is put on a tie"
And I think, "look, you can have me shine,
Well, maybe not shine but at least get by
Like this,
Or you can have the last light in me die."

It's easy to say we care
And that is not enough
It's easy to say we want the best for everyone
And that is not enough
It's easy to write beautiful mission statements
And that is not enough
It's easy to put faces on our walls,
It's easy to celebrate the ones who did it all
It's easy to embrace a culture of support
Until we fall
And we must do all of that
But that is not enough

We talk glibly of a human cost
As though we know
A world that will not change
Becomes a junkyard where depositories of genius are tossed
But this is also hope
Damped down
It's smoking embers of a dream stamped out like cigarettes
It's kisses choked before they leave the throat

It’s everything that adds up to a life
Lost.

We’ll not beat stigma with celebrations of highflyers,
By filling dreaming spires with choirs of good intentions idolising outliers
By glamorising myths of brilliant madness
Or fetishizing funeral pyres.

Your victory is this,
That you are known not by a label but a name.
My wish, my dream, my right
Is for the same.