Case 2 A 47-year-old woman who lives in fear that God will punish her

A Nigerian woman, Rebecca, who is a practising Christian, has been talking to her priest about her fears of eternal damnation. He says that she has become 'obsessed' with God's punishment and expresses concern that she has lost weight and does not appear to be sleeping. The priest advises her to see a doctor. When Rebecca comes to see you, she appears low in mood and tells you she is only here because her priest told her to come. Throughout your conversation she thumbs through a well-worn Bible in her hands.

Based on this information, what three groups of psychiatric symptoms do you think you will prioritize in taking her history, and how will you go about exploring them?

1 *Mood symptoms* (Table 13): how does she feel at present?

Begin with Rebecca's current concerns and then focus on systematic exploration of her mood. When and why did she start to feel like this? Open questions (e.g. 'How are you lately? Is something worrying you at the moment? Has anything bad happened to you recently?') should naturally lead you to specific questions about her mood within the context of recent events in her life.

If mood is low, establish if this varies during each day. Diurnal mood variation: is mood worse in the mornings but better as the day goes by? This strongly supports a diagnosis of depression.

The 10 areas of Table 13 are essential to exploring mood. Identify whether or not they are present, and record their duration.

KEY POINT

The assessment of mood is inherently subjective. Ask patients to benchmark their current mood in relation to their usual range of mood (1–10, with 1 worst, 10 best), explaining that most of us would rate our usual mood as 7/10. Chart their current episode of depression: '4/10 last month, but 2/10 today'. This is also a useful marker of progress (or otherwise) when you initiate treatment.

2 *Psychotic symptoms:* what are the nature of her spiritual concerns? Key questions to establish the delusional nature of any such beliefs need to explore *how* she came to believe them, the *certainty* with which she believes them and the *cultural context* of those beliefs (Box 3, p. 10).

Even though it is Rebecca's priest who has expressed concerns, he may be from a different cultural background to her. If possible speak to her partner, siblings or parents to determine whether her views are in keeping with her background and whether they are *out of character* for her.

If she appears to hold delusional beliefs, then systematically explore for *other delusions* and psychotic symptoms.

KEY POINT

If unfamiliar with your patient's religious or cultural background, you need to clarify both what is culturally normative within that community, and what is normal for them as an individual. Family and friends are an ideal starting point.

3 *Obsessional symptoms:* why is Rebecca so preoccupied with God's punishment? The priest described her as 'obsessed' but we do not know if his use of the term describes Rebecca's difficulties with any phenomenological accuracy. You need to establish the quality of this preoccupation:

- Is Rebecca trying to resist thinking about this topic or is she choosing to dwell on it (i.e. is it 'ego syntonic', under her conscious control)? Remember, with obsessional thinking the individual attempts to resist the thoughts (at least at first) as they are experienced as intrusive and unwanted
- *If* her thinking does appear to be obsessional, you need to establish whether there might also be evidence of compulsive behaviour to (temporarily) reduce the associated anxiety. For example, she might visit her church to excess and create her own prayer rituals, leave in a certain way, or wash her hands 12 times each hour (e.g. once for each apostle) to make the obsession go away (Box 36, p. 195).

KEY POINT

The public frequently use 'psychiatric' language to describe how they and others feel (e.g. *depressed, obsessed, paranoid, manic*). These terms do not correspond to precise psychiatric definitions. Do not be misled.

On direct questioning, Rebecca describes 2 months of low mood with loss of energy, lack of interest in things and poor sleep. She tells you she has been thinking a lot about how she is failing to be a good Christian and that she deserves God's punishment. She is not resisting these thoughts. These beliefs do not appear to be held with delusional intensity and she agrees her priest may be right; nevertheless, she has continued to lose sleep worrying about her faith.

Bearing in mind the above discussion about symptoms, if her beliefs about God's punishment are not delusional, how else might you describe these beliefs in your MSE?

1 *Non-pathological preoccupation* with culturally sanctioned ideas in keeping with her subculture. This is often the case with some religious beliefs or core family values. A person's religious beliefs could come under pressure during a crisis and her preoccupation could reflect these doubts. Collateral history will usually clarify this.

2 Depressive or anxious *ruminations*: preoccupation with past events is a cardinal feature of depression and fear of future events indicates anxiety. Her depression may be characterized by acute loss of self-esteem and hopeless-

Table 13 Mood symptoms (ICD-10).

Three major criteria	Depression	Mania and hypomania
Mood	↓ subjectively + objectively	↑ and/or irritable
Energy	↓ with fatigability	↑ subjective excess energy
Interest and pleasure	↓ with loss of emotional reactivity	↑ excessive interests, overtalkative
Seven other symptoms		
Concentration	↓ subjectively + objectively	↑ but objectively reduced, highly distractible
Appetite	↓ weight loss common	↑ or ↓ (forgets to eat)
Sleep	↓ for most depressed people, with initial insomnia and early morning wakening	↓ because of a reduction in the person's *subjective* need for sleep
	↑ in minority of cases	
Ideas of self-harm, suicide	Very common	Uncommon but always ask about these
Self-esteem	↓ worthlessness	↑ inflated self-confidence if extreme: grandiosity
Ideas of guilt	Common	Absent. Take more risks than usual for that person
Views of the future	Bleak, hopelessness: strong predictors of suicidality	Unrealistically positive

ness (Table 13), and she may be experiencing excessive ruminations about punishment in this context.
3 A *mood congruent belief* may have developed that her symptoms (low mood, poor sleep, loss of pleasure) are a punishment of some kind. As the belief does not have delusional intensity, she can be persuaded that there are other probable causes for how she feels, specifically, her preoccupations reflect her depression.
4 An *overvalued idea* (i.e. a comprehensible, deeply held idea that dominates an individual's life for long periods). This seems unlikely in Rebecca's case.
5 An *obsession*: again this seems less likely as Rebecca is not resisting these thoughts. However, obsessional thinking can occur in some people who become depressed, and this improves (as do 2–4) once the primary problem of low mood is successfully treated.

There is clearly overlap between these categories. It is helpful to record direct quotations of how she describes her experiences, as well as your own conclusions about her phenomenology. These are likely to change over time and with treatment.

You establish that Rebecca is depressed – what crucial piece of current information about her mental state are you missing?

Suicide risk: has she any suicidal ideas, plans or intent? Has she harmed herself? What has she done or planned?

KEY POINT

Always enquire about suicidal ideation. If you have not asked about suicide, you have not interviewed the patient properly.

You are satisfied from the history you have taken that this appears to be the first presentation of depression in a 47-year-old woman, not associated with any immediate risk of self-harm.

What do you need to do now?

Exclude an organic cause of low mood. There are many physical causes of depression (Table 14) and these may have additional physical signs. Look for physical evidence of depression and its possible consequences (weight loss, self-harm, effects of alcohol and substance misuse), as well as comorbid anxiety (Fig. 2, p. 37).

Carry out a **physical examination** in a systematic fashion.

What physical investigations will you recommend to screen for common disorders that could cause or contribute to Rebecca's depression?

Table 14 sets out the common disorders but you need a system to collate these with the common investigations. Start with common tests, easy to carry out and interpret:

- Full blood count (FBC) to rule out anaemia, and a high mean corpuscular volume (MCV) of alcohol misuse, hypothyroidism or folate deficiency
- Urea & electrolytes to rule out dehydration, renal impairment, electrolyte imbalances
- Random glucose may suggest diabetes
- Liver function tests to indicate alcohol misuse (typically, raised gamma glutamate transferase), systemic illness or previously unknown intravenous drug misuse (the vast majority of intravenous drug users are positive for antibodies to hepatitis C)

KEY POINT

Take the time to tell patients the results of the investigations when they are known. This reduces anxiety and prevents excessive preoccupation with physical health. An informed patient is less likely to present to another doctor requesting unnecessary tests in the future.

- Electrocardiogram to rule out ischaemic heart disease in this age group
- Chest X-ray is also useful in patients over 30 years, especially if there are physical findings – in a smoker there may be infection or cancer
- Urine drug screen for legal and illegal drugs
- Calcium and thyroid levels if indicated

All Rebecca's investigations are normal.

With reference to Table 13, would you define her depression as mild, moderate or severe?

A **mild** depressive episode is diagnosed by two major criteria and two of the others (Table 13) being present for at least 2 weeks; the person usually continues normal social roles and *medication is rarely indicated*.

Table 14 Common organic causes of mood changes.

	Mostly cause depression	Mostly cause elevated mood
Alcohol and substances	Alcohol: the most common legal depressant drug	Alcohol may precipitate or be associated with mania
	Cannabis, cocaine, opioids: heroin, ecstasy	Amphetamines, cocaine, cannabis
Iatrogenic: prescription drugs	Benzodiazepines, sedatives (especially antipsychotics), chemotherapy drugs, β-blockers, digoxin, nifedipine, dopamine agonists, isotretinoin	Steroids, antidepressants, isoniazid, dopamine agonists, amphetamines, antimalarial agents
Neurology	CVA, Parkinson's disease, cerebral haemorrhage, head injury, multiple sclerosis	CVA, acute trauma or bleed affecting frontal lobe, HIV, multiple sclerosis; postpartum psychosis (1/3 organic cause)
Infectious disease	Glandular fever, hepatitis B or C, brucellosis	Malaria
Immunological	Rheumatoid arthritis	Systemic lupus erythematosus
Endocrine	Hypothyroidism, Cushing's syndrome, high calcium: hyperparathyroidism	Hyperthyroidism (also causes depression), Cushing's syndrome,
Cancer	Any cancer: primary or secondary	Unusual
Deficiency states	Pellagra, renal/liver failure	Unusual

CVA, cerebrovascular accident.

A **moderate** depressive episode is defined by at least two major criteria and at least three (preferably four) of the others present for at least 2 weeks. Many of these features will be present to a marked degree and the person has considerable difficulty with social, work and domestic activities.

In a **severe** depressive episode, all three major criteria and four or more out of seven others are present, some of which are of severe intensity. People with severe depression show considerable outward distress, unless psychomotor retardation (sometimes leading to depressive stupor) is a prominent feature. It is highly likely these patients will be actively thinking about suicide and they may even have made plans. If the symptoms are of rapid onset, the diagnosis can be justified before 2 weeks.

You must further classify a **severe** depressive episode as **with or without psychotic features**. By definition, if the low mood preceded delusions or hallucinations (typically both are mood congruent), this is severe depression. The presence of stupor also makes the diagnosis 'severe depressive episode with psychotic features'. Because severe depression tends to present relatively early in Western Society, many of these cases have not yet developed psychotic features.

Most people who develop a first depressive episode will have further episodes. The category **recurrent depressive disorder**, *current episode mild/moderate/severe* describes these. This category is used even if the person has experienced brief elevations of their mood immediately following a depressive episode and/or while taking antidepressant medication.

> *Rebecca has a moderate depressive episode. She reluctantly agrees with the diagnosis but says there must be a 'cause' of her condition, and knowing this is essential to getting better.*

How would you respond to her concerns about what's wrong?

Before giving Rebecca information on depression, first enquire as to whether she has any ideas what has caused her to become depressed. This will help you tailor your answer to address her concerns.

Generally speaking, various factors are known to contribute to vulnerability to depressive illness:

- *Biological:* family history (i.e. genetic inheritance), some medications, current physical illness, alcohol misuse (Table 14)
- *Psychological:* history of loss – especially early parental loss; problems with attachments and relationships; childhood maltreatment
- *Social factors:* such as adverse life events, reduced social networks, poverty

For any individual who has become depressed, relevant factors can be grouped as **predisposing, precipitating** and **maintaining** factors for illness. Note that if any of these factors are present for Rebecca, we cannot be certain that they *caused* her depression: they are associations not causes. There is a complex interplay between someone's temperament, life experience and lack of 'protective factors' such as social support. With recent adverse life events (e.g. Rebecca being in conflict with members of her church), there are strong subjective components to individuals' responses. Was the life event an attack on subjective self-esteem (e.g. Rebecca's sense of her standing in that community)? Did it undermine a core role (e.g. her church activities and sense of purpose there)?

You might discuss a **stress vulnerability model** with her. She had a vulnerability to develop low mood in the context of multiple stressors. Often, a temporary physical illness (e.g. heavy cold, ankle sprain) can act as the 'last straw' in precipitating depression. Social stress also contributes to her difficulties – related anxiety symptoms reinforce her depressive symptoms, and vice versa.

KEY POINT

Depression rarely has a single, simple cause.

Although this is Rebecca's first diagnosed episode of depression, you identify long periods of low mood in her past history.

Does this fit your working diagnosis?

Yes. *Dysthymia* (i.e. persistent low mood that does not fulfil the criteria for moderate or severe depression) can coexist with superimposed periods of clear depressive illness. With dysthymia the person describes long periods over many years (usually beginning in adolescence and continuing throughout adult life) when their mood is below what they perceive it should be, and pleasure is impaired. When someone with dysthymia has a depressive episode, this is sometimes described as 'double depression'.

What is your treatment plan for Rebecca?

Table 15 sets out three broad treatment approaches you need to consider. With the exception of the core principle of avoiding polypharmacy, none are mutually exclusive. The first four of each of biological, psychological and social interventions are commonly prescribed. General and antidepressant specific advice (Boxes 5 and 6, pp. 20 and 21) should be considered prior to choosing a particular medication (Table 7, p. 17).

Given her moderate depression, you refer her for cognitive behavioural therapy and prescribe an antidepressant. Two months later, Rebecca's depressive symptoms are unchanged.

What is most likely to account for this?

Despite current practice there is little evidence to start treatment with both medication and psychotherapy at the same time. Address apparent treatment failure by first revisiting Rebecca's treatment preferences.

Non-concordance with treatment (medication or psychotherapy) is the most common cause of poor treatment response. There may be specific difficulties with medication (e.g. cultural beliefs, fear of becoming addicted, side-effects, drug interactions, cost, inconvenience), or misunderstanding about how she needs to take it (e.g. some patients only take antidepressants on their 'bad days'). You must establish what dose she has been taking, and how often she takes it.

You have referred her to a psychologist – but *has she attended the sessions*? Does she have a problem either with the therapist or the therapy? Cognitive–behavioural therapy (CBT) does not suit everyone. Many patients want the space to speak about their past rather than examine their current difficulties in detail, and may resent the homework that CBT entails. If this is the case here, other psychological approaches to consider include a more focused approach such as problem solving treatment (PST) or psychodynamic (individual psychotherapy, cognitive analytic therapy). Most services have a waiting list for CBT longer than 2 months; PST can be carried out by nurses and doctors in primary care or specialist settings.

Rebecca has complied with treatment but remains depressed.

Table 15 The range of possible treatment approaches in depressive illness.

Biological	Psychological	Social
Improve physical health: exercise, diet, stop alcohol and caffeine, substance misuse	Problem solving treatment (see text)	Provide/improve housing, finances, networks, activities, etc.
Treat medical illness, change/stop depressant medication (Table 14)	CBT (see Cases 7 & 10)	Meet family: empower to use own resources and increase social contacts
Antidepressants: SSRIs, tricyclics, SNRIs as second line (Table 7)	Self-help strategies: see Williams (2001)	Vocational interventions, day hospital referral, occupational therapy
Change antidepressant if no response at 6 weeks	Family/couples therapy if relevant to the patient	Refer to community mental health team; consult Home Treatment Team
Additional strategies to consider if treatment refractory depression		
Lithium augmentation of her antidepressant: lithium at low doses (e.g. 400 mg/day) plus antidepressant	More intensive psychotherapy: interpersonal therapy, cognitive analytic therapy	Nidotherapy: manipulation of patient's environment (Tyrer & Bajaj 2005)
Addition of antipsychotic or thyroid hormone	Group therapy: supportive or psychodynamic	Consider hospital admission
Other specialist medication: see Maudsley Guidelines	Specialist psychoanalytic assessment	Support worker to help structure activities
Electroconvulsive therapy: in severely depressed or psychotic patients, this is *not* a last resort	Consider therapeutic community	Assess for supported accommodation

CBT, cognitive–behavioural therapy; SNRI, serotonin and noradrenaline reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor.

Identify other possible causes for her non-response

1 Comorbidity with *anxiety* symptoms is common. Anxiety symptoms may be overlooked in favour of the more obvious features of depression. The treatment plan must now address these: if they are driving her depressive symptoms they may also have led to maladaptive behaviour obstructing recovery.

2 Cormorbidity with *alcohol* or substance misuse. Do not overlook this in women or in cultures not known for it. Many people use alcohol to alleviate low mood/anxiety in the short term where it can 'block out' problems.

3 Comorbidity with problematic *personality traits* or personality disorder.

4 *Misdiagnosis*: you have only assessed Rebecca once. She may have been guarded and reluctant to elaborate on what were delusional ideas, or obsessional symptoms. You might have missed physical illness.

KEY POINT

The best clinicians are able to challenge diagnoses, including their own.

5 Are there *maintaining factors* for her depression. How are things for Rebecca at home – with relationships, with finances? What is it like for her as a single Nigerian woman to live in the UK? There may be adverse events ongoing that she has not confided in you. Racist abuse and attacks on perceived 'asylum seekers' are very common in Western cities. What are her social supports?

6 *Treatment refractory depression* is usually defined as failure to respond to a therapeutic regimen of an antidepressant (specifically 150 mg of a tricyclic or SSRI equivalent) after 6 weeks. There is currently no agreed approach here. Consider:

- Alternative approaches to medication (Table 15)
- Consult prescribing guidelines (e.g. Maudsley Guidelines). There are no guarantees that an alternative antidepressant will improve her symptoms, but it is certainly worth trying this if there has been no response. Choose one from a different class: there is little gain from replacing one SSRI with another
- Discussion of the case with a colleague may be valuable. Her therapy may need to be modified and made more culturally sensitive. Rebecca coped very well up until now, and is likely to have developed a good coping style of her own in the past. Her therapist should collaborate with her to utilize this to maximum effect

What is Rebecca's 1-year prognosis at this point?

We would have expected some positive responses by now if her depression had a good prognosis. Social factors may be the key here. She may have become isolated and lack meaningful activity in her life. Are there possible environmental changes (nidotherapy, p. 27) that would make a difference here? Her prognosis is guarded, but is likely to be better with the right treatment (Table 15) and if her existing support network improves.

> *Rebecca recovers 4 months' later. She expresses a new confidence in herself and has moved in with a close friend whose husband died some years ago. They both had wanted children but it has not been possible. Rebecca has applied to be a foster carer, with her friend, but the authorities raised some concerns about her mental health.*

What is Rebecca's 10-year prognosis at this point?

Over two-thirds of people with an episode of moderate depression will experience a recurrence of depression symptoms over the following 10 years. The positive aspects are that they can recognize the problem earlier and will have a strong indication of the measures that improve it. There is good evidence for the role of prophylactic antidepressant use in people with frequent episodes. There is no contraindication in Rebecca's history preventing her from sharing the role of foster parent.

CASE REVIEW

One in four people will become depressed at some stage in their lives. It is the most common psychiatric disorder encountered by the GP. Unless these patients have experienced depression before – in themselves or others – they may not volunteer depressive symptoms (Table 13). Like Rebecca, they present because *something else* happens, usually a change in social functioning. It takes time to tease out the presenting complaints (see the five non-psychotic explanations above). Of all patients with depressive disorders attending GPs, the diagnosis is missed 50% of the time and, of those diagnosed, adequate treatment is initiated in only 50%. Here, the following lessons can be drawn:

- Careful open, then closed questioning (Table 13) confirmed depression
- At the first assessment, four major areas of concern were explored:
  - risks of suicide and self-harm
  - an underlying medical illness that could cause or exacerbate low mood
  - possible psychotic symptoms that would persist with antidepressant treatment alone
  - comorbid psychiatric conditions of anxiety and substance misuse
- Diagnosing low mood as, for example, moderate depression is useful in decision-making about treatments (Table 15) and likely prognosis
- Even a common disorder such as depression represents a challenge when patients or their families ask what 'caused it'. In the same way as we speak about heart disease, it is best to identify a number of 'factors' (family history + childhood experiences + recent stressors) to avoid blaming the individual or others
- Rebecca's presentation raised cultural and religious issues, which required sensitive exploration
- Unusually, her depression did not lift in the first 2 months with the dual prescription of cognitive therapy and antidepressant. Careful follow-up identified treatment non-response, and would have uncovered deterioration in mental state. She might have begun to consider suicide

Continued

- Open discussion with collaborative decision-making at the start of the treatment process is the best way to maximize response to treatment. Your patients may dislike the CBT 'here and now' approach and prefer other therapies. Treatment options change over time
- It is best to conceptualize depression as a chronic medical illness. It is calculated that by 2020 it will be the second most common cause of disability worldwide.

A parallel, more positive approach identifies factors that *prevent* depression in a given individual (e.g. their resilience, coping skills, use of social networks, religious beliefs, lifestyle, ability to take breaks/relieve stress). When these are overwhelmed, a pattern of low mood can emerge. If these factors can be improved, any episode of depression will be of shorter duration and less severe.

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Further reading

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