# Contents

## Part B

**Part B**

## Part B

# CHAPTER 1

# Double Depression and James Avery

An inpatient psychiatrist was called to see James Avery, a 62-year-old man who had just been hospitalized after he took an overdose with the intention of killing himself. He said he was depressed, hopeless, and ready to die. His wife was threatening divorce, his employer had put him on probation, both of his children had left home, and he had poorly controlled diabetes and hypertension. He believed he was at the end of his rope.

Mr. Avery had considered suicide for many years, but the possibility had become a plan only in recent months. After doing Internet research on suicide methods, he decided to use a combination of 120 mg of diazepam, 8 grams of acetaminophen, and alcohol. Soon after his wife had gone to spend the weekend with her family to "clear her head" about their marriage, the patient had methodically begun to swallow pills. He had intended to die but had been interrupted by the arrival of his son, who had unexpectedly returned home from college to do laundry. The son had taken away the pills and called an ambulance. Mr. Avery was stabilized and evaluated in the emergency room and then transferred to the psychiatric unit.

The patient said he had gradually gotten more stressed during his lifetime and had never felt really happy. He described long-standing disturbances of sleep (early and middle insomnia) and appetite (nothing tasted good, but he overate anyway). His energy was generally poor, and he felt chronically worthless. He tended to get some pleasure from fishing and playing with his granddaughter, but everything had become dark and flat in recent months.

Mr. Avery had no history of suicide attempts, hospitalizations, or substance abuse. He said he had sought psychiatric help twice. Twenty years earlier, he had seen a psychotherapist weekly for 5 months but had discontinued treatment because "all the guy wanted to talk about was my mother." Mr. Avery had tried an unknown antidepressant at that time but had discontinued it after 1 week because it made him feel sedated and dizzy.

During the year prior to hospitalization, Mr. Avery had met monthly with a psychiatrist for 20-minute sessions. He had tried 12 weeks of fluoxetine (Prozac) at a maximum dosage of 40 mg/day and 6 weeks of sertraline (Zoloft) at a maximum dosage of 100 mg/day. He said these medications had had no effect, so he had quit the treatment. He expressed skepticism that psychiatry had anything to offer him and had agreed to sign in to the hospital only after his wife had applied pressure.

Mr. Avery said that nobody in his family had psychiatric illness except his mother, who had killed herself while he was in college.

The history was elicited from the patient, the wife, and the medical records.

## Personal History

Mr. Avery was a married, African American man with two children, ages 22 and 31, and one granddaughter. He was the eldest of three children born to parents who had owned and operated a small business in South Carolina; the business had failed just prior to his mother's suicide, when the patient was 21. After graduating from a well-known, historically black university, the patient moved to New York with the intention of using his engineering degree. He had been unable to find work in his field, a failure that he attributed to racism. Instead of engineering, he began work as a post office clerk, a job for which he felt overqualified but which he had maintained for 30 years. For much of that time, he said that his brain felt like it was in molasses and that he alternated between passive helplessness and irritability. An argument with a supervisor had led to the probation, but his wife was confident that it would not cost him his job.

Mr. Avery had met his wife, Martha, soon after moving to New York, and they married the following year. They had two children and a 7-year-old granddaughter. He said the relationship had been ruined by his depression and minimal success as a provider, but he added that he was also convinced that his wife had always had one foot out the door and had never loved him very much. He rarely visited his father and two younger siblings, because "they lived a long ways away." Unlike his parents and wife, he was not religious.

## Personal Psychiatric History

The patient described a lifelong history of depression along with failed medication trials. He was unable to characterize his efforts at psychotherapy, although the first appeared to be an exploratory psychotherapy.

The patient's most recent treatment had been in the hospital's outpatient psychiatric clinic. He had been offered several choices, including cognitive-behavioral therapy (CBT), interpersonal psychotherapy, and psychodynamic therapy, but he had chosen to enter the psychopharmacology clinic. The trials of fluoxetine and sertraline seemed to have had no effect. The patient said he discontinued treatment because the medication did not work and the psychiatrist "didn't understand my situation and background." The psychiatrist had noted that Mr. Avery appeared mistrustful and seemed to lack curiosity about his own problems. His wife said that her husband had been depressed "for at least 20 years" and that his blue moods were often caused by a real or imagined rejection.

## Family Psychiatric History

The patient's mother had killed herself by barbiturate overdose. The patient said his mother had been a chronic worrier but had had no specific psychiatric diagnosis; he believed she had killed herself because of the bankruptcy. He denied illness in other family members.

## Medical History

Mr. Avery's hypertension and diabetes were poorly controlled, primarily because of nonadherence to his medication regimen. His prescriptions included a β-blocker, a diuretic, and insulin. He had no drug allergies.

## Mental Status Examination

The patient was a stocky, tired-appearing African American man who looked somewhat older than his stated age. He was dressed in a hospital gown, he had no tremors, and his gait was steady. He tended to avert his bloodshot eyes. His speech was slow and marked by a southern accent. His thought process was goal directed but without spontaneity. He said he felt "stressed," and his affect was constricted and appropriate to stated mood. He did not smile at references to fishing or his granddaughter. He said he wished he had died but denied intending to kill himself while in the hospital. He denied homicidality and all psychotic symptoms. He specifically denied believing that anyone was "out to get him," but he did feel

that no one cared. He was oriented to person, place, and time but was inattentive and had reduced concentration. His score on the Mini-Mental State Examination (MMSE) was 24/30. His clock drawing test was poorly planned and yielded a score of 2/4. His insight and judgment were thought to be impaired on the basis of his having overdosed and his insistence that his life had no meaning.

## Summary

Mr. Avery was admitted to an inpatient psychiatric unit after he had made a serious suicide attempt in the context of an acute exacerbation of a chronic depression. The discussants in the following sections 1) explore the biological, psychological, and sociocultural issues that might have contributed to Mr. Avery's depression and 2) review interview techniques and treatments that might help him begin to recover.

# Discussions of the Case of James Avery

# Depression

*David Kahn, M.D.*

Depression refers to a symptom as well as a cluster of syndromes. As a symptom, depression is generally equated with sadness, a feeling state that is protean in its manifestations, ranging from mild, transient disappointment to severe, enduring melancholy. Brief episodes of sadness are normal and can even be adaptive by encouraging us to connect with people for comfort and take steps to compensate for important losses. We have a complex relationship with feelings of sadness and loss; most of us "enjoy" sad books and movies, and many of us work through difficult events by rehashing them with friends and through contemplation in solitude. Among the most important and universal of human emotions, sadness or even mild depression remains normal as long as it is transient and does not interfere with our basic ability to appreciate ourselves, relate to others, work, or experience pleasure.

James Avery's symptoms are consistent with a syndrome called *major depressive disorder*, an affective illness marked by persistent feelings of sadness and/or an inability to feel pleasure or interest. He describes his moods in ways that are characteristic of severe depression (e.g., "dark and flat"). Nothing brings him pleasure, a state known as *anhedonia*. Many depressed people also have intense feelings of worthlessness and self-criticism; Mr. Avery's feelings of never having achieved anything of importance approach this picture. Anhedonia and intense self-criticism are particular features of

major depression that can help distinguish it from more limited reactions to situational loss, such as grief following the death of a loved one. Some patients with depression say they feel just flat rather than sad or down; they may lack the ability to understand and describe their inner worlds, a condition called *alexithymia*. Although depression is generally viewed as a subjective experience, an objective observer is likely to notice dysfunction in one or more of the following areas:

- *Thinking:* Poor concentration, worthlessness, hopelessness, and sometimes delusions and hallucinations
- *Behavior:* Crying, psychomotor retardation or agitation, and suicidality
- *Physical functioning:* Alterations of sleep, appetite, libido, and/or energy

To meet the criteria for major depressive disorder, a sufficient number of symptoms must be present for at least 2 weeks; episodes can, in fact, last for months or years. Some patients recover fully from each episode, particularly with treatment, and may remain well for years; others recover only partially or endure frequent relapses despite treatments with medication and psychotherapy. Up to 13% of people with major depression remain in a chronic, severe state of illness (Kennedy et al. 2004).

It seems that the initial years of Mr. Avery's depression had been marked by relatively mild symptoms that persisted and worsened over the ensuing decades, a syndrome known as *persistent depressive disorder* (formerly *dysthymia*). Persistent depressive disorder was once thought to be a mild form of major depression. As we see with Mr. Avery, however, most people with persistent depressive disorder go on to have episodes of major depression—a course known as *double depression*. Even if it does not develop into a major depression, chronic milder depression alone can have serious long-term psychosocial consequences.

Depressive illnesses can start at any age, although they tend to begin in late adolescence and young adulthood. In the United States, major depressive disorder occurs in more than 5% of individuals in any given year, with a lifetime incidence of over 13% (Hasin et al. 2005). The rates of depression do vary between subpopulations. For example, one community survey comparing whites, Caribbean blacks, and African Americans found that a greater percentage of whites had had an episode of major depression, whereas both the Caribbean blacks and African Americans tended to have been treated for depression less often than whites but were more likely than whites to rate their depressions as severe or very severe and more disabling (Williams et al. 2007).

Significant symptoms of depression may also be seen in conditions other than major depressive disorder. Depressed mood, poor concentra-

tion, sleep disturbance, and suicidality can be seen with bipolar disorder (depressed or mixed episodes), substance use disorders, and many personality disorders, in addition to other psychiatric illnesses. Medical conditions such as hypothyroidism or early-stage dementia can sometimes mimic depression.

Duration also determines the diagnosis of depression. Had Mr. Avery presented with the identical symptoms and suicide attempt but the duration of his symptoms had been less than 2 weeks, he would be better characterized as having an adjustment disorder with depressed mood. Clarifying the diagnosis is vital in the development of a useful treatment plan. For example, missing a bipolar diagnosis would likely lead to a treatment that would increase his risk for a manic episode, whereas missing substance abuse or hypothyroidism would likely lead to a persistence of both his comorbid problem and his depressive symptoms.

Mr. Avery's brain has long felt like "molasses," as he describes it, and depression frequently leads to cognitive impairments. Deficits in concentration and executive function are well documented in depression, as are abnormalities in brain imaging. Neuropsychological changes may be reversible, but only with resolution of the depression (Gualtieri et al. 2006).

Mr. Avery is on probation at work, and he neglects his medical problems. One of the strongest public health arguments for aggressive intervention in depression is the high level of functional impairment due to the disorder. Depressed patients spend as many or more days in bed than patients with conditions such as arthritis and diabetes (Wells et al. 1989). There are also differences between populations in medical outcomes. For example, African Americans with depression are more likely than whites to have serious comorbid medical problems, including hypertension, obesity, and liver disease (Hankerson et al. 2011).

In terms of etiology, we cannot yet identify or prove any single cause for Mr. Avery's depression. As with other illnesses that are common in large populations, depression appears to be caused by both genetic and environmental factors that combine to contribute risk. The case report indicates that his chronic symptoms developed in the context of his mother's suicide, societal racism, underemployment, and marital difficulties, whereas his acute suicidal ideation was precipitated by a threatened divorce, work probation, and his youngest child's going off to college. These stressors correspond to Claudius's lament in *Hamlet*: "When sorrows come, they come not single spies/but in battalions." It may be that several stressors combined to overwhelm Mr. Avery's ability to rebound from normal sadness.

In terms of the genetic factors, family history is a known risk factor for depression. We do not know his mother's diagnosis beyond the his-

tory that she had been a "chronic worrier," but her suicide following bankruptcy implies she likely had a mood disorder, and family history is a strong risk factor for depression. Efforts to locate a genetic cause for depression have so far failed to show that specific markers or mutations are highly associated with the illness. In fact, the best current understanding is that many genetic variations contribute to familial risk but in ways that may differ greatly among families. Genetically, depression turns out to be an extremely heterogeneous group of illnesses with shared final common pathways (Flint and Kendler 2014). It is hoped that ultimately finding the genetic patterns that contribute to the risk of depression will lead to a better understanding of its etiology as well as more specific treatments.

Genetic discoveries will eventually inform the nature-nurture debate, but it is likely that environment played a role in the development of Mr. Avery's depression. Although Mr. Avery appears to dismiss the importance of his mother's suicide, such an event would likely have been shattering. Furthermore, she may have had mood problems during his childhood that would have left her relatively unavailable to him. These experiences would have primed him to be unusually sensitive to the possibility of later losses. The history notes that he believed his wife "had always had one foot out the door and had never loved him very much." We might want to talk to his wife to determine the extent to which this might be true, but we do know that depression tends to lead to pessimistic distortions. Mr. Avery asserts that his marriage was ruined by his depression and underemployment, but it is not clear that he recognizes that his curmudgeonly view of the marriage might have led his wife to act distant and unloving. Similarly, while his views on racism have their basis in reality, his depression has likely contributed to a pessimistic, self-fulfilling prediction of job failure. His failure to maintain close ties with his family of origin and religious community might also be implicated in his depression. Indeed, lack of social support is a strong predictor of depressive symptoms among older African Americans (Miller et al. 2004).

Mr. Avery's isolation appears to have worsened in the context of a long-standing view that his mother, wife, and previous therapists had failed him. It would be surprising if these feelings were not to be transferred at some point onto the current treatment team. His feelings of inadequacy and self-blame are likely to have combined with his cognitive deficits to create an amotivational syndrome that would also have contributed to incomplete and unsatisfactory treatments.

As will be discussed in greater detail in the subsections that follow, Mr. Avery has just been admitted to an inpatient psychiatric unit after a suicide attempt. Members of the team will debate pharmacology and consider ways in which his prior response to medications may have been

affected by the dosages and durations of the medication trials, the likelihood of noncompliance, and the ways in which genetic variability might affect the medication's effectiveness and side effects. Treatment team members will talk to him in order to provide support, develop an alliance, understand him and his background, and gain greater insight into ways in which he contributes to his depression. To accomplish these goals, they will do individual psychotherapy and couples therapy, focusing to varying degrees on such factors as psychodynamic insight and support. Perhaps most importantly, the treatment team will maintain an explicit focus on safety, because the grim hopelessness of depression is often associated with suicide.

# SUICIDE

*Peter M. Marzuk, M.D.*

The assessment and management of suicide risk involves four related goals: 1) assurance of the patient's immediate safety, 2) assessment of suicide risk, 3) provision for longer-term management of suicidality, and 4) documentation of the risk profile and the rationale for clinical decisions. Because a thorough initial suicide assessment requires gathering and organizing a lot of clinical and historical data and because patients may have ulterior motives for minimizing, denying, or even exaggerating suicidality, it is critical to obtain data from a variety of sources, including the patient, family members, treating therapists, and, if available, friends, police, or others who may be familiar with the patient or the immediate suicidal crisis. In addition, charts and other physicians' notes should be used but should never be a substitute for one's own first-hand inquiry.

## Assurance of Safety

James Avery has already been admitted to an inpatient unit, which is presumably locked and environmentally secured. Ongoing evaluation might,