The South Staffordshire Network for Mental Health is a charitable organisation commissioned by Staffordshire County Council to promote and develop mental health services from the perspective of people with experience of mental illness. We work in partnership with local mental health providers within the NHS and the charitable sector to develop the provision of services, and also work with commissioners within local authorities and Clinical Commissioning Groups to represent people who may use such services.

We are always developing methods to represent our membership of people with experience of mental illness to have their voices heard. Additionally, we have a successful, recovery-focused volunteer programme, which looks to promote and make use of the skills of our volunteers. By bringing these two aspects together, we can really promote meaningful community development.

This report highlights a real identified need from one of our members, and a brilliant, high quality response from one of our valued volunteers.

We very much look forward to working with our partners and people affected by the condition in finding solutions to meet health and recovery outcomes.

Thank you to Stephanie for taking the time and courage to approach SSNMH with her experiences and has also contributed to the report, and to Rachel Butcher, who has provided us an amazing report which will go towards making a difference.

*Keri Lawrence, Project Coordinator, SSNMH*
About the Author

Rachel Butcher has been a volunteer with South Staffordshire Network for Mental Health for almost five years. Having trained as a biologist, Rachel graduated with a BSc (hons) in Human Biology in 2010, having focussed on the physiology and phenomenology (symptoms) of mental health for her degree specialism. She is also an Associate Member of the Society of Biology, the UK’s professional body for biosciences graduates and uses her work volunteering in mental health as part of her Continuing Professional Development work with the Society.

Introduction

Accurately diagnosing any mental illness can be challenging; it requires an experienced and skilled clinician with an expert knowledge of mental health. Equally, receiving a psychiatric diagnosis can be very difficult to accept and come to terms with; however, as in the case of recurrent brief depression (RBD), if the condition is not as well recognised within the field of mental health in general, then getting an accurate diagnosis can be much more challenging. Whilst this report aims to look at RBD as a condition, it also seeks to find out how difficult it is to find research and accurate information on it as a subject, what treatments are recommended and whether a lack of awareness of the condition truly exists, and if so, how this affects the person experiencing the illness.

Purpose of the Report

This report was produced at service user Stephanie’s request, following her experiences of lack of awareness of RBD and the difficulties this has caused her. The desired outcome of this report is that service providers and commissioners, as well as service users throughout Staffordshire can gain an increased knowledge of RBD, through increased awareness of its signs and symptoms as well as exploring what treatment and recovery options exist.

Identification of Need

The unfortunate reality of why this report is needed can be outlined by both Stephanie’s own experience of trying to receive treatment, alongside the need for further research into the condition. Stephanie has found that despite RBD being a relatively common mental illness, she found it to be under-researched, commonly unrecognised and frequently misdiagnosed by mental health professionals; that much more research is needed is highlighted by there being no specific recommended course of treatment.

Symptoms/Clinical Features of Recurrent Brief Depression

According to Anderson et al., (2010), RBD is a mood disorder that is characterised by mild to severe depressive episodes of less than two weeks’ duration (typically 2-3 days) but that occur every month for at least a year. This must be unrelated to women’s menstrual cycle, with complete recovery from symptoms between episodes occurring (Anderson et al., 2010; Lee, 2007).
Apart from duration of episodes, as Pezawas et al., (2002) report, the actual symptoms that occur during the depressive episodes in RBD are the same as found in major depressive disorder (MDD), hence the following symptoms are relevant for either disorder, with at least five symptoms occurring during these depressive episodes:

- Persistent sadness
- Poor concentration.
- Tiredness, energy loss
- Loss of enjoyment of things that normally bring pleasure
- Persistent anxiety
- Cutting social contacts and increasing isolation.
- Loss of hope and feelings of helplessness.
- Sleep problems - difficulties falling asleep or waking up much earlier than usual.
- Extreme feelings of guilt/worthlessness.
- Disturbance in regular functioning at work/school etc.
- Loss of appetite.
- Loss of sex drive and/or sexual problems.
- Experiencing physical aches and pains.
- Thoughts of suicide and death.
- Self-harm

(Mental Health Foundation, 2010)

In the same way that the severity of depressive symptoms varies with MDD, so, too does the severity of depression within RBD; episodes can be of severe intensity despite only lasting a few days (Pezawas, 2003). According to Lee, (2007), a population prevalence rate of 10% is estimated, yet of those affected only half seek treatment. Unlike those with dysthymia, low mood is not present at all times, but when RBD occurs in those with a history of prolonged episodes there is a significantly high risk of suicide. This is worse when a person suffers with RBD and MDD together, otherwise known as Combined Depression (CD). The despair felt during episodes of depression can mean that a greater level of input from mental health services may be needed at these times. Depression can be severe, thus increasing the risk of suicidal behaviour; hence its cumulative morbidity can be highly significant both in terms of individual suffering as well as costs to the mental health services (Lee, 2007).

Diagnosis

RBD is recognised by both the World Health Organisation’s International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-V), with both offering diagnostic criteria. The ICD-10 states that for a diagnosis of Recurrent Brief Depressive Disorder, four criteria must be met:

A. The disorder meets the criteria set for a mild, moderate or severe depressive episode
B. Depressive episodes occur approximately once per month over at least a year
C. Each episode lasts less than two weeks (typically 2-3 days)
D. Episodes occur independently of the menstrual cycle
These symptoms must occur consistently over the course of at least one year to accurately diagnose (World Health Organisation, 1993).

The recently reviewed DSM-V classifies RBD with “Other Specified Depressive Disorders.” It states that, alongside depressed mood, at least four other depressive symptoms must be present for 2-13 days every month for a minimum of 12 consecutive months. This must exclude any association with the menstrual cycle, whilst also ensuring that criteria for any other depressive disorder, bipolar disorder or psychotic disorder, is not met (DSM-V, 2014).

Despite this recognition by the World Health Organisation’s ICD-10 and the American Psychiatric Association’s DSM-V, awareness of it still appears to be limited. This is also reflected in how difficult it has been to gather information on the condition, as shall be seen in the report when discussing resource availability.

Whilst making a correct diagnosis is, of course, important for both clinician and service user, with no clinician wishing to incorrectly diagnose a patient, psychiatry is not an objective science; there are no physiological tests available to aid diagnosis. This means that to correctly diagnose, clinicians are mainly dependent upon the service user being able to verbalise their symptoms, or symptoms are identified through observed behaviour or the clinician is guided by diagnostic-aiding questionnaires like the Hamilton Depression Rating Scale, the Beck Depression Inventory or the Patient Health Questionnaire (Bienenfeld and Stinson, 2014). This subjectivity means that making a diagnosis is far from an exact science.

All other diagnoses within the field of depressive illness require that symptoms persist for two weeks or more, however, within RBD, although symptoms are frequently severe, they last on average three days a month, therefore, unless a clinician is particularly familiar with RBD as a condition, patients can be misdiagnosed, as was experienced by Stephanie. There are several conditions that patients can mainly be incorrectly diagnosed with instead of being correctly diagnosed with RBD. Incorrect labels include personality disorders, adjustment disorder, and post-traumatic stress disorder, alternatively a patient can just be labelled as exhibiting bad behaviour, or even just displaying attention seeking behaviour. A correct diagnosis can be very hard to achieve. Due to a general lack of articles and information available on RBD, the only source with any explanation of misdiagnosis has been on website healthguideinfo.com which uses referenced sources for information. Here it explains in an article entitled “Spotlight on Recurrent Brief Depression” that signs of RBD are often be mistaken for Borderline Personality Disorder, firstly because the lack of mood stability found in RBD is also found in borderline personality disorder, as too are other symptoms like impulsivity, suicide attempts and relationship problems. Additionally, RBD is sometimes confused with bipolar disorder due to the rapid mood changes that are exhibited (Arnold, 2011).

This is why increased awareness of RBD in needed both amongst clinicians and service users. The only journalistic reference to be found was from 1994 in a letter to the editor of the British Medical Journal questioning whether a patient who had been diagnosed with borderline personality disorder actually was displaying symptoms of RBD and that this should be
considered as a differential diagnosis when diagnosing borderline personality disorder (Hawley, 1994).

**Diagnostic Validity**

Even though the symptoms of RBD have been recognised for some years, its validity as a classification of disease (its nosology) was still being questioned as recently as 2009 whereby Lövdahl et al., (2009) debated the diagnostic status of RBD by querying its classification as a disease in its own right through studying the phenomenology (symptoms) of RBD in a clinical sample of patients. Having clinically examined 40 patients and 21 gender matched and mentally healthy controls by interview and through the use of questionnaires, the authors concluded that RBD is valid as a disorder separate from bipolar II, recurrent major depressive disorder and cyclothymia. Interestingly, the authors observed brief hypomanic symptoms of less than one day’s duration, however, not meeting the criteria for bipolar disorder, the conclusion was that hypomania as a symptom is a marker of the severity of the RBD as opposed to part of a bipolar diagnosis (Lövdahl et al, 2009).

**Treatment/Management of RBD/Recovery**

The lack of reliable resources available, combined with the lack of awareness and lack of recognition of RBD as a valid diagnosis all together means that there is not the same availability of recommended treatment course as is afforded to other conditions. Whilst some studies do exist, as shall be seen, there is, as yet, no specific recommended course of treatment, be it pharmacological or psychological. The National Institute of Health and Clinical Excellence has no guidelines published and even when contacting the library at the Royal College of Psychiatrists, there was no published information available at all on any area of RBD, showing its lack of validity at this present time.

Continuing with pharmacological treatment, there are a handful of studies that have looked into treatment of RBD using medication, most of which are from the mid-1990s and were inconclusive. Several studies used antidepressants with mixed success and some used mood stabilizers but many of these are individual case studies as opposed to studies with multiple participants. Prakash, Mandal and Sagar, (2013) reported a case study using antidepressant Paroxetine, however, aside from just reporting success in one case, the authors discuss the overall availability of research carried out into RBD treatment, citing the controversy around its treatment. Despite the use of various psychotropics from Lithium to Prozac the authors conclude that there is simply not enough evidence to recommend any specific treatment options, instead making the suggestion that there is some evidence of antidepressants as a first line treatment and mood stabilizers as a second line treatment option. However, there are still no NICE guidelines, and no recommendations of any particular treatment, be it pharmacological or psychological (Prakash, Mandal and Sagar, 2013).

The difficulty in finding evidence for treating RBD is confirmed by Cathy Riley, Director of Pharmacy and Medicines Optimisation for South Staffordshire and Shropshire NHS Foundation Trust (SSSFT). Riley confirms that there is still no clear evidence-based approach when treating RBD. Efficacy of pharmacological treatment – more specifically antidepressants
and mood stabilisers – is controversial; only being able to use case studies rather than clinical trials means that optimal treatment remains unclear. Treatment, therefore, often follows the guidelines given for major depression.

Although severe, the brief duration of episodes means that clinical trials would be difficult, if not impossible to conduct, so individual case studies are relied upon. However, the problem with this is that there are many variable factors that may influence one individual case study. Whilst these may be totally unrelated to the condition, due to the lack of other participants/controls these unrelated factors may well influence and skew the results/outcome.

Regarding psychological treatment, having been approached by myself, a response was received from Dr Christopher John, a SSSFT’s Clinical Psychologist from the Mental Health Division. Whilst Dr John’s approach as a Clinical Psychologist means that he has reservations regarding the use of diagnoses, he kindly responded that psychological treatment for a person presenting with brief but disabling episodes of depression would be the same as all other mental health problems. It would mean firstly understanding the relevant historical, contextual, systemic and individual factors that led to the person’s symptoms developing. Gaining this understanding is termed a Formulation and treatment involves forming a plan individually tailored to the person to address these difficulties. Psychological Therapies used post Formulation may be Cognitive Analytical Therapy, Cognitive Behavioural Therapy, Mindfulness approaches, Intensive Short-Term Dynamic Psychotherapy or systemic psychotherapy, these are available within the Trust with expertise dispersed across the psychologists.

According to Dr John, it is unsurprising misdiagnosis occurs as there are no biological markers for any mental health condition. For those meeting the criteria for RBD, that the depressive episodes are relatively brief, alongside the inevitable delay between symptom occurrence and being assessed, it may be that their problems are evaluated as lower in severity as distress may have reduced by the time a person is seen by a clinician. However, Dr John highlights that a “correct” diagnosis is not needed to receive help.

That people with RBD can present in less distress by the time they are assessed also applies to care clustering. Care clustering is not diagnosis mediated; Dr John explains that care clustering is a way of grouping people based upon similar levels of risk, need and dysfunction and depends on people’s individual circumstances. Therefore, due to varying distress levels, it is fully comprehensible that people with RBD symptoms are ‘mis-clustered’, although it should be emphasised that clustering is a matter of clinical skill and judgment.

Resource Availability

This would, perhaps be better entitled, lack of resource availability; several sources of information were explored with very little success. As well as general internet searches using reliable websites, there were several other sources that were used with varying success.

Five resource points, as such, were used with varying results. Firstly the Mental Health Research Network’s Birmingham hub was asked for any information but were unable to respond and nothing was found on their website of any help. Healthwatch Staffordshire
responded positively and whilst very keen to help, the response back from Hester Parsons, Development Officer, showed that there were very few resources available even to Healthwatch and there was nothing to add that had not already been found, again showing the need for more research and increased awareness.

As stated earlier, there are no NICE guidelines available for Recurrent Brief Depression, with no source of recommended treatments for RBD being found in any literature. Indeed even the Royal College of Psychiatrists’ library service that offers up to date information on virtually all mental health conditions, had no information at all on RBD! Finally a great response was had from the local South Staffordshire and Shropshire NHS Foundation Trust, with Clinical Psychologist Dr Chris John researching and finding information.

Recognition and Awareness of RBD amongst SSSFT Staff

Unfortunately, aside from the responses from Clinical Psychologist Dr John and Pharmacist Cathy Riley, no other responses from Trust staff were received. This makes it purely speculative as to whether this could reflect a lack of awareness of RBD amongst Trust staff as it may simply reflect that the busyness of the staff allows little time to respond; nothing can be fairly concluded. This still leaves room to raise and improve awareness of RBD, with this need being reflected in Stephanie’s account of her experiences of the impact that the lack of its recognition by staff, as seen below.

Impact that Lack of Recognition of RBD had had upon Service User, Stephanie

Stephanie has not had a good experience when it comes to knowledge and awareness of RBD; its lack of recognition has had such an impact upon her life that she asked for this report to be commissioned so that other people with RBD do not have the bad experience and inappropriate treatment she had because of this lack of understanding of this illness.

Lack of awareness and knowledge of RBD amongst mental health service providers has meant that Stephanie has been misdiagnosed with several different conditions. Stephanie did not respond to treatment and lack of research has not yet resulted in a recommended treatment for this disorder. This lack of response to treatment led to Stephanie being misdiagnosed with post traumatic disorder, adjustment disorder, depression, and finally, when Stephanie did not respond to treatment, a severe personality disorder was diagnosed due to fluctuations in mood and lack of response to treatment.

Sadly, ignorance and prejudice amongst staff has been very apparent. Stephanie’s experience was that staff were supportive whilst she had the diagnosis of major depression, however due to not responding to treatment along with becoming a “revolving door” patient (frequently in and out of hospital) and being misdiagnosed with a personality disorder led to a lack of support and a lack of interest from nursing staff. Stephanie reports that most staff attitudes changed and that she was no longer regarded as ill. This lead to negative talk in ward meetings which meant that a new psychiatrist whom Stephanie had not previously met decided that she was addicted to attention seeking, causing complete hopelessness for Stephanie and further deterioration. Although not the primary purpose of this report it is sad Stephanie saw a change in attitude of staff because of an (incorrect) alternative diagnosis of
personality disorder as people experiencing mental distress of any kind should be able to receive the same level of care and compassion from staff regardless of diagnosis.

To summarise, Stephanie reports that the lack of staff awareness of RBD affected her very badly, being clear this lack of understanding caused misdiagnosis leading to a label of being an attention seeker with a personality disorder. This meant that Stephanie’s symptoms were disregarded, to the extent of being labelled as “not suffering a mental illness” when brought to hospital by police following concerned members of the public alerted police to Stephanie’s condition.

However, Stephanie is keen to point out that there were some very caring staff including Community Mental Health Nurses (CPNs) and psychologists who supported Stephanie despite lack of awareness of her correct diagnosis.

Thankfully in the end the correct condition was diagnosed, but not without a great deal of harm caused to Stephanie. When asked if things would have been different had the clinicians treating Stephanie had a greater awareness of RBD, Stephanie responded by saying this is best answered by explaining how being accurately diagnosed affected her.

“I would also like to tell you of the day I finally saw a psychiatrist who listened and recognised my symptoms.

He was a relatively young doctor. I explained my symptoms and he asked me to keep a daily mood chart. I was asked to record my symptoms severity from 0 to minus 10. I did this and just before my next consultation I made a graph record of them. When I showed him the graph it clearly showed in visual form the repetitive brief depressions and also their varying severity. He looked at me and explained the symptoms I was having. They were so accurate that I remember tears rolling down my cheeks in relief that at last a doctor had got it right. He gave me a working diagnosis of recurrent brief depression with a history of major depression. He explained it to me. At last I understood what was happening to me. I only wish I had been asked to keep a mood chart years before maybe someone would have recognised this disorder. Although I am aware it has taken many years to be recognised.

My diagnosis of a personality disorder was removed. Although it will always be in my past records. I have certainly had some insights into some professional staff’s prejudice towards patients with certain diagnoses. Thankfully I think this is beginning to be changed through further education.”

Overall, recent experiences have been that, once RBD was recognised and diagnosed it has been life changing, with positive support from CPNs and her present psychiatrist, although Stephanie has had to explain RBD to two out of three CPNs, showing the lack of awareness of RBD even once a person has received this as their correct diagnosis!

Stephanie states that her hope for the future is that more research is done into this very debilitating and potentially severe illness. This should develop further understand of causes and hopefully one day provide correct treatment as RBD is still under recognised. Stephanie
has not found any books that are specifically about this type of depression. Service users and many professionals are still in ignorance. Stephanie concludes by assuring us that in this instance ignorance is not bliss, being certain that this lack of awareness is continuing to cause much unnecessary suffering and probable loss of life. Overall, more training on recurrent brief depressive disorder is necessary for all mental health staff if this ignorance is to be rectified.

Recommendations Arising from this Report

For a variety of reasons it can clearly be seen that the lack of awareness of RBD certainly has a negative impact upon people with this condition. Greater understanding of the condition is needed, with acknowledgements that because the average depressive episode occurs for such a short amount of time, that the extreme distress that this causes is often unseen by the time the mental health services actually assess the person experiencing RBD. Increased knowledge and awareness of the condition is needed in order to ensure correct diagnosis in the first place; encouraging the use of mood charts would be helpful, especially as this was the diagnostic resource that really aided the correct diagnosis of RBD for Stephanie, with mood charts offering a visual resource, completed over time to aid correct diagnosis.

Hopefully this report will go some way to highlighting the lack of resources regarding RBD and the lack of research done into the condition. However, more is needed, so as a response a leaflet will be produced to outline the basic information regarding RBD, why it is so difficult to recognise, and also how mental health staff can become more aware of RBD.

Conclusion

For a variety of reasons it can clearly be seen that the lack of awareness of RBD certainly has a significantly negative impact upon patients with this condition. Much more research is needed, not just individual case studies. More research in needed on a large scale so that national guidelines offering recommended treatment option can be produced as currently there is no guidance on treatment options. Although RBD is listed within the DSM-V, the lack of knowledge and understanding of RBD needs challenging. Knowledge is needed to accurately diagnose RBD in the first place, which leads on to obtaining the appropriate course of treatment (pharmacological or psychological). Also, correct diagnosis is needed to challenge staff attitudes; once Stephanie was diagnosed with RBD, the attitudes of staff around her changed to mean that she received a more appropriate level of support (although not the purpose of this report, it could be argued that staff members’ attitudes should not be changing with diagnoses but remain consistent for all patients).

Additionally, mental health professionals need to understand that because the average depressive episode occurs for such a short amount of time, the extreme distress that this causes is often unseen by the time the mental health services actually assess the person experiencing RBD. Hopefully this report can be used to encourage clinicians to begin filling any gaps in their knowledge of RBD and importantly too, to encourage further research and awareness of the condition for those who have RBD but do not, as yet, have a diagnosis.
Next steps for this Report

Hopefully this report can be useful as a resource to a variety of different services. Whilst it is important that there is a greater level of understanding by clinicians in order to accurately diagnose and correctly treat RBD, other organisations that offer support may also benefit from the conclusions of this report. Hence the report shall be sent to the following bodies or organisations:

**Potential Next Steps:**

1. This report to be distributed to the following providers and commissioners:
   - South Staffordshire and Shropshire Healthcare NHS Foundation Trust, with particular reference to Psychological Services, Public and Patient Involvement and Performance Management, and Community Mental Health Team Management
   - Staffordshire County Council Mental Health Commissioning
   - Healthwatch Staffordshire
   - South East Staffordshire and Seisdon Peninsula CCG
   - East Staffordshire CCG
   - Cannock Chase CCG
   - Stafford and Surrounds CCG
   - Changes Wellbeing
   - Richmond Fellowship Life Links
   - Making Space Work4You
   - Quest Day Opportunities
   - Burton and District Mind
   - Mid Staffs Mind
   - North Staffs Users Group
   - Carers Association Southern Staffordshire
   - Mental Health Research Network

2. A summary report produced for SSNMH Network News Multimedia Newsletter
3. A Leaflet coproduced by SSNMH, service members and SSSFT – this will be suggested at the Service User Reference Forum
4. An Awareness Session coproduced by service members to be delivered once funding sought
5. Further opportunities to be explored with commissioners and providers regarding regional or national impact
References