When depression masks bipolar disorder

Depression and bipolar disorder must be differentiated and treated appropriately, write Angela Carballedo and Patrick McKeon

DO YOU HAVE PATIENTS who get recurring depression, who have depression that does not respond to antidepressants or who benefit initially or even worsen with antidepressants? If so, the underlying problem may be bipolar disorder, masquerading as depression.

It was thought that the lifetime risk of bipolar disorder was 0.8%. Now it is realised that when lesser forms of bipolar moods are taken into account, the prevalence is 6%. The term bipolar spectrum is used to cover bipolar moods in all their diverse manifestations.

Bipolar spectrum is clinically relevant because:
• Shorter and less intense hypomanic moods than described in Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) carry a significant morbidity in terms of relationship and work difficulties, alcohol and substance abuse, and high-risk behaviours, including a high mortality through suicide
• Unpleasant elations or dysphoric hypomanias and manias are frequently misdiagnosed and treated as depressions
• Some 30% of recurring depressions switch to bipolar disorder, sometimes almost imperceptibly. What this means for the busy GP is:
  • Lesser degrees of hypomania need to be detected as it is usually not possible to treat depression which accompanies it unless the hypomania is also successfully treated
  • When patients complain of 'depression', 'anxiety' or 'distress', unpleasant elation of dysphoric hypomania needs to be considered as an equally probable diagnosis
  • Patients who have recurring unipolar depression may also have mild or moderate hypomania that cannot be detected because they are either pleasant experiences, euphoric hypomanias, which the patient would be unaware of; or unpleasant experiences, dysphoric hypomanias, and so will be reported by the patient as depression.

This article will focus on recognising these aspects of the bipolar spectrum.

Bipolar disorder versus bipolar spectrum

Brief phases of elation are common, maybe even as common as depression. Just as we distinguish normal depression from clinical depression by the number and duration of symptoms and whether they are within the persons coping range, so too with hypomania.

The main point made by experts in this area is that the duration of symptoms set out by the (DSM) – that hypomanic symptoms of four to seven days for hypomania and greater than seven days for mania – be reduced or dropped as a diagnostic criterion.

Diagnostic issues

• There are three key issues of which to be mindful:
  Euphoric hypomania: This is a pleasant experience which the patient will not report as they generally are unaware of it and will often indicate that they have 'never felt better'. Friends and work colleagues may also be unaware of it, while close family members will be the first to spot it.
  Dysphoric hypomania: Will present most typically with a complaint of depression, but sometimes as intense anger, marked difficulty getting to sleep, anxiety or as a suicide attempt.

Hypomanias can be very brief: When euphoric or dysphoric hypomanic episodes are brief they are even more difficult to detect. While they are not clinically relevant for the emotional distress or morbidity they cause in their own right, they appear to drive the recurring depressions which accompany them. The depressive episode lasting days to months may not be successfully treated until the brief hypomanias are also eradicated. Such hypomanias occur before or after depressions, are frequently induced by antidepressants and where there are recurring depressive episodes, these brief hypomanias are present but difficult to detect.

When is a GP likely to encounter less obvious bipolar moods?

• When the patient is complaining of depression but doesn't benefit from an antidepressant. While it is most likely that the patient has emotional distress as reaction to some stress or loss, not infrequently they are going through a dysphoric hypomania presenting as depression
• When the patient benefits quickly from antidepressants, but they lose their effect over time
• The patient’s complaint of depression, but they may become agitated or suicidal
• When a recurring depression does not respond to antidepressant medication or counselling/psychotherapy.

Diagnosing hypomania

• When depression is present, consider the possibility of euphoric and dysphoric hypomania, particularly before or immediately after an episode of depression
• The following features of depression make the presence of hypomania more likely:
  – Sudden onset of episode
  – Early age of onset of episode
  – Presence of psychotic symptoms
  – Presence of marked psychomotor retardation
  – Presence of atypical features such as hypersomnia
  – Family history of bipolar disorder.
• When enquiring about euphoric hypomania:
– Ask the patient do they ever: feel ‘too well’; feel ‘full of the joys of life’; feel giddy; have too much energy; have a reduced need for sleep; feel they can achieve anything they wish or are taking big risks; have periods of intense and unexplained irritability; have trouble getting to sleep
– Interview a relative using the same line of enquiry (as above)
– Note even a brief episode of hypomania, as they will need to be eradicated before the accompanying depression can be successfully treated
– Distinguish depression from dysphoric hypomania. The symptoms of depression and dysphoric hypomania are almost identical, but the signs are quite distinct. Psychomotor slowing as represented by reduced rate and expanse of thinking, slower rate of speech, impaired concentration, inability to think beyond the immediate future, reduced expressiveness, reduced rate of eye movement, reduced rate of limb movement. However, for depressions that are relatively mild, the features of psychomotor slowing may not be evident, particularly during a brief assessment in a busy clinic and without knowing a relative’s observations.

There is a very significant overlap in the symptoms of depression and dysphoric hypomania in that both tend to have symptoms of low mood, anxiousness, distress, poor concentration, hopelessness, fatigue, poor appetite and suicidal feelings. However, dysphoric hypomania has the following distinguishing symptoms: initial insomnia; evening worsening of symptoms; anger or irritability or uncharacteristic impatience; weepiness – most patients who have unipolar depression are unable to shed tears except at the point of entry to and exit from depression.

The signs of increased psychomotor activity that may be present in a dysphoric hypomania are as follows: restlessness; over-talkativeness; eyes darting; foot or finger-tapping; hostility/anger; increased psychomotor activity more in the evening.

As with psychomotor slowing, increased psychomotor activity may not be evident during consultation and the patient may need to be observed for a period of time.

It is essential to ask a family member about any changes in the person’s level of activity.

**Burden and comorbidity**

The WHO has listed bipolar disorder as the sixth leading cause of disability-adjusted life-years (DALYs) for males and females in western society.

Most of the studies on which it bases its findings are for bipolar disorder as described in the ICD-10/DSM-IV and not the broad definition of the disorder as currently envisaged in bipolar spectrum disorder. In spite of this, the socio-economic consequences of bipolar disorder are known to be considerable, with some 60% being unemployed, a similar percentage reporting difficulties maintaining long-term relationships and some 34% being separated or divorced.

Studies indicate that substance misuse occurs more commonly in bipolar disorder than other psychiatric illness, with 44% abusing alcohol. Twenty-five to fifty percent of people with bipolar disorder attempt suicide.

**Bipolar spectrum disorder**

Although bipolar I and II are part of the official nomenclature of DSM-IV, the DSM-IV or ICD-10 have yet to define the full extent of bipolarity. These softer versions of bipolar moods are associated with a significant morbidity and mortality and are likely to be incorporated in the official diagnostic guidelines in the near future.

**Bipolar 1**

Bipolar 1 is the classical form of mania, which by definition lasts longer than one week and is usually bad enough to require hospitalisation. Frequently, there are psychotic features. It is usually, but not always, followed by a depression.

**Bipolar 2**

Bipolar 2 is characterised by recurring depression of at least two weeks’ duration with accompanying hypomanias which last four or more days. Recent research indicates that the modal duration of hypomanias is two days in 90% of patients.

**Bipolar 3**

Brief hypomanias that become evident with antidepressant medication, phototherapy, sleep deprivation or ECT. These patients usually have a depressive or dysthymic temperament and have a family history of bipolar disorder. In between the depressive episodes the person has irritable hypomanias, which are mistakenly diagnosed and treated as depressions and carry a high rate of suicidality.

**Bipolar 4**

Bipolar 4 includes depressive states superimposed on hyperthymic or hypomanic temperaments. This typically presents in the late 50s. The person has a depression that poorly responds to antidepressants and frequently becomes converted into an agitated depression with motor restlessness, racing thoughts and sexual excitement. These patients do not have clear-cut hypomanic episodes as isolated episodes, but have hyperthymic temperaments.

**Conclusions**

It appears that the prevalence rate for bipolar affective disorder is much higher now than previously reported and that the disorder is commonly seen in primary care settings. The socio-economic, personal and family burden is considerable, and often the illness is not recognised.

Patients with bipolar spectrum disorder commonly present with depressive symptomatology. If this results in a diagnosis of a depressive disorder and the patient is treated with antidepressants, this will frequently worsen the outcome.

**Features of depression that make hypomania more likely**

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<tr>
<th>Features</th>
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<tbody>
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<td>eyes darting</td>
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References on request