



written by Professor Gordon Parker

## mind over matter

# Highs and lows of mood disorder

A young woman presents with an eight-year history of debilitating depressive episodes.

## PRESENTATION

MISS D, a 23-year-old secretary, presented with an eight-year history of intermittent depression and possible post-traumatic stress disorder.

## HISTORY

Dianne had slowly completed a law degree but was unable to function as a lawyer because of debilitating depressive episodes, emerging suddenly and usually without triggers, lasting up to three months, preventing her from getting to work.

At such times, she kept to her room, not answering phone calls from anyone.

Clinical review of depressive symptoms favoured a melancholic type of depression, with symptoms including an anhedonic and non-reactive mood, profound psychomotor disturbance (worse in the morning) with impaired concentration, difficulty getting out of bed, and intermittent agitation (e.g. at times, pacing up and down).

However, rather than insomnia and appetite loss (classic 'endogeneity' symptoms), she reported excessive sleep and weight gain, as a consequence of craving and eating "crap foods".

There was a family history: a grandfather with depression, and two cousins had suicided.

Dianne gave a developmental history, suggesting a longstanding circumspect and rather anxious personality, no use of illicit drugs, rare alcohol intake, and only two rather superficial relationships. When asked about a possible "post-traumatic stress reaction", she initially brushed

aside "an event, which I've put behind me now".

## DIAGNOSTIC QUESTION

In my experience, melancholic depression is uncommon in individuals younger than 40, unless they have either bipolar disorder or the propensity to develop it.

The seeming paradox of reporting excessive sleep and eating (hypersomnia and hyperphagia) is not uncommon in younger people with true melancholia. Thus, did she have bipolar disorder?

## CLUES FOR IDENTIFYING BIPOLAR DISORDER

I tend not to ask "Do you experience highs?", as this can encourage a defensive reaction to the cue word.

A more useful probe is: "Do you have times when you are more energised and wired?"

Just as melancholic depression is a low energy state, highs are as much states of high energy as of elevated (or irritable and angry) moods. If affirmed, subsidiary questions (all predicated with "During those times...") should pursue mood state nuances, and whether the individual talks more than usual, talks over peo-

## The disorder began with a non-psychotic high at the age of 15

ple, needs less sleep and is not tired, spends more money (purchasing unnecessary things), is verbally or otherwise indiscreet (e.g. ticking off the boss, having an unwanted tattoo), has increased libido, and feels more creative or "at one with the world".

If the individual has such episodes, seek details on onset (particularly a 'trend break' where highs 'emerge' and differ

from pre-morbid personality), duration (ignore DSM criteria, as 'true' hypomania and mania can be as fleeting as mere hours or a day), concurrent delusions or hallucinations (indicative of bipolar I disorder), and exclude other diagnostic possibilities (e.g. stimulant or steroid drug abuse, ADHD, borderline personality disorder).

## DIAGNOSIS

Dianne's mood disorder commenced with a non-psychotic 'high' at the age of 15, when, uncharacteristically, she had stayed up all night talking to older surfers at a beach dance.

She had enthusiastically followed one (whom she found "incredibly handsome") back to his flat and had had consensual sex (as judged at the time) for the first time in her life.

A week later she had developed the initial episode of melancholic depression and, feeling profoundly guilty and ashamed, had consulted her GP to check for genital herpes.

In retrospect she was mortified by her actions, unable to discuss her behaviour with family or friends, stating that she would "never be able to put it behind me".

Subsequent highs occurred every few months and lasted a day or two. While disinhibiting (and "dissolving my anxiety"), she had learned to minimise deleterious consequences. She was unaware of bipolar disorder, thinking instead that the highs were part of her personality and that the earlier event had reflected a character flaw.

## MESSAGES

Bipolar disorder (particularly bipolar II) appears on the increase. In bipolar II, the highs are generally not too severe – and often enjoyed by the individual – so that they fail to

mention them to the assessing practitioner. Thus, all people presenting with clinical depression should be screened for the possibility of bipolarity.

The depressed episodes in such a condition are nearly always melancholic or psychotic in nature. This indicates a profoundly debilitating disorder and necessitates drug treatments (antidepressant drugs and/or mood stabilisers) as a treatment priority, complemented by education about the condition,

counselling to address 'collateral damage', and 'stay well plans' to manage incipient and actual mood states. **MO**

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Information reference: see Bipolar Self-assessment Test and fact sheets on bipolar disorders on the Black Dog Institute website [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au).