

‘No worries’ a cause for concern



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As doctors, we expect that patients will present with problems, but if they deny any, what is the problem?

CASE STUDY

Janet, a 40-year-old former secretary, presented to a tertiary service at the instigation of her GP. His referral note described a 10-year history of severe depressive episodes that had caused her to lose her job and her husband, and estrangement from her children.

He detailed a history of a treatment-resistant melancholic depression that had failed trials of six antidepressants and two antipsychotic drugs.

PRESENTATION

Janet had recently moved to a rural location that necessitated two days travel to attend the appointment. At interview, she stated that she was not depressed. Nor did she look depressed.

During the assessment, she minimised the documented history of depression, saying that such issues were now irrelevant. When asked why she had come so far to be interviewed when there were no longer any problems, she stated that she felt we might learn something from her story – that any depressive episodes she might have had over the previous two decades were all related to the pressures of city life.

Since she had moved to a small country town she felt free of stress and any depression had disappeared.

Her explanation was presented rationally. She was composed, there was no thought disorder, and she related pleasantly to secretarial staff and interviewing doctors. When asked why she had relocated to this particular country town, she related that she had accepted an advertised secretarial position; however, when she got there the position had

been filled, and she had then rented a flat some way out of town. There, without the pressure of work, her depression had disappeared.

When asked about her finances, she acknowledged that her bank balance was running down but she had enough money to pay rent and meet expenses for another six weeks or so. She appeared unperturbed about her deteriorating financial situation and sanguine about whether she would obtain work.

When asked what she planned to do in Sydney before returning to the

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country, she said she was picking up a lounge suite that she had imported from Thailand, after seeing it on the Internet and paying several thousand dollars for it. Though she had no information that it had arrived, she was going to the wharves to find it and have it transported to her new abode. She seemed unaware of any logistic or financial problems.

This last information suggested the possibility of a bipolar disorder with its

attendant impulsivity and disinhibition. She then denied all specific questions assessing the possibility of a hypomanic or manic mood in the past or currently.

BIPOLAR DISORDER

Both bipolar I and II disorders are marked by oscillations in energy and mood, with most people in a manic or hypomanic mood showing ‘out there’ behaviours. They are often bright-eyed, overly talkative, loud, ‘buzzy’, enthusiastic, disinhibited and flirtatious. Common alternate expressions include angry, paranoid and litigious states.

However, of note, some manic and hypomanic individuals will not display any significant overt behavioural indicators. Even patients who have been hospitalised for a manic state may just sit quietly by themselves.

MAKING THE DIAGNOSIS

Overt manic and hypomanic behaviours clearly signal the possibility of a bipolar disorder to a clinician. However, clarification is often dependent on longitudinal as well as cross-sectional information, and frequently benefits from a corroborative witness (e.g. family member) report, rather than relying on the patient.

With Janet’s permission, her ex-

husband was contacted and he described a longstanding pattern of mood oscillations, with manic periods marked by excessive spending – especially purchasing jewellery (from a pay TV channel) – and he was aware that she was in such a mood when she had left Sydney for an imagined job in a country town.

Janet’s lack of insight and her seemingly sanguine response to increasing financial pressures indicated that she no longer had the treatment-resistant depression promoting the referral, but was in an insightful manic state, putting herself at some risk. However, as her behaviour was not at a level that necessitated involuntary admission, she was wished well by the staff and left with a smile, saying that she was pleased to have been able to help others to learn that getting out of the city was a cure for depression.

The local rural mental health team was notified that she was likely to come to attention before too long. In addition, as the assessment had identified some medical problems, she was linked in to a rural GP – who was contacted and made aware of her likely presentation.

Just as it is time to start worrying when someone says “no worries”, there is usually a problem if a patient presents denying any problem. 