Borderline or Bipolar? Part II

[NOTE: Part I of this article appeared in the Spring 2009 issue.]

By Brian Quinn, LCSW, Ph.D.

Recognizing Bipolar Spectrum Illness in Depressed and Personality Disordered Patients

Have you worked with patients who have tried several different antidepressants, improved for a time on one or more of them, and then slipped back into depression? Have some of your patients become mired in lethargic, irritable, unrelenting depressions despite combinations of antidepressants and other drugs such as Abilify? The most common reason is that these patients do not just have depression or a personality disorder. They have undiagnosed bipolar illness (Sharma et al., 2005). Antidepressants can cause a number of problems in bipolar patients that may make effective psychotherapy difficult if not impossible.

Primary care physicians and psychotherapists misdiagnose 3 out of 4 bipolar patients, typically as having unipolar depression. Patients spend roughly 9 years working with these professionals before a correct diagnosis is made. Alarmingly, psychiatrists do not fare much better, making the wrong diagnosis in about half of bipolar patients and allowing 6 ½ years to pass before getting the diagnosis right (see charts below).

In the Spring 2009 issue of the newsletter, I discussed how familiarity with the seven cardinal symptoms of mania and hypomania* and asking patients and their families about episodes of increased activity and productivity (the hallmarks of a hypomanic episode), can help clinicians identify depressed or character disordered patients who are bipolar.

Clinicians can further improve their chances of identifying bipolar illness by learning to recognize "features of bipolarity" in depressed and character disordered patients who do not have a history of mania or hypomania (Ghaemi, 2008). Features of bipolarity include symptoms, course of illness patterns, family histories, and responses to antidepressant medication that occur in patients with clearly identified bipolar disorder but that are not typically found in those with classic unipolar depression.

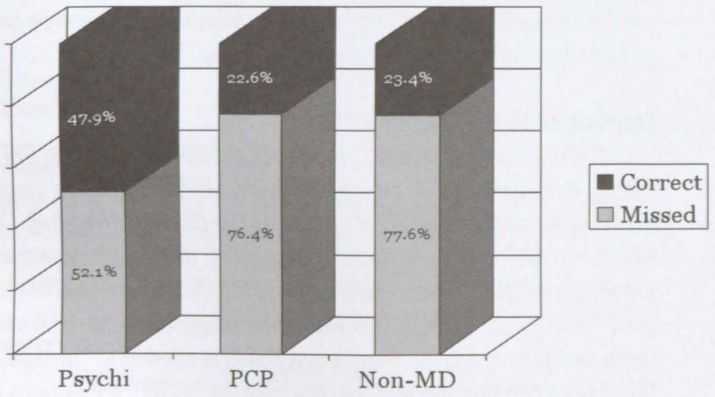
Following are the features of bipolarity clinicians should look for in depressed and character-disordered patients (especially those patients with DSM Cluster B disorders such as borderline and narcissistic personality). Patients with varying combinations of these features should be suspected of having a "bipolar spectrum illness" (Akiskal, 1996; Ghaemi, 2008) even if they have not had a clear-cut history of mania or hypomania.

Symptoms and Signs Suggesting Bipolar Spectrum Illness

There are three symptom clusters that should alert the social worker to the possibility a patient may have bipolar spectrum illness: depressive mixed states, atypical symptoms of depression, and psychotic depression.

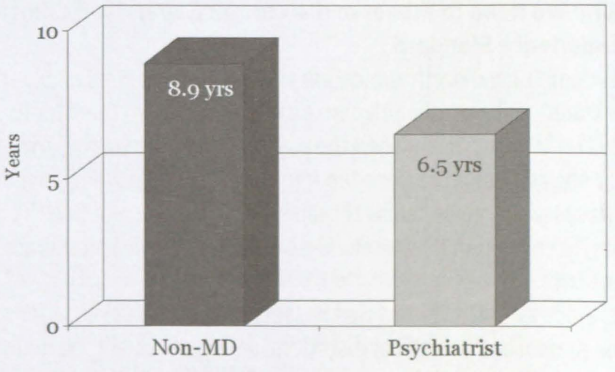
Patients are said to be in depressive mixed states when they have many symptoms of depression but also some hypomanic ones, as well. Hypomanic symptoms may include distractibility, racing or crowded thoughts (flight of ideas), and loud, rapid, and sometimes difficult to interrupt speech. These individuals may be animated, engaging, and amusing

Correct Diagnosis of Bipolar Disorder by Profession



Hirschfeld, R., et al. (2003)

Delay in Diagnosis by Profession



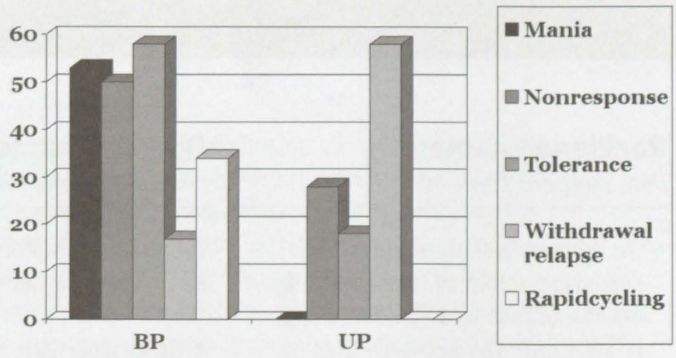
Ghaemi, S., et al. (2000).

despite meeting criteria for depression, but often their mood is irritable or dysphoric. Because these patients are talkative, therapists may have little opportunity to speak without feeling as if they are interrupting. Patients in depressive mixed states may have an increased sex drive (patients with unipolar depression complain of decreased sex drive).

Unipolar patients often have "typical symptoms" of depression: Middle of the night or early morning awakening and loss of appetite. The clinician's index of suspicion for a bipolar spectrum illness should rise if, by contrast, the patient has so-called "atypical symptoms:" oversleeping, overeating or leaden paralysis (a feeling of overwhelming heaviness and fatigue in the arms and legs). Atypical features are more common in bipolar patients than unipolar ones (Angst et al., 2006).

An adolescent or young adult with psychotic depression (depression accompanied by delusions or hallucinations) is likely to later develop mania. Psychotic depression is sometimes not as easy to spot as the clinician might expect: Psychotically depressed patients tend not to reveal their delusions and hallucinations. Psychotic depression should therefore be suspected in an adolescent or young adult who is very guarded, excessively guilt-ridden, confused or has extreme psychomotor retardation (Goes et al., 2007).

Antidepressant Outcomes in BP and UP Depression



N = 40 BP
N = 38 UP

Ko, J. et al. APA 2002

Course and Temperament Characteristics of Patients with Bipolar Spectrum Illness

Individuals with unipolar disorder typically have their first episode of depression in their late twenties. Bipolar depression begins, by contrast, in the mid to late teens. The younger the age of onset of depression, the more likely the patient will eventually develop a manic or hypomanic episode (Goodwin & Jamison, 2007).

Bipolar depressions typically have a more rapid onset than unipolar depressions (days to weeks as opposed to months), may last less than 3 months (unipolar depressions typically last 6 to 12 months) , and are highly recurrent.

Individuals who, before their depressive episode, consistently got along on 6 hours of sleep a night or less, and were cheerful, talkative, over-confident risk-takers may have what is referred to as a hyperthymic temperament (Akiskal, 1996). These individuals often end up in business, sales, politics, or entertainment. Depressed patients with premorbid hyperthymic and cyclothymic (chronically moody, irritable, and unstable) temperaments should be suspected of having a bipolar spectrum illness.

Post-partum onsets of depression (especially psychotic forms) and seasonal cycling of depression should raise clinicians' suspicion of bipolar illness, as well.

Family Histories of Patients with Bipolar Spectrum Illness

According to DSM-IV a depressed patient without a history of mania or hypomania whose father or mother has bipolar illness is considered to have a unipolar disorder. Yet, antidepressants don't work as well in depressed patients with an immediate family history of bipolar disorder and can prompt the earlier expression of hypomanic or manic episodes in these individuals (Calabrese, J. et al., 2006; O'Donovan et al., 2008).

But, the *absence* of a clear family history of bipolar disorder does not rule out the possibility of a bipolar spectrum illness. The most common disorder found in the family histories of patients with bipolar disorder is, in fact, depression, not bipolar disorder. Multiple relatives over several generations with depression or other evidence of mood dysregulation such as explosive temper are a marker for bipolar illness. Other family history features of bipolarity include a family history of completed suicide and alcoholism (Guillaume et al., 2009; Winokur et al., 1996).

Clinicians should consider the possibility of bipolar disorder in depressed patients who have ambitious, successful, or creative relatives. Some of the genetics at the root of bipolar disorder may also confer on some family members the drive and energy needed for high achievement (Simeonova et al., 2005).

Responses to Antidepressants That Suggest Bipolar Spectrum Illness

In perhaps 20 percent of patients with bipolar depression, SSRI antidepressants precipitate a manic episode within 8 weeks of the start of treatment (Goodwin and Jamison, 2007). The use of mood stabilizing medication with an antidepressant lowers but does not eliminate the risk of mania.

A more common outcome of antidepressant treatment in bipolar patients is referred to as cycle acceleration: An initial positive response to an antidepressant is followed by repeated relapses into depression despite dosage increases (Goodwin & Jamison, 2007). Sometimes patients have had this experience with two, three, or more antidepressants. Women are likely more vulnerable to this adverse outcome.

Antidepressants can thus *hasten* the onset of another depressive episode in bipolar patients and actually *increase*

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the number of depressive episodes the patient experiences in the long run. The frequency of adverse outcomes of antidepressant treatment in bipolar and unipolar depression is shown in the following chart.

While no one feature of bipolarity is diagnostic, the presence of several of them together (particularly a family history of bipolar illness or antidepressant-induced mania) increases the probability that the patient has a bipolar spectrum illness. Effective psychotherapy with these patients generally becomes possible only after accurate diagnosis leads to withdrawal of destabilizing antidepressant medications.

*The seven cardinal symptoms of mania and hypomania can be recalled using the mnemonic **DIGFAST** (William Falk, MD Massachusetts General Hospital; Ghaemi, 2008): **D**istractibility; **I**nsomnia; **G**randiosity; **F**light of ideas; **A**ctivity: goal-directed hyperactivity; **S**peech: Pressured, loud, rapid; **T**houghtless behavior: foolish business ventures, overspending, sudden travel, sexual indiscretions

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IN MEMORIAM

On January 1, 2010, the New York State Society for Clinical Social Work unexpectedly lost Sharon Lasky to cancer. Sharon served on the State Board for over four years as voting representative of the Brooklyn Chapter. She also served as treasurer of the Brooklyn Chapter and was tireless in her work to build the chapter.

Sharon's dedication to life and community service was reflected not only in her contributions to the Society, but in her leadership of the Hadassah Bay Ridge Chapter as well. A deeply moving memorial event was held in Brooklyn by Hadassah on February 21. Society members, work colleagues and Hadassah friends spent a touching afternoon remembering all her contributions to all of our lives and celebrating her life.

Sharon worked at Kings County Hospital for over 40 years as a Level 5 Supervisor of the Maternal Child and Pediatrics Service. She handled many high profile trauma cases and proved relentless in getting patients' needs met and following up with families. The memorial service held at the hospital was so crowded that it spilled into the corridor. There are plans to name a portion of the hospital in her honor.

Sharon was also in charge of social work training and the education of social work interns. She worked as a field supervisor for four schools of social work. She was always an enthusiastic, life-affirming person who worked hard and played hard. Her passing is a tremendous loss to everyone who knew her.