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Is It Bipolar Depression or MDD? Diagnostic Criteria

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Dr. Singh:
Hello, my name is Manpreet Singh. I'm joined today by Dr. Joseph Goldberg. And we're going to talk today about the question: Is it Bipolar Depression or MDD, or Major Depressive Disorder? The question is really important. It stymies lots of clinicians, because there are a lot of potential alternative diagnoses while you're trying to figure this one out.

So I've got a case, Dr. Goldberg. She's an 18-year-old college freshman. You know, college students don't necessarily come in to be treated right away. They often come when they're in distress or sad or empty, so we're going to call her MT. She was referred for presumed but inadequately treated depression and some attention deficit. She might be seeking stimulants, but she complains that everything is her fault, no one understands me, I'm scared, I'm easily set off, and I can't focus. Her low mood and lack of interest have escalated over the last couple of months in particular. So what are you thinking right off the bat, Dr. Goldberg?

Dr. Goldberg:
Typical presentation. Maybe first time away from home, college freshmen. She's right in the epidemiological window for lots of things around mood disorders. Had a prior treatment. You had said inadequately treated depression and ADD. So probably what I want to do, Manpreet, is resist the temptation to jump to premature closure and anything. She sounds like initial presentation. But I would like to know how far back the depression goes with her. Is it someone who's been depressed for the last few months? Or the last few years? Or pre-adolescent? Prepubescent? What the qualitative nature of the depression is, has it been a kind of a coming and going sort of thing? Or a more persistent phenomenon? I'm curious about the attention complaints, you know, problem with attention is, it's arguably one of the most ubiquitous symptoms in all of the DSM-5. Name me one disorder that does not have impaired attention. Certainly, depression has impaired attention. But the hint here is that she was having some psychiatric ailment before age 12. If that is, in fact, ADHD. And so from a mood standpoint, I'm eager to know if she had mood symptoms before age 12 that might have been misconstrued as ADD? Or if that was more of like a haphazard diagnosis? People with depression have attention problems. So I'd love to tease that out from the timeframe, you know, love to know what inadequate prior treatment was? Does that mean that she took an SSRI for a week and didn't like it, so stopped? Did she have an adequate trial? And if so, of what? Uh, of one medicine?

Dr. Singh:
Alright, and let's dig into it.

Dr. Goldberg:
Yeah, yeah.

Dr. Singh:
Yep, let's dig into it. Here are some -

Dr. Goldberg:
I feel like this should evoke lots of questions and, for our colleagues, just resist the temptation. This is not name that tune, where you want to get to the answer, you know, within five notes, you want to be all inclusive, because then you're going to narrow this down, and the careful evaluation is the way to get there.

Dr. Singh:
So let's go into the history a little bit more deeply. MT had a history of depressive episodes with outbursts and suicidal behavior since age 11. So this is predating age 12, unprovoked or triggered outbursts. She would also assault her brother or bang her head against the wall. She overdosed on over 150 pills on two separate occasions and attempted multiple times to hang herself on the doorframe of her room. But she was never hospitalized. The outbursts that she had, which were episodic, usually came after prolonged periods of very severely depressed mood and lack of enjoyment in life. Triggers were sometimes due to poor coping with disappointment, some rejection, or a reaction to stress associated with a belief really that the only academic success that she had could prevent her mother from being deported to another country. And that was a reason that she actually says that she lives and continues to live until the age of 21, so that she can prevent her mom from getting deported.

It's really notable that many of her, so to speak, outbursts were accompanied by A symptoms that we often associated with mixed states that we describe in DSM-5 categories of mixed features: anxiety, agitation, anger/irritability, attentional disturbance and distractibility, as well as anhedonia. Our friend, Dr. Roger McIntyre, talks about these A symptoms, but in the context of youth onset of depression, these A symptoms are almost normative. They're often along for the ride with the episodes but the problem is, is getting the time criteria right. So yes, you've got the reporting of the symptoms, but how do you make a diagnosis?

With this particular group of symptoms, you have to kind of think about what are the quality of the symptoms? You know, she describes like she's feeling like she's taking a drug. Like she's looking up at the stars when she's having elevations in mood, or feelings of irritability or agitation. But what is the qualitative feel - features associated with these symptoms end up becoming very important as part of the diagnostic evaluation. Any comments here?

Dr. Goldberg:
It would sure be nice if she had a sign over your head that said, 'I've had periods of a week or longer where I'm over energized and don't need much sleep,' because then we can start to go down the, is this a bipolar trajectory? You know, unfortunately, she's got, you know, a few things that I think make us wonder. Before we embark down that pathway and being the non-child psychiatrist here Manpreet, I'll impersonate one. I just want to know about the developmental history, with that headbanging, and whether she's doing self-soothing behaviors when stressed that would speak to some sort of a developmental issue. We don't have the history, you know, before age 11. I don't know if you have that available, or if we should just take for granted that this is a normal gestation, normal early toddlerhood or early development, and that this is not a kid who's whose stimming? Or who's in the spectrum or who has, you know?

Dr. Singh:
Right. It's a great question, Joe. When you have children who are self-soothing with headbanging or other kinds of destructive behaviors or self-inflicting behaviors, you have to wonder about intellectual capacity and other neurodevelopmental conditions. This kid was not at all developmentally delayed. In fact, she was whip smart, got into an Ivy League school even, and is presenting to us in a very, very advanced academic situation. So you'd be surprised to hear that history that she actually self-soothes in the ways that she's described it in the past, but it's not an uncommon history, it sort of adds some color to understanding that you could be very, very smart and very intellectually advanced and potentially even get into a very accomplished college and still struggle with mood regulation issues. So I'm going to -

Dr. Goldberg:
If I could let me now say three impressions from the data you just supplied us. So one, prepubescent depression going back to 11 puts her in a high risk category. So follow-up studies of prepubescent depressed kids, talk about a 20 to 40% chance that you will grow up in the next 10 years, not even grow up, over time to manifest a mania or hypomania. So let's say symptoms of mood dysregulation and depression began before like age 11. So she's got up to 40% chance of just that alone, carrying her to Bipolar Disorder.

Dr. Singh:
Yeah.

Dr. Goldberg:
Second, trait impulsivity. There's some interesting work that says people with Bipolar Disorder have trait impulsivity. And thirdly, suicidality, which goes with depression, is not an ADHD thing. It can be a unipolar thing, but it's a little more likely in the bipolar realm. And you get especially worried about a kid like this. If there is trait impulsivity and prior suicide attempts, she's very high risk. And so whatever we're going to do with her, we better be very, very careful.

Dr. Singh:
You got it. And in fact, the suicide attempts - the history of the past suicide attempts raised some significant questions for every clinician who had seen her up to till when she presented to me. And when you describe issues around the quality of the mood symptoms, I think about Barbara Geller's work in cardinal symptoms, when you think about early onset, depression, as well as mania symptoms and the emergence of them earlier in life, it's not to say, we can debate all we want about whether it's common to see a patient with mania present below the age of 12. The prevalence is much more common in adolescents and young adulthood. But the early signs and symptoms can be useful for us to follow and track over time, and they tell us some very useful information retrospectively. So when you hear a young adult come and present with the kinds of symptoms that MT was describing, you begin to piece together a story that maybe raises some index of suspicion.

So but let's talk about cardinal symptoms for a moment, because when Barbara Geller did her study about 20 years ago, she found that the cardinal symptoms of hypersexuality, elated, elevated euphoric mood, those are the kinds of symptoms that tracked to continue between childhood and adulthood. These are what we believe represent classic mania symptoms that don't necessarily just spontaneously resolve. In MT's case, her mood was described as both sad where she couldn't get out of bed, was suicidal. But also at the same time, she would describe simultaneously feeling elevated, high, jumbled with mind fogging, and high energy when she finds herself saying and doing impulsive things that she regrets doing after they've happened. It's almost as if she believes she's having an out-of-mind, out-of-body experience when she's experiencing these elevated moods. So then what we did was -

Dr. Goldberg:
Now the fourth thing you're making me think about – sorry to interrupt, but I can't resist, with mind fogging, so that you really want to delve into the potential for psychosis.

Dr. Singh:
Sure.

Dr. Goldberg:
Because psychotic features may not be crystallized delusions or hallucinations, the way you or I might have them as old people. But you know, in terms of her ability to tell what's real from what's not, relevance being psychosis in depression in youth, a big risk factor for polarity conversion over time.

Dr. Singh:
No doubt. And certainly, neurological evaluation also is warranted. When you think about mind fogging and memory impairments, you want to maybe do a more thorough neurological evaluation look to see if there's a potential for seizure history in the family or in the patient herself. And we were able to rule all of those issues out. But it is of concern that she couldn't really remember her episodes terribly clearly, which makes it complicated to make a diagnosis. If you don't have great reporting because of a lack of memory, then it's hard to put the pieces of the puzzle together.

She did describe having gone a week and sometimes more with elevated and explosive moods. So the index mood was at least 50% of the day every day for at least a week, and was accompanied by several DIGFAST symptoms. So these are the combination of index mood symptoms in addition to cardinal symptoms that are necessary in order to make a diagnosis of Bipolar Disorder. She was distractible, increased goal-directed activity, grandiosity, flight of ideas, accelerated speech, decreased need for sleep, and then what I call trouble: sex, drugs, and rock and roll, indiscretion, impulsivity, and hypersexuality that overlapped in those periods of time when she felt elevated or euphoric for 50% of the day for at least 7 days. Some kids don't last that long, and they get hospitalized before that happens, but that's okay. That's definitely something that you want to look for in the history.

Interestingly, when we talk about neurology and the differential diagnosis, there she is someone who suffers from migraine headaches, and is on amitriptyline for prophylaxis for migraines since 11th grade. But importantly, she's never had any history of antidepressant-induced mania, and the mania symptoms actually were preceding the prescription of the amitriptyline. But it is another important factor to consider in her history as you're piecing it together.

And this is exactly what we did with MT. So just to give you a sense of it, we did a screening questionnaire, the typical ones used in pediatric clinics or general practitioner clinics are the PHQ-9 that can be done in the waiting room, it's kind of now ubiquitously used for screening for depression. So people screen in to have moderate levels of depression all the time. But what about screening for mania? That, you know, is again, triggered by an index of suspicion and some of the symptoms that kind of corroborate a potential mania history, but every patient could be rapidly evaluated for mania symptoms, just by asking a few questions related to the onset of their depressive symptoms. For example, younger age of onset of depression is a risk factor. Family history, though not as strongly linked, can potentially be a factor. But there are a number of other cardinal symptoms that are very obvious to screen for that can potentially

also allow you to then ask about DIGFAST symptoms. So we did a screening followed by a semi-structured interview, and then we did some severity ratings based on dimensional severity of both depression and mania.

And then what we did was we reviewed the timing of the episodes because in order for you to make a diagnosis, it's not just important to have the symptoms, but you need to have the meet-the-time criteria, 1 week for mania, 2 weeks for depression, and understand what happens in between episodes. When several episodes are endorsed at the same time, it's very important to understand if there are overlapping mixed states because that can have an impact both on what you decide to do clinically from a treatment perspective, but also how you understand the nature of the condition. And it's true that over the course of the patient's history, you're going to find that younger kids are going to have more prevalence of mixed states and symptoms of mixed features than adults and older adults do, where maybe depression is more of the predominating episode. And so, this makes it even perhaps a little bit more likely for you to find a mania in a younger patient compared to an older one.

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