

Is it bipolar depression? 'WHIPLASHED' aids diagnosis

Despite much education and research, bipolar disorder is still under-recognized and inappropriately treated in many clinical settings.¹ Bipolar and unipolar depression display similar symptoms, making correct diagnosis difficult. The differential diagnosis is especially problematic in patients suffering a first major depressive episode, when there is no clear history of mania or hypomania.

Nevertheless, bipolar depression does have telltale signs—remembered with the mnemonic WHIPLASHED—to guide diagnosis.²⁻⁸

Worse or “wired” when taking antidepressants. The patient complains of feeling “antsy” or being agitated or unable to sleep when taking traditional antidepressants.

Look for numerous failed antidepressant trials, apparent tolerance to antidepressants that does not resolve with increased dose, and antidepressant-induced mania or mood cycle acceleration.

Hypomania, hyperthymic temperament, or mood swings in a patient’s history. Patients with hyperthymic temperament show persistent traits such as intense optimism, increased energy, reduced need for sleep, extroversion, and overconfidence.

Dr. Pies is clinical professor of psychiatry, Tufts University School of Medicine, Boston, MA.

Ask about periods of elevated mood or energy that might not fit formal DSM-IV-TR criteria for hypomania—such as episodes that last only a day or two. Mood lability in younger patients can be especially dramatic and poorly demarcated.

Irritable, hostile, or mixed features. Some patients show one or more hypomanic features, such as racing thoughts when depressed.

Psychomotor retardation appears more common in bipolar I depression than in unipolar major depression. Psychomotor *agitation*, however, is more likely in bipolar II than in unipolar major depression.

Loaded family history of mood swings, frank bipolar disorder, or affective illness. A family history of comorbid mood disorder and alcoholism may also point to bipolarity.

Abrupt onset and/or termination of depressive bouts or relatively brief episodes (<3 months). Some patients will report a brief burst of increased energy or sub-threshold hypomanic symptoms immediately before depression onset.

Seasonal or postpartum depression. “Winter-type” seasonal affective disorder—feeling depressed in the fall and winter, hypomanic in the spring—and postpartum psychosis have clinical and epidemiologic links with bipolar disorder.

Hyperphagia and hypersomnia—sometimes termed atypical features—are common in bipolar depression. Paradoxically, hypersomnia may co-exist with psychomotor agitation in bipolar II patients, resulting in so-called “sleepy speeders.”

Early age of onset. Major depression that appears before age 25—especially with psychotic features—may herald subsequent bipolarity.

Delusions, hallucinations, or other psychotic features are more common in bipolar than in unipolar depression.

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