This case study of a 21-year-old woman—referred by a relative because of long-standing severe interpersonal, academic, and occupational impairment—illustrates the importance of screening patients with brief episodes of depression for mixed features.

Jane, who is 21 years old, was referred by her mother because of long-standing severe interpersonal, academic, and occupational impairment. She was euthymic on the day she presented.

Jane had a history of unstable relationships and impulsive, self-destructive behavior. She failed to achieve educational objectives and to maintain stable employment. From early adolescence, she was defiant. When she was 15 years old, her parents became so frustrated with her that they sent her to a residential treatment facility for troubled girls.

In the years before presentation, she abused alcohol and experimented with a number of substances, but had not done so for more than a year before the evaluation. She had 3 first-degree relatives, none of whom were known to have a mood disorder.

Jane had been assessed by mental health professionals, including psychiatrists, over the years. Information about previously rendered diagnoses was not available. She had received psychotherapy but not a somatic treatment.

When interviewed, Jane was asked whether she had ever had episodes of depressed, irritable, or elevated mood, or some combination of these, lasting a week or longer. She did not recall this being the case. She was then asked whether she had ever had 2- to 3-day episodes characterized by some combination of these mood states. She said she had brief episodes of affective disturbance since early adolescence. These episodes occurred every 1 to 2 weeks, lasted about 2 days, and were marked predominantly by depressed and irritable mood. On these days, Jane had particularly low self-esteem, slept about 3 hours more than usual, ate excessively, and had a low level of energy and psychomotor slowing in the morning and restlessness late in the day and at night.

During some of these brief periods of depression, there were times throughout the day when Jane had brief bursts of strangely elevated mood, had hypertalkativeness but not frank pressured speech, was distractible, and had racing and crowded thoughts. She had never had a hypomanic episode or psychotic features. Jane's presentation most closely conformed to the criteria for “recurrent brief depression,” as specified in Appendix B of DSM-IV-TR. She was viewed by her physician as having “recurrent mixed depression.”

Although Jane was euthymic, a decision was made to use a pharmacological intervention aimed at interrupting the cyclical process. She was treated with lamotrigine rather than lithium because of its tolerability. She was instructed to take morning doses as follows: 25 mg for 14 days, then 50 mg for 14 days, followed by 100 mg for 7 days, and then 200 mg thereafter. Jane tolerated the medication well. She had 1- or 2-day periods of mixed depression weekly through the fifth week of treatment. However, from that point onward, she was free of symptoms.

After 9 months of treatment, Jane stopped taking lamotrigine. She became very depressed on the second day. Her mother called Jane's psychiatrist asking for guidance; he recommended that Jane restart her medication, since she had missed only 2 doses. Within a day, she felt well and did not cycle into an episode until 6 months later, when she decided to stop taking the medication. Two days later, Jane was in crisis and her mother called the psychiatrist. He recommended she resume taking lamotrigine. The symptoms remitted within 1 to 2 days. The cyclical process did not recur during the following 2 months, at which point she was lost to follow-up.

**Discussion**

Recurrent brief depression is defined as a phenomenon marked by the presence of impairing depressive episodes of at least 2 days’ duration that meet all criteria for MDD (except for the duration criterion) and that occur at least once a month for 12 consecutive months and are not associated with the menstrual cycle. Recurrent brief depression was included in Appendix B of DSM-IV and is now included in the main
body of DSM-5. Mixed depression was not included in DSM-IV, but it is part of the chapter on MDD in DSM-5.

Mixed depression was first described by Kraepelin, but the concept was ignored until quite recently. The diagnosis of mixed depression, as described in the literature in recent years, focuses on the admixture of subthreshold symptoms of hypomania in the context of DSM-IV-defined MDD. By this standard, Jane did not have mixed depression because she never had an episode lasting at least 2 weeks. However, she did meet the criteria for recurrent brief depression and had significant mixed features during these episodes.

Angst and colleagues have proposed validated changes in the criteria for hypomania that apply to this case. Their data suggest that hypomania is reasonably defined without reference to duration and includes symptoms of overactivity, euphoria, or irritability along with any 3 DSM-IV-specified symptoms of hypomania that lead to subjective or social impairment. By this standard, Jane would be viewed as having recurrent brief mixed hypomania.

Jane was euthymic when she presented, yet a psychotropic was prescribed for the purpose of aborting a cyclical process. Lithium would have been a reasonable option. One might have also used divalproex. However, owing to its tolerability, lamotrigine was selected. Jane did well but had symptom relapse within 2 days on both occasions she stopped the medication; with resumption of treatment, she had prolonged asymptomatic periods. This strongly suggests that lamotrigine was causal in interrupting the cyclical process.

This case illustrates the value of assessing patients with histories of stormy interpersonal relationships, impulsive behavior, and low social function for the presence of brief, episodic affective disturbance. It also illustrates the importance of screening patients with brief episodes of depression for mixed features. The use of an antidepressant in an effort to abort the cyclical process might have further destabilized mood and worsened the course of illness.

Disclosures:

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References:


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