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Research report

High-risk behaviour in hypomanic states

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ABSTRACT

Background: Risk-taking behaviours during hypomanic states are recognised, however the high-risk nature of some behaviours—including the potential for harm to both the individual and others—has not been detailed in the research literature. The current study examines risk-taking behaviours and their consequences (including their potential for impairment) in those with a bipolar II condition.
Method: Participants were recruited from the Sydney-based Black Dog Institute Depression Clinic. Diagnostic assignment of bipolar II disorder was based on clinician judgement and formal DSM-IV criteria. Participants completed a series of detailed questions assessing previous risk-taking behaviours during hypomanic states.
Results: The sample comprised a total of 93 participants. Risk-taking behaviours during hypomania included spending significant amounts of money, excessive alcohol or drug use, dangerous driving and endangering sexual activities. Key consequences included interpersonal conflict, substantial financial burden and feelings of guilt, shame and remorse. Despite recognition of the risks and consequences associated with hypomanic behaviours, less than one-fifth of participants agreed that hypomania should be treated because of the associated risks.
Limitations: Study limitations included a cross-sectional design, reliance on self-report information, lack of controlling for current mood state, and comprised a tertiary referral sample that may be weighted to more severe cases. Findings may therefore not be generalisable and require replication.
Conclusions: Risk-taking behaviours during hypomania are common, and often linked with serious consequences. Whilst hypomania is often enjoyed and romanticised by patients—leading to ambivalence around treatment of such states—careful consideration of the impact of risk-taking behaviour is necessary, while the study raises the question as to what is 'impairment' in hypomania. Findings should advance clinical management by identifying those high-risk behaviours that would benefit from pre-emptive weighting in developing individual's wellbeing plans for managing the condition.

1. Introduction

The bipolar disorders (I and II) are associated with significant social and economic burden, viewed as highly costly behavioural conditions (Wyatt and Henter, 1995) and compromise quality of life (Awad et al., 2007). Bipolar II disorder—characterised by recurrent episodes of depression and hypomania—may be more prevalent than previously considered, with recent estimates in the order of 5% (Hadjipavlou et al., 2012). Whilst positioned by some as a 'milder' form of bipolar disorder (and, in DSM-IV as either not impairing or minimally impairing), the condition is characterised by a chronic course, with recurrent depressive symptoms, and contributing to similar levels of disability and suicide risk to that quantified in bipolar I disorder (Benazzi, 2001; Judd et al., 2003, 2005; Joffe et al., 2004, as cited in Hadjipavlou et al., 2012).

Risk-taking behaviours during hypomanic states are broadly recognised as integral to bipolar illness. DSM-IV criterion B states the possibility of "increased involvement in pleasurable activities that have high potential for painful consequences" (APA, 2000, p. 365), and with Criterion B7 indicating "there may be impulsive activities such as buying sprees, reckless driving, or foolish business investments" (APA, 2000, p. 366). Whilst DSM-IV diagnostic criteria recognise risk-taking behaviours in bipolar II disorder—DSM definition and formal criteria state that impairment is either absent in hypomania or slight—and not require hospitalisation. Such features—in addition to psychosis during manic episodes distinguishes bipolar II from bipolar I disorder, however the distinction is not clear-cut (Benazzi, 2007), while the very nature of clinically observed mood-related risk taking can suggest distinctive 'impairment.' The severity of risk-taking

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behaviours clearly varies—for example, over-spending can range from simply buying three pairs against one pair of needed shoes through to spending hundreds to thousands of dollars on personal items during shopping sprees, by excessive gambling, or by purchasing property without adequate funds and risking bankruptcy or financial ruin. Seemingly harmless gregarious and flirtatious behaviour can lead to unconstrained sexual activity, risking sexual infection or unwanted pregnancy and the potential breakdown of the individual's primary relationship. Whilst 'marked' impairment in functioning may not be recognised by the individual during a hypomanic state—and with a percentage reporting or experiencing enhanced functioning during such times (Judd et al., 2005)—a less positive intepretation may emerge following episodes and upon further reflection.

Clinically, risk-taking during hypomania is commonly reported by patients (albeit generally with guilt or shame after return to a euthymic mood or in a post-hypomanic depressed mood). Whilst such behaviours may be perceived positively in-the-moment (e.g. adrenalin rushes from driving fast, pleasure from sexual activity or gambling)—the associated risks and consequences are many. Moral indiscretions occurring during such times drive guilt, remorse and shame, and even suicidal intent. High-risk behaviours are also commonly clinically observed as contributing to interpersonal conflict, relationship breakdowns, financial hardship and potentially life-threatening outcomes (e.g. whether death by misadventure during hypomania or when the mood has normalised or moved to a depressed state).

High-risk behaviours and their negative consequences—including interpersonal difficulties and loss of relationships (Michalak et al., 2006; Angst, 1998; Tranvag and Kristofferson, 2008)—have been examined broadly as a general issue of relevance to the bipolar disorders. A higher prevalence of reckless activity has been reported previously in bipolar I versus bipolar II disorder as might be expected (Serretti and Olgiati, 2005), however articulation of the high-risk nature of such activities in bipolar II patients is lacking. By contrast, clinical and literary anecdotes provide rich descriptions of hypomanic behaviours and their associated risks:

> *"When you're high it's tremendous…Shyness goes…Sensuality is pervasive and the desire to seduce and be seduced irresistible"*. (Jamison, 1995, p. 67)

> *"In hypomania…the elated mood leads to faulty judgement… ∜ hypersexuality may lead to venereal disease in men and pregnancy in women…."* (Fish, quoted by Hamilton, 1974, p. 73)

On recounting his high school years, Stephen Fry commented:

> *"I was expelled from [high school]. I felt so intensely alive…in a constant state of edginess…I was so often alone, wandering the roofs…a mixture of risk and power when you are looking down on people [below]. The awful thing was the stealing…[it] gripped me…your heart is in your throat, and it is a real buzz…I progressed to credit cards from the jackets of my parents friends…I used the money in the most grandiose way…when I was about 17…going around London…bought the most ridiculous suits…drink cocktails…you are the centre of your own universe. After months of travelling the country using my stolen credit card, I was arrested"*. (Fry, 2006)

Despite the high-risk potential and associated collateral damage, we are unaware of any studies examining in detail risk-taking behaviours associated with hypomania in those with a bipolar II disorder, and hypothesised that both the severity of such behaviours and their ensuing impact is underestimated. The current study therefore sought to explore in detail—both quantitatively and qualitatively—risk-taking domains and behaviours associated with hypomania in addition to the ensuing consequences, and as a corollary consider whether such behaviours are either not impairing or only minimally 'impairing' as defined by DSM-IV. Risk-taking behaviours were defined as those presenting both a potential risk to the participant (or those around them), as well as those that produced actual negative consequences, and our study was limited to those with a bipolar II condition.

2. Methods

Patients referred to the Sydney-based Black Dog Institute Depression Clinic for diagnostic clarification and treatment advice were invited to participate in research. Patients were requested to complete a detailed questionnaire booklet prior to attending the clinic, assessing demographic information, as well as their mood disorder and treatment history. Booklet questions reported on in the current study focused on behaviours undertaken when hypomanic, including any associated consequences. Specifically, patients were asked: (i) have you ever spent a large amount of money (yes/no), and if affirmed, asked to detail the 'most' ever spent (AUD), what was purchased, and with an open-ended question regarding any consequences associated with the purchase; (ii) have you ever drunk too much/much more than you usually would (yes/no), and if affirmed, asked to detail the highest number of standard drinks consumed, and any consequences (open-ended question) of drinking this amount. Patients were presented with a list of disinhibited behaviours (see Table 2), and asked if they had engaged in any such behaviours whilst hypomanic (yes/no). They were additionally asked to briefly describe 'the most dangerous thing you ever did' when hypomanic, including any associated consequences (open-ended). Finally, patients were asked whether they believed they were able to control 'mild' highs, or, because of their risks, that all highs should be treated. Three response options were provided, with multiple responses allowed: (i) "No, I can control mild highs and do not think they should all be treated"; (ii) "Yes, I think all highs should be treated because of their risks"; (iii) "Yes, I think all highs should be treated because if I go high, I will then go into a depression". Open-ended responses were analysed qualitatively to extract key themes and then coded to capture primary thematic components, with quotations used to illustrate identified themes.

Questionnaire data were collected from patients referred to the clinic over the 2008–2011 period, and written informed consent was obtained in line with the University of New South Wales Ethics Committee. An Institute psychiatrist conducted a detailed clinical interview to derive a diagnosis of bipolar II disorder (on the basis of affirming a number of features of hypomania as per DSM-IV criteria, and weighting the absence of psychotic features during highs over lifetime). The Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) was conducted independently by a research assistant to derive lifetime and current DSM-IV diagnoses. The MINI formally assesses all DSM-IV criteria as part of a structured interview, including a probe to assess functional impairment associated with hypomanic epsiodes ('Did these symptoms last at least a week and cause problems beyond your control at home, work, school, or were you hospitalised for these problems'). Problems beyond the patient's control, including requirement of hospitalisation, are exclusion criteria for a hypomanic episode. Partients with subthreshold hypomanic symptomatology (defined as the presence of three of more DSM-IV hypomanic symptoms not meeting hypomania duration criteria) were excluded from the study. Patients were eligible to participate in the study if 18 years or