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Research report

The phenomenology of recurrent brief depression with and without hypomanic features

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Abstract

Background: The nosologic status of recurrent brief depression (RBD) is debated. We studied the phenomenology of RBD in a clinical sample of outpatients.

Methods: Forty patients (mean age 33; 73% females) and 21 age- and gender-matched mentally healthy controls were examined (clinical interview, M.I.N.I. neuropsychiatric interview, MADRS, Stanley Foundation Network Entry Questionnaire). Exclusion criteria were bipolar I or II disorders, a history of psychosis, concurrent major depressive episode, organic brain or personality disorders (clusters A and B).

Results: The mean age of onset of RBD was 20 years with a mean of 14 episodes/year with brief (mean 3 days) severe depressive episodes. Nineteen (47%) reported additional short episodes of brief hypomania (>1 day duration; RBD-H) of which nine (23%) never had experienced a major depression. Twenty-one (53%) patients reported RBD only (RBD-O) with or without ($n=12$) past history of major depression or dysthymia. During the last depressive episode, 76% of the RBD-O and 90% of the RBD-H patients had a melancholic depression. Seventy-one % of the RBD-O and 79% of the RBD-H reported at least two out of three atypical symptoms. Nineteen (48%) of the patients reported anger attacks and panic disorder, the latter being more prevalent in the RBD-H subgroup (68% versus 29%, $p=0.012$).

Limitations: Cross-sectional study of self-referrals or patients referred by primary care physicians or psychiatrists.

Conclusions: The study supports the validity of RBD as a disorder separate from bipolar II, cyclothymia and recurrent major depression. A brief episode of hypomanic symptoms is a severity marker of RBD.

Keywords: Recurrent brief depression; Bipolar disorder; Chronic depression; Atypical depression; Melancholia

1. Introduction

Disorders characterized by periods with depressive episodes lasting hours to days have been described since 1852 and have been labelled “periodic melancholia”, “intermittent depressive disorder” or “very brief depression” (Pezawas et al., 2005). Nevertheless, the third

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version of the Diagnostic and Statistical Manual of mental disorders which relied heavily on findings from studies conducted in psychiatric in- and outpatient settings, required at least 14 days duration for a diagnosis of depression. No diagnostic category allocated a depressive episode of shorter duration. Intermittent depressive disorder, included in the Research Diagnostic Criteria was considered to identify minor versions of major depression ("minor depression") and not included in the DSM-III (Baldwin, 2003).

However, the prospective Zürich epidemiological study conducted by Jules Angst and co-workers (Angst and Dobler-Mikola, 1985) observed a subtype of mood disorders characterized by recurrent but brief (mostly days) major depressive episodes corresponding to earlier clinical reports. Although of short duration, the depressive episodes had similar severity and functional consequences that were observed in patients with major depressive disorder. Angst and co-workers observed that recurrent brief depression (RBD) might develop into major depression and vice versa in about the same percentage of cases. A significant subgroup remained stable RBD patients over time, however. RBD was associated with considerable suicidality and treatment-seeking and was co-morbid with anxiety disorders (Angst and Hochstrasser, 1994).

Those observations corresponded to clinical descriptions by Paskind (1929) and Buzzard et al. (1930) (cit. (Baldwin, 2003)). Further support for the clinical importance of RBD was provided by Montgomery (Montgomery et al., 1990). In a prospective follow up study of patients with a history of repeated suicidal behaviour almost all suffered recurrent episodes of brief depression, mainly of moderate to severe intensity (Montgomery et al., 1990). Two thirds of the episodes lasted between 2 and 4 days. The recurrences were frequent, irregular, and apparently unpredictable. The episodes were distinguishable from major depression only by their short duration.

Jules Angst coined the concept "recurrent brief depression" (RBD) for this type of mood disorder (Angst and Dobler-Mikola, 1985; Angst, 1990). RBD was defined as intermittent depressive episodes, in women not related to menstrual cycles, occurring at least once a month that fulfilled the diagnostic criteria for major depressive episodes apart from duration, which was stipulated to be less than 14 days. RBD was included in the 10th classification of mental and behavioural disorders (ICD-10 F38.1) published by the World Health Organization in 1992 (WHO, 1992, 1993). Less frequent episodes of brief depressions were labelled infrequent brief depression and not included in ICD-10.

A number of studies addressing the prevalence of RBD have used the Zürich research criteria adopted in the ICD-10 (WHO, 1993). In four different community-based cross-sectional studies the lifetime prevalence was estimated at 2.6 to 10.0%, and the one-year prevalence at 5.0–8.2% (Altamura et al., 1995; Carta et al., 2003; Maier et al., 1994a,b; Pezawas et al., 2001). The World Health Organization project on "Psychological problems in general health care", which was based on primary care samples, reported a one-year prevalence of 3.7–9.9% (Maier et al., 1994a; Weiller et al., 1994). However none of these studies differentiate between RBD with and without a history of other mood disorders (e.g. major depression). The prevalence of RBD in psychiatric settings is not known, but is claimed by clinicians to be lower than the above figures. This may be because greater attention is paid to co-morbid disorders. Another explanation may be the misdiagnosis of RBD as dysthymia, premenstrual dysphoric syndrome, or a personality disorder. However, the low prevalence may also simply reflect lack of referral of RBD patients to psychiatric services due to the short duration of the depressive episodes.

The nosological status of RBD has remained controversial, however. In the DSM-IV field trial 91% of the subjects met the criteria for current or lifetime major depression or dysthymia compared to 2–3% of RBD only (Keller et al., 1995a). Despite these findings, the authors concluded that additional categories for milder forms of depression were not needed, but provisional criteria were provided. However, in contrast to the ICD-10, the DSM-IV provisional criteria limit RBD to subjects who have never experienced a major depressive or hypomanic episode. This requires the clinician or researcher to decide whether a previous depressive episode fulfilled the symptomatic criteria for a major depressive episode or was merely a sub-threshold episode.

The issue is further complicated by the observation that a significant subgroup of patients may have very brief hypomanic episodes (Angst et al., 2003b), suggesting that RBD perhaps may belong to the bipolar spectrum. Such observations also stress the importance of differentiating RBD from cyclothymia.

1.1. Objectives and hypotheses

Considering the prevalence rates and severity of RBD reported, and the conflicting views on the nosological status of the disorder, it is surprising that so few studies have addressed the phenomenology of RBD in clinical samples (Baldwin, 2003). The present paper is part of a comprehensive study of the phenomenology