Depression Following Mania: A Retrospective Study in Bahrain

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ABSTRACT

In a retrospective study conducted on 40 inpatients admitted to the Psychiatric Hospital, Bahrain, for treatment of hypomania during the years 1986-1990, we observed that depressive symptoms occurred in 40% of cases during the first three months after euthymia.

The data analysis included age, sex, past history of mania and depression, family history of psychiatric illness, neuroleptic and lithium therapy.

A past history of depression had a significant association with the occurrence of depression following mania.

A hypomanic or manic illness may commonly be complicated in early convalescence by depressive symptoms. Occasionally this is severe and can present a danger to the patient because of concomitant suicidal impulses.

Kraepelin stated that depressive symptoms during the course of mania were unusual[1]. This statement was challenged by Morgan, who estimated that 60% of patients showed depressive symptoms during the course of their recovery from mania, with half of them being sufficiently severe to require treatment[2]. A study done by Lucas et al[3] revealed that the occurrence of depression subsequent to mania was significantly associated with three main factors:

1. Cyclothymic pre-morbid personality
2. Family history of affective disorders
3. Past history of depression

In the present study a retrospective case note analysis was carried out on cases of hypomania to find out what percentage of these cases had depressive symptoms in the three-month follow-up period.

METHODS

The case notes of all patients with a discharge diagnosis of mania admitted to the Psychiatric Hospital of Bahrain during the years 1986 to 1990 were studied. In those cases who were repeatedly admitted, the most recent admission was included in the study. The inclusion criteria were:

a) all cases be in the age group of 18 to 60 years

b) fulfil the WHO International Classification for Diseases - Version 9 (ICD 9) criterion for mania.

Two groups of patients were identified:

- Those who became depressed following an episode of mania (either immediately or within a period of up to three months after euthymia).
- Those whose recovery was not complicated by depression.

The following particulars were noted - age, sex, past history of mania and depression (based on ICD 9 criteria), therapy with neuroleptics and lithium.

RESULTS

Forty patients who fulfilled the inclusion criteria were included in the study. There were 24 males with a mean age of 34 years (+ SD = 11.7) and 16 females with a mean

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age of 31 years (+ SD = 9.5). Young adults under the age of 45 years made up the majority of our sample (80%). The depressed group consisted of 16 patients (40%) of whom 11 were male and 5 were female. The mean ages of the depressed and non-depressed group were 36 and 30 years respectively.

The observations were statistically analysed employing the Chi^2 test (Table 1).

Of the parameters studied we observed a significant association (P=<0.05, X^2=5.8) with the occurrence of depression following mania in cases who had a past history of depression. The other parameters studied were not significantly different.

Table -

Association of age, sex and past history of psychiatric illness with subsequent depression

	Total No.	*Depressed group*	*Non-depressed group*	*Significance*
Sex			$X^2 = 0.8$	
Male	24	11	13	dF = 1
Female	16	5	11	P = >0.50
Mean Age	36	30	t = 1.8	dF = 1
				P = >0.05
Past History of Manic Illness			$X^2 = 0.3$	
Positive	28	12	16	dF = 1
Negative	12	4	8	P = >0.50
Past History of Depression			$X^2 = 5.8$	
Positive	18	11	7	dF = 1
Negative	22	5	17	P = <0.05
Family History of Psych. Illness			$X^2 = 3$	
Positive	16	9	7	dF = 1
Negative	24	7	17	P = <0.1 >0.05

Table 2

Drug treatment during manic episode

Drug treatment	*Depressed group*	*Non-Depressed group*	*Total*
Neuroleptics only	9	19	28
Neuroleptics + Lithium	5	5	10
Lithium Carbonate only	1	0	1
No drug	1	0	1

The drug treatment during the manic episode in the two groups of patients is shown in Table 2. Twenty-eight patients (70%) received neuroleptics alone (17 of whom were on butyrophenone, 7 on phenothiazine and 4 received a combination of both). Nine of these patients developed depressive symptoms following euthymia (5 of whom were on butyrophenone, 2 on phenothiazine and 2 on combination of both). Ten patients received lithium carbonate in combination with neuroleptics, five of these patients developed depressive symptoms following mania. Only one patient received lithium carbonate alone and he became depressed.

DISCUSSION

The study revealed a predominance of male (24) to female (16) patients, a ratio of 3:2 with a preponderance of young adults under the age of 41 years (80%). The difference in sex ratio and the preponderance of young people is most likely due to the fact that young males form 70.5% of admissions at the Psychiatric Hospital of Bahrain[4]. The higher representation of young people and the larger number of male patients correspond to the population structure of Bahrain, where 95% of the population is below the age of 50 years and those above 60 years constitute only 2.2% of the population[5] (CSO Statistical Abstract 1988).

We observed that the past history of depression has been significantly associated with the occurrence of depression following mania. In the study of Lucas et al[3] similar observations were made. Our study supports these findings. Morgan observed depressive symptoms in 60% of his cases; half of these were judged sufficiently severe to warrant specific treatment[2].

Mendelwicz et al[6] showed that a more severe form of illness was seen in those patients with a positive

family history and post-manic depression. We did not observe a positive correlation between family history and occurrence of depression following mania. This could be because of the small sample size of the present study. Morgan[2] found that patients receiving butyrophenone were more prone to develop depression than those receiving phenothiazines. Lucas et al[3] observed no effect on the likelihood of depression among patients given either phenothiazine or butyrophenones. Our study supports this finding.

Lithium is an effective prophylactic agent in both bipolar and unipolar disorder, and there is some evidence that it possesses an acute antidepressant effect[7]. No such effect was seen in the Lucas et al[3] study. We had only one case on lithium and he became severely depressed.

In the present study we have observed that patients receiving only neuroleptics showed more severe forms of depression following mania, and the majority of these patients required treatment in the form of antidepressant drugs, ECT or just a decreased dose of the neuroleptic drugs, while most of those who received neuroleptics in combination with lithium therapy showed mild and transient depressive symptoms which did not require any treatment.

CONCLUSION

The frequency and severity of depressive symptoms during convalescence from hypomania make it important that such patients, especially those with a past history of depression, receive psychological support and frequent follow-ups in the recovery period, particularly during the first three months after their discharge from hospital. Careful clinical assessment would help early detection of depressive symptoms, which may indicate the need for special attention and therapy.

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