

## Case Study 2

**Diagnosis:** Other Specified Bipolar and Related Disorder, short-duration hypomanic episodes (2-3 days) and major depressive episodes *with* anxious distress (moderate), ICD-10: F31.89

**Diagnosis Rationale:** The patient presented to the clinician with symptoms representative of a Bipolar II diagnosis, but absent certain required symptoms, and with additional specifiers.

However, as we explore the totality of the patient's experience, we will discover the complex features that may be seen as contributing factors to the mental deterioration of the patient, particularly within the last 2 years. We will explore the diagnosis, rationale, differential diagnoses, and cultural formulations as they relate to this patient's case.

Representing the hypomanic episode of a bipolar II diagnosis, the patient experiences spasmodic episodes of excessive energy that last up to 2 days (not meeting criteria for standard hypomanic episodes) and which include events where the patient cleans the entire home in under 2 hours. Additionally, the patient reports that these hypomanic-like episodes are the only times when she drinks alcohol and is sexually promiscuous (a criteria of hypomania). The patient, at age 43, indicates that she couldn't remember a time when she didn't have these episodes, indicating a probability that onset began in her 20s, when most bipolar is indicated to begin. These distinct episodes of excessive energy are uncharacteristic of the individual typically, it is observable to others (in that sexual partners respond to her during these periods of time), and it is not severe enough to cause impairment. However, the patient did *not* represent that they had an inflated self-esteem, decreased *need* for sleep, were more talkative than usual, experienced a flight of ideas, or were easily distracted. Thus, criteria for a hypomanic episode were not fully met, though distinct features were present.

Representing the major depressive episode, the patient had a depressed mood and a desire to “avoid life” most days. She struggles with insomnia nearly every day, which lead her to feel fatigued and causes her to drink 3-4 5-hr energy drinks daily. She experiences excessive feelings of worthlessness and guilt that her children and parents do not love her. The patient also has had recurrent suicidal ideation and intent, with one suicide attempt 2 years ago. The patient’s anxious distress was represented by her feeling tense, unable to shut off her mind at night and her pervasive worrying most days. Moreover, she had been prescribed Xanax (for anxiety).

### **Differential Diagnoses:**

#### ***Major Depressive disorder, with anxious distress ICD-10: F32.2***

This diagnosis seems plausible considering the patient’s excessive guilt which lead to periods of intense sobbing, and aforementioned symptoms which support such a diagnosis. However, the presence of hypomanic episodes that recur over a long span of time indicates an anomaly that must be represented as co-occurring with depression.

#### ***Cyclothymic Disorder with anxious distress, ICD-10: 34.0***

This diagnosis was quite compelling and one which I would have chosen, however the criteria indicated that the depressive symptoms should not meet the criteria for a major depressive disorder when, in fact, they did. There were 5 or more symptoms of major depressive disorder present in the patient, though hypomanic episodes were also present.

### ***Medical/Physical Health considerations***

The patient, medically, was not in the best of health and would be considered clinically obese given her height and weight and poor adherence to medical treatment. According to Batrakoulis and Fatouros (2022), inactivity (reflected by her desire to stay in bed all day) is correlated with depression and obesity. Thus, the patient’s obesity is related to both her inactivity

and her clear depression. Additionally, obesity includes limiting factors that inhibit the positive psychosocial potential wellbeing of these individuals (ibid.). Thus, the patient's obesity may be related to their depression. Supporting this finding, Ishida, et al. (2020), found that middle-aged men with a strong sense of stress and depression had a greater incidence of obesity. To combat the linkage between obesity and feelings of depression and stress, they recommend a focus on dietary education and coping skills education (ibid.).

The patient also exhibited signs of hypertension for which she was being treated. Hypertension is comorbid with both depression and anxiety (Amaike, et al., 2024), making it difficult to determine which condition produced the other, though they are both related. It is possible that the ability to manage one's hypertension can be related to a reduction in depressive mood affects.

### **Cultural Formulation**

Though the patient experiences periodic hypomanic-like episodes for as long as the patient can remember, the longevity of the major depressive symptoms is not clearly defined in the narrative. The patient indicated a number of stressors within the context of their environment that could have precipitated these experiences. To begin with, the patient appears to have divorced her husband within the last few years, a decision not supported by her church community. Then, either following or in tandem with the divorce the patient began a relationship with "Marie", signifying a lesbian relationship. This relationship was met with dislike by her 3 children. The lack of social support seems to have caused her to question her decision and feel that she is unloved by everyone.

With the level of stress potential that each of these experiences represent, it is possible that the source of the depressive symptoms is the change in social dynamics that the patient has

recently experienced as a result of the divorce. In fact, emotional divorces have the most significant impact on depressive symptoms exhibited by divorcees (Zakizadeh, 2023). A protective feature in coping with stress and depression is often encapsulated in one's faith. In fact, trusting God and offering prayers is directly correlated with a more hopeful outlook on life and the alleviation of anxiety and stress (ibid.). With the patient's disconnection from their faith community due to their lack of support for her divorce and perhaps a disconnection from the patient's personal relationship with their faith, as well, this protective feature is absent and unable to help them cope with the challenges they face.

Sexual orientation is also correlated with depression. In fact, due to social stigma sexual minorities experience increased levels of depression and suicidality (Affuso, et al., 2024). Interestingly, lesbian youth actually experience higher levels of depression and anxiety in coming out than do gay youth, suggesting that lesbians have increased potential for depression (ibid.), even within the minority orientation community. It can be suggested that the experience of lesbian youth is similar to what lesbian adults would experience, thus highlighting a major form of depression in a newly "outed" lesbian.

In conclusion, the patient presented with features of depression, anxiety, hypomania, and suicide ideation. In determining the diagnosis it was important to determine the dominant presenting factor. It was determined that major depression was the predominant mood experienced by the patient with features of anxious distress. Apart from those, the patient was also experiencing intermittent episodes of hypomania. With incomplete symptoms to suggest full hypomania but with full symptoms representing major depressive disorder with anxious distress, we arrived at the above diagnosis. While other factors may be seen to have contributed toward the depression, the diagnosis remains unchallenged.

## References

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