

# Bipolar II disorder — diagnostic and management lessons for health practitioners from a coronial inquest

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In October 2010, New South Wales Deputy State Coroner MacPherson reported that Charmaine Dragun “was 29 years old when she jumped to her death from The Gap”, with the inquest examining the reasons why she took her life and lessons to be learnt “to try to prevent similar tragedies”.<sup>1</sup> Charmaine was a well respected television newsreader, and an award-winning documentary covering her life and death was presented on the ABC’s *Australian story* program in 2008.<sup>2</sup>

In his findings, the Coroner focused on diagnostic and clinical management issues involving Charmaine, as I do here in this personal overview of his report. Quotes shown in this article are taken directly from the Coroner’s report<sup>1</sup> or from associated documents.

## Overview of the Coroner’s report

### Summary of Charmaine’s mood disorder and its management

The Coroner noted that Charmaine’s mood disorder commenced in mid adolescence and that a psychiatrist had prescribed her the antidepressant sertraline in 1996. In 2004, she consulted a naturopath who encouraged her to cease taking sertraline, which she did. Following a relapse, she began taking venlafaxine. In early 2007, she sought assistance from a psychologist whose treatment philosophy focused on meditation, mindfulness techniques and Buddhist teachings. Over the course of that year, she attended three Sydney general practitioners, with the third one referring her to a psychiatrist for management.

In mid October 2007, Charmaine consulted a psychiatrist, who recorded a diagnosis of recurrent major depression and anxiety disorder, and recommended tapering the venlafaxine and introducing escitalopram and high-dose fish oil. After that initial consultation, Charmaine described the recommended treatment to her mother and partner as “revolutionary”, and said that it offered her “a light at the end of the tunnel”. Charmaine’s mother described her as “elated”. However, by the end of October, she was described by friends and colleagues as distinctly depressed, and she visited The Gap to spend some time there alone. On 2 November 2007, she returned to The Gap and jumped from the cliff edge.

### Signal indicators of a bipolar disorder

In reports prepared for the Coroner and in evidence given at the coronial inquest, several of Charmaine’s friends and colleagues reported their observations of her mood over time. Expert reports to the Coroner interpreted some of these observations, as in the representative extracts shown below, as markers of possible hypomanic mood swings:

[Charmaine would be] bouncing at the front door [and, when compiling a video for a friend’s birthday, she was] a bit hyper about the video. [LD]

Charmaine’s “ups” were very up and all-encompassing ... [BH]

## ABSTRACT

- A coronial inquest into the suicide of television newsreader Charmaine Dragun identified that a likely contributory factor to her death was the failure of many health practitioners to diagnose a bipolar II disorder and to provide more specific treatment for her condition.
- Lack of awareness about bipolar II disorder among practitioners and the public, as well as screening and detection problems, may have contributed to the failure to diagnose this disorder over the course of a decade.
- Detection and management of bipolar II disorder generally differs from that for a unipolar disorder, in that mood stabilisers rather than antidepressants are more often a priority. The diagnosis therefore has distinctive implications for management and course of the illness.
- The Coroner recommended “increased awareness by health professionals of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression” and highlighted the need for “readily available” screening tools.

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She would bounce into the room, jumping up and down. She wouldn’t just hug you, she would squeeze you. [SV]

She was ... [v]ery effervescent and it struck me as a little bit unusual ... sometimes within an hour she’d be very up and then sort of come down quite quickly. [S B]

[She was like] the Energiser Bunny ... When Charmaine was on a high she was fun and funny ... [T W]

After returning from a trip overseas in the year before she died, Charmaine’s own diary recorded coming “... back into normal life without the highs ... I slowly came down to earth ... no longer was my mind racing like a chicken ... free of manic mood swings”. She recorded her “post holiday high” and being “worried about highs and lows ... aware of highs ... look at bipolar”.

In terms of depression, a work colleague noted that when “very low”, Charmaine would “have a very faraway look in her face and she was difficult to engage”. In early October 2007, Charmaine’s diary recorded: “Losing brain function ... I cannot live like this and I don’t want to live like this”.

At the inquest, Charmaine’s mother Estelle corroborated the presence of mood swings. She reported that, in mid 2007, she had raised the possibility of a bipolar disorder with Charmaine. Charmaine had replied that she had already been “through tests and they don’t think I’ve got bipolar”.

### Professional assessment of a bipolar disorder

From November 2006 onwards, Charmaine consulted three GPs; the first two detailed at the inquest how they had managed her

depression. The first rejected the possibility of a bipolar disorder as Charmaine did not have any “sustained elevated period”, and reported that if she “thought a patient had a bipolar disorder she would refer on to a psychiatrist”. The second GP stated that she “had no concerns about a bipolar disorder” and that “I would always involve a psychiatrist if I had [any such] suspicion”. The third GP had only one brief consultation with Charmaine. Her history recorded Charmaine describing “ups”, when she “would be really firing on all cylinders ... make very funny jokes ... could conquer the world ... [and was] overjoyous”. When asked at the inquest whether she thought depression was the right diagnosis, she observed that a diagnosis of depression “just didn’t fit”. She wrote referrals to two psychiatrists: one for management and the other for clarification about a bipolar disorder.

At the inquest, the psychologist Charmaine first consulted in January 2007 stated that she neither observed nor obtained any history of elevated mood states. At Charmaine’s request, she had screened her for bipolar disorder in May and rejected that possibility. The Coroner judged this assessment as being “cursory”. Counsel assisting the Coroner submitted that the psychologist’s management could be criticised because of her failure to take a proper history and to recognise that Charmaine had a “biologically-based mental illness”. The psychologist’s counsel submitted that “even if Charmaine did have a bipolar condition the psychological treatment would be the same”. The inquest sought expert advice from a clinical psychologist, who stated that “instruments should not be used” to make a diagnosis of bipolar disorder, and that “psychologists were ‘not allowed to diagnose’ a condition like a bipolar disorder”, which was “a matter for a *clinical psychologist*”. (Most clinical psychologists are accredited on the basis of having completed a university clinical Masters or Doctorate course; a higher level of clinical training than generally provided to psychologists.)

Counsel assisting the Coroner argued that the psychiatrist to whom Charmaine was referred for management should have explored the possibility of hypomania “properly”, as the referring GP had done. The psychiatrist’s counsel argued that bipolar disorder was “not an easy diagnosis to make”, that there was “a difference of opinion in the psychiatric community about whether a bipolar II disorder was a distinct entity at all”, and that the psychiatrist did not have access to corroborative evidence.

## Discussion

In recent decades, the term bipolar disorder has replaced the older diagnosis of manic–depressive illness, with bipolar I disorder involving alternating states of mania and depression, and bipolar II disorder essentially comprising non-psychotic episodes of hypomania and melancholic depression.

While less symptomatically severe than bipolar I disorder, bipolar II disorder involves comparable impairment levels and suicide risk. Those with a bipolar II disorder experience oscillations (often brief) of mood and energy. In hypomanic phases, individuals feel energised, wired, “buzzy”, playful, creative and often “bullet-proof”. They need less sleep and do not feel tired, and can be verbally and behaviourally indiscreet. They may spend more money, and increased libido can create predictable problems. They often take stimulant drugs or consume alcohol to induce or maintain a high. The depressed state is a mirror-image state of low mood and low energy, associated with a non-reactive, anhedonic and morbid mood, with mood and energy levels generally worse in the mornings, and with “atypical” depressive features of hypersom-

nia and overeating being common. Bipolar II disorder is far more common than bipolar I disorder, with a 6% risk in adolescents and young adults.<sup>3</sup>

Detection and diagnosis of bipolar II disorder is important because its management generally differs from that for a unipolar disorder. Antidepressant monotherapy assists only a small proportion of patients, and can worsen the condition’s course.<sup>4</sup> Most individuals benefit from a mood stabiliser, education and a “stay well plan”. In a real-world study of patients diagnosed at the Black Dog Institute Depression Clinic, the diagnostic subset with the best outcome at 3 months were those with a previously undiagnosed bipolar II disorder whose management was changed,<sup>5</sup> confirming that diagnosis-specific management strategies improve the trajectory and outcome.

Why is the Dragun case important? First, because it captures a common story — onset of bipolar II disorder in mid to late adolescence, prolonged failure to make the diagnosis, and no disorder-specific management implemented — that illustrates the need for greater awareness about bipolar disorder and its signals. Second, it shows the limitations of non-specific diagnoses such as “major depression” and “anxiety”, as practitioners making such diagnoses then risk providing non-specific treatments. Third, submissions from the GPs involved in the Dragun case indicated that they view the diagnosis of a bipolar disorder as intrinsically difficult. Fourth, counsel for some of the practitioners argued that even if a bipolar disorder had been diagnosed, management would not have differed — an argument rejected by the Coroner.

I submit that if practitioners manage “depression”, they should be aware of the bipolar disorders, screen for them, and then either elect to manage them or to refer the patient to a practitioner with relevant expertise. Clinical screening for bipolar disorder is not difficult and there are readily available screening tools — such as the Black Dog Institute’s web-based and validated<sup>6</sup> self-report Bipolar Self-Test, and the Mood Assessment Program (MAP) for health professionals — with such tools complementing diagnostic decision making.

The Coroner in this case made firm and unequivocal recommendations — “increased awareness by health professionals of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression” and the need for “readily available” assessment tools. Detection of a bipolar disorder relies on accepting the existence of such disorders and screening patients with depressive conditions for evidence of mood swings consistent with a bipolar disorder. The coronial inquest into the death of Charmaine Dragun has advanced these clinical imperatives.

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## Competing interests

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