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Evaluating hypomania in the current clinical research about depression in Japan

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Depression is currently considered to be one of the most important causes of disability worldwide. But, would that conclusion still hold true if subthreshold bipolar depressives were correctly diagnosed and identified as bipolar? The clinician's commentary presented by Angst [1] seemed to be convincing in line with his recent several research suggesting the heterogeneity of depressive disorders [2, 3]. As far as we know, this point of view has often been mentioned, but few have been suggested among evidence-based clinical research about depression in Japan. In the current Japanese society, there are growing numbers of depressive subjects referring to psychiatric clinic. The transition of the diagnostic criteria of hypomania symptoms seemed to be one of the most important topics in the DSM-5 draft [4]. Afterwards, it would be indispensable to seek to evaluate a large number of "as if" unipolar depressed patients for the presence of hypomanic features within our daily busy clinical setting, which could facilitate us to administer a resilient bipolar psychopharmacology.

Among biological research literature of contemporary bipolar spectrum concepts, it would be crucial to define subthreshold bipolar depression. In parallel, it is necessary to recognize depression with hidden hypomania cases appropriately in our daily clinical practice [5, 6]. Looking back to historical research in psychiatric epidemiology, Angst and his groups firstly showed that the prevalence of hypomania symptoms was about 4% among the young adult population based on the Zurich cohort study in Swiss [7]. As we know well, several series of psychiatric epidemiology concerning hypomania have already been carried out in France, influenced by them (i.e. EPIMAN, EPIDEP and Bipolact study). These previous epidemiological studies strongly suggested that hypomania symptoms were often unrecognized and under-evaluated not only for subjects themselves but also for clinicians. For example, Hantouche et al. have already revealed that the rate of hypomania is as high as around 62% in recurrent depression and 55% in resistant major depression [8], and also showed that suicide attempts could be explained by the "irritable risk-taking" dimension of hypomania in the BP-II disorder group based on the Bipolact Surveys [9].

After continuing to emphasize underrecongnition of hypomania symptoms, Angst and Hantouches' research group have invented the self questionnaire tool concerning hypomania, the Hypomania Check List 32 (HCL-32) published in 2005, and since then has been spread into many countries [10]. This might prove a promising tool for recognizing hypomanic components in patients presenting only depressive symptoms in clinical setting, and also will serve as a psycho-educational tool in the public mental health in Japan. Making use of this scale might permit both

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clinicians and users to become more aware of hypomania symptoms in daily life. That enlightenment could restrain the growing tendency in relying on the enlarged indication of prescribing antidepressants and improve patients' self-help conducts about hypomania.

Our research group has just finished back-translating Angst's HCL-32 Revised version (HCL-32 R1) into Japanese. Since we haven't challenged the clinical research yet based on it, our point above only stressed the fact that had been recognized for a long time in clinical research fields. However, since the clinical reality of the heterogeneity of "depression" still lacks evidence especially in Japan, it is time we applied it to future clinical research about depression. If possible, our group would like to launch a clinical research network among both clinicians and research scientists who are interested in the bipolar spectrum concepts in order to exchange mutual viewpoints.

We admit that our discussion above may boost the overdiagnostic tendency of bipolar spectrum in Japan, and rather lead to non-thoughtful use of mood stabilizers and second-generation antipsychotics. We understand well that current post-modern critics, claiming that the undergoing strategy of pharmaceutical companies, created the myth of mood stabilizer market in potential bipolar disorders [11]. What we have stressed here, is that therapeutic intervention focusing hypomania towards some supposedly depressive patients might be helpful. Previously, we had experienced one clinical case which showed us this clinical implication through her 4-year recovery process. Giving a co-diagnosis of bipolar spectrum, i.e. a focus on developing a therapeutic alliance led to the way for initiating therapeutic intervention for her borderline symptoms [12].

Some colleagues are still apprehensive that there may seem to be increasing concern of overdiagnosis of bipolar disorders especially in younger subjects in the U.S. It is true that, in the last years, such risks/benefits have often been discussed [13]. Although controversy surrounds the frequency of underdiagnosis vs overdiagnosis of bipolar disorder especially in children, we agree with Galvez et al's recent remark; "bipolar disorder" is associated with the positive psychological traits of spirituality, empathy, creativity, realism, and resilience [14]. Clinical and research attention to preserve and enhance these traits may improve outcomes in bipolar disorder. If this were to be the case, why should we need to be afraid of such an increasing tendency? As Ghaemi has often suggested, we also find it odd why we rarely have brought up as a topic the risk of current increasing tendency of adding comorbid adult developmental disorder in Japan.

Besides, some pedopsychiatrists may point out the overdiagnosed childhood bipolar disorders in clinical practice and a notion of "Temper Dysregulation Disorder with Dysphoria" is proposed as a new diagnosis in coming DSM-5 [4]. In the first place, concerning child and adolescent fields, we have to take into account that both psychopathology and drug treatment indication/response between adults and minors should be considered separately in terms of brain maturation and development. Even if both diagnosis, as defined above, were to be introduced, children suffer from significant impairment. At least, in the coming several years, there will not be a "miracle" treatment and therapeutic approach emerging for both. Their suffering will always reflect their social and parental insecure environment. With the clinician's help, look for ways to address their particular problems, consider all reasonable options, such as medication, psychotherapy, and school or home supports [15]. Those are still a sound and sensible eclectic approach to provoke their resilience.

We think that the HCL-32 will be useful as a sort of « catalogue » of hypomanic symptomatology, thus being applicable to non-clinical adolescent mental health [16]. Some colleagues may consider that we mentioned a rather optimistic viewpoint. Though, the above-mentioned studies in psychiatric epidemiology [2, 3] have shown that, when bipolars are properly identified, there can be a major shift of comorbidity from the depressive to the bipolar group; especially, comorbid alcohol use and some anxiety disorders become much more strongly associated with bipolarity than with pure depression [1]. Therefore, we wish we could construct the interdisciplinary network, as French groups did before, which we believe, will eventually contribute to clinical practice about depressive patients.

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