Part 1. Basic concepts of the Bipolar Spectrum

An Introduction to the Bipolar Spectrum

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Abstract

Affective or mood disorders form part of a spectrum of bipolar disorders. Here we describe such a spectrum. We also describe the main diagnostic markers and give an overview of the need to achieve early diagnosis with appropriate treatment.

Key words: bipolar spectrum, affective disorders, early diagnosis, treatment.

Affective disorders, or disorders of the bipolar spectrum (including sub-threshold forms) are very common. Indeed, they are more common than it is usually believed, especially when we include the sub-threshold forms. Hence, these conditions are often underestimated epidemiologically, under-diagnosed, and ineffectively treated or untreated (Agius, 2007; Tavormina, 2007). Inadequate diagnosis and consequent inadequate treatment of these illnesses can lead to various public health issues, with serious consequences, including abuse of substances, employment difficulties, suicidal risk and problematic or criminal behaviour. (Akiskal-Rihmer, 2009; Tavormina, 2010).
Mood in a person who is euthymic is stable; in mood disorders, the mood "swings" between depression and euphoria/irritability and therefore in mood disorders there is "unstable mood".

It is essential to emphasize that depressed mood is subject to the normal oscillation of the tone of mood. Hence patients should be only diagnosed as depressed when they complain of sadness or low mood for a period of at least two weeks. Often, a depressive episode is in fact only one phase of a broader "bipolar spectrum of mood", in which instability of the mood is the main component. The average age of onset of an episode of instability of mood is usually relatively early, between 20 and 40 years. However a significant number of these illnesses start very early or very late (the first episode being in adolescence or after age 50). About 20% of the population presents a picture of "mood instability" (including the subsyndromal conditions or temperaments). Epidemiological studies have found an incidence of depression among women which is double that of men.

Here we present a classification of mood disorders, based on Akiskal's original proposition of a spectrum of disorders, and the proposal of the present author (Tavormina, Agius, 2007), which ranges from bipolar I disorder at one end to unipolar depression at the other end, while including all the other types of instabilities between. We have excluded post-traumatic stress disorder for the sake of clarity, and we have accepted the subsyndromal 'temperaments' as being within the full spectrum. We have re-arranged the different states, when compared to our previous article, to indicate that items 1-6 are all conditions of the bipolar spectrum which carry high suicide risk, and hence need effective treatment, but of course, many patients with unipolar depression, whether recurrent or not also may have a high risk of suicide.

1. Bipolar I [mania/depression]
2. Rapid cycling bipolarity
3. Bipolar II [hypomania/depression]
4. Bipolar III [Bipolarity induced by anti-depressants]
5. Mixed Dysphoria (depressive mixed state)
6. Agitated depression (a mixed affective state)
7. Cyclothymia

8. Cyclothymic temperament
9. Hyperthymic temperament
10. Depressive temperament
11. Recurrent depressive Disorder
12. Unipolar Depression.
(Based on Tavormina, Agius, 2007).

Assessment of the patient

The main 'markers' which are important in the early diagnosis of mood disorders and which should be assessed during the clinical interview, are as follows.

A family history of bipolar disorders (or suicide).
Previous episodes of hypomania/ euphoria/ irritability.
A history of 3 or more depressive episodes in the last few years.
Acute initiation of the disorder or flare-up of the illness in certain seasons (especially winter and/or summer).
Previous episodes of cyclothymia (oscillations of mood which are constant and continuous).
The presence of comorbid anxiety (GAD, PAD, OCD, Social phobia and simple phobia: because the symptoms of anxiety should not be clinically considered separately from a disturbance of the bipolar spectrum).
Presence of frequent headache, muscle tension, stomach somatisations.
A history of substance abuse (periodic or continuous).
A history of disorders of appetite.

Clinical evaluation

In order to make a correct diagnosis of disturbance of mood within the bipolar spectrum it is essential to evaluate the longitudinal psychiatric history of the patient carefully, with particular attention to any sub-threshold symptoms and careful evaluation of the patient's temperament and the family psychiatric history (Tavormina, 2007).

The main symptoms present in mood disorders are the following.

Hyperactivity (euphoria) alternating with periods of serious psychomotor retardation (apathy).
Depressed mood and/or irritability.
Antisocial behaviour.
Substance abuse (alcohol and/ or drugs).
Disorders of appetite.
Suicidal ideation.
A sense of despair.
Anhedonia and widespread apathy.
Delusions and hallucinations.
Hyper/hypo-sexual activity.
Insomnia/ hypersomnia.
Reduced ability to concentrate.
Mental overactivity.
Gastrointestinal disorders, headaches, and various somatic symptoms.

It is essential at the beginning of the clinical interview to evaluate the present clinical situation which led the patient to consult the psychiatrist, and to assess what had led up to the present situation, including when the first symptoms of mood disturbance started, even though the first symptoms might have been very attenuated.

The co-presence of various types of somatic symptoms, as well as the presence of substance abuse should suggest the possibility of the presence of a condition within the bipolar spectrum.

It is extremely important to evaluate clinically the somatic symptoms described by the patient by conducting a physical examination (Tavormina, 2012). The chronic presence throughout life in these patients of some somatic symptoms, (especially: colitis, gastritis and headache) should draw the attention of clinicians (both psychiatrists and primary care physicians) to the possibility of the presence of an illness within the bipolar spectrum, and hence may be important in the early diagnosis of a bipolar spectrum mood disorder (Tavormina, 2011).

Evaluation of the characteristic temperament of the patient at the beginning of his history of mood disorder is an essential in making a correct diagnosis and providing the correct therapy. Rihmer and Akiskal (Rihmer, Akiskal, 2009) have commented: "The sub-threshold types of temperament have an important role in the evolution of clinical episodes of mood disorder in that they indicate the direction of the polarity and the formation of symptoms of acute mood episodes ….. They also significantly affect the course and development of these pathologies, thus influencing the suicidal risk and other forms of self-destructive behaviours such as substance abuse and eating disorders".

Mood disorders can cause substance abuse as an attempt to self-medicate. The abuse of substances (alcohol, cannabis, cocaine and cannabinoids, etc.) may, in turn, cause depression, dysphoria, anxiety and the so-called "amotivational syndrome". The concomitant abuse of substances in patients with mood disorders can make such patients resistant to treatment and lead to a worse prognosis. Patients who present with substance abuse always need to be screened for the presence of bipolar spectrum disorders: abuse of substances needs to be considered as a possible symptom of bipolar spectrum disorder, not as a separate illness.

Concluding remarks

The consequences of the lack of recognition and consequent lack of treatment of a mood disorder can include higher risk of suicide, reduction in the expectation and/or the quality of life (personal, family and work), increased loss of working days, increased use of health care resources, including the resources needed to manage concurrent diseases; the mood can finally become chronic and the clinical picture can become worse. The pharmacological therapy of mood disorders may require polypharmacy with mood stabilisers (mainly: lithium, carbamazepine, valproate, gabapentin, oxcarbazepine, lamotrigine, topiramate, olanzapine or pipamperone) and antidepressants (mainly: SSRIs or SNRIs). One should never use antidepressants alone and/or in combination with benzodiazepines (nor should benzodiazepines alone be used for a long period), in order to avoid an increase in mood instability and evolution toward states of dysphoria (Agius, 2011; Tavormina, 2010, 2012). The correct maintenance therapy should be assessed on an individual case-by-case basis, depending on the clinical picture, and it should always include a mood stabiliser which may, if appropriate, be combined with low or small doses of an antidepressant. Frequent necessity of the patient to resort to the use of benzodiazepines is a tangible sign of clinical deterioration, which must require both patient and psychiatrist to consider the need for adjusting the dosage of maintenance therapy.

GP Comment

What have I learned from this paper?

As a jobbing GP, I found the concluding points helpful –the use of benzodiazepines is a tangible sign of clinical deterioration. However, finding a correct maintenance dosage within a primary care environment would be challenging. Re-classifications recommendations may cause confusion as which one should we follow. Currently a GP would refer to NICE guidelines which are dated July 2006. It highlights the importance of being aware & clinically recognising mood instability.

Dr Vishal Naidoo, GP.

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