

AN APPROACH TO THE DIAGNOSIS AND TREATMENT OF PATIENTS WITH BIPOLAR SPECTRUM MOOD DISORDERS, IDENTIFYING TEMPERAMENTS

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SUMMARY

Disorders of the bipolar spectrum (including sub-threshold forms) are very common, more so than is normally considered: these pathologies are often underestimated, not diagnosed or badly treated. In this article we describe a method whereby a patient with bipolar disorder is evaluated clinically, having regard to establishing the patient’s underlying temperament.

Key words: bipolar spectrum – temperaments - somatic symptoms

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BACKGROUND

We have highlighted in previous publications that disorders of the bipolar spectrum (including sub-threshold forms) are very common, more so than is normally considered: these pathologies are often underestimated, not diagnosed or badly treated (Agius 2007, Tavormina 2007); inadequate diagnosis and consequent treatment of these illnesses can lead to various issues of public health, with serious consequences including abuse of substances, business difficulties, suicidal risk, rape, etc., (Akiskal-Rihmer 2009, Tavormina 2010).

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 at least a period of two weeks.

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”.

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.

This is made clear by this new classification which includes all mood disorders (with the exception of PTSD and the mismatching of stressful events), and is divided into ten diagnostic subtypes:

- Bipolar I;
- Bipolar II;
- Cyclothymia;
- Irritable Bowel Syndrome Cyclothymia (rapid cycling bipolarity);
- Mixed Dysphoria (depressive mixed state);
- Agitated depression;
- Cyclothymic temperament;
- Hyperthymic temperament;

- Depressive temperament;
- Brief recurrent depression (Tavormina 2007).

CLINICAL EVALUATION

In order to make a correct diagnosis of disturbance of the mood within the bipolar spectrum it is essential to carefully evaluate the longitudinal psychiatric history of the patient, with a particular attention to any sub-threshold symptoms and careful evaluation of the patient’s temperament. In addition to a careful 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);
- mental over-activity;
- depressed mood and/or irritability;
- antisocial behavior;
- 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;
- gastrointestinal disorders, headaches, and various somatisation symptoms.

ASSESSMENT OF THE PATIENT

The main 'markers' which should not be overlooked in the early diagnosis of mood disorders, and which

should be assessed during the clinical interview, are: - 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 the mood which are constant and continuous);
- presence of comorbid anxiety (Generalised Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder, 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;
- history of substance abuse (periodic or continuous);
- history of disorders of appetite.

It is essential at the beginning of the clinical interview to evaluate the clinical situation present (the most recent acute phase) that led the patient to the psychiatrist, and assess the past history so as to establish a longitudinal sequence of events from the time the present acute phase s presented to the time when the symptoms began, even if they originally were attenuated.

Next it is essential to determine the characteristic temperament of the patient from the beginning of his history of mood disorder, starting from the time that he was about 20 years of age. In patients who are very young, this must be done with great clinical care.

In order to do this in is necessary to ask the patient a question with 3 choices: "Could it be considered that, at the age of about 20 years, you were a person of very lively character-hyperactive and extremely cheerful... ", or "a person who always tended to be tense and irritable... ", or "a person always tended to be taciturn, solitary and melancholy... ".

The aim of this question is to identify by a positive response to the first choice a "hyperthymic temperament", a positive response to the second choice a "cyclothymic temperament", a positive response to the third choice a "dysthymic-depressive temperament". The co-presence of various types of somatisation symptoms, as well as the abuse of substances should suggest the possibility of a "mixed picture" of the bipolar spectrum.

It is extremely important to evaluate clinically the somatic symptoms described by the patient by a physical examination of the patient.

The chronic presence throughout life in these patients of some somatic symptoms, (especially: colitis, gastritis and headache) should be considered by clinicians (both psychiatrists and primary care physicians) as "key-symptoms" which may suggest an

early diagnosis of a bipolar spectrum mood disorder (Tavormina 2011).

The characteristic temperament of the patient at the beginning of his history of mood disorder is essential to make a correct diagnosis and therapy of the bipolar spectrum: "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 behaviors such as substance abuse and eating disorders" (Rihmer 2009).

In an observational study (Tavormina 2010) the subtypes of the temperaments which emerged from the history of patients with sub-clinical symptoms of the "bipolar spectrum" were: hyperthymic temperament (35%), cyclothymic temperament-irritable (49%; included the temp. "weakly unstable", an attenuated subtype of the cyclothymic temperament), depressive temperament (16%).

Mood disorders can lead to 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 with the mood disorders can make such patients resistant to treatments and lead to a worse prognosis.

The average age of onset of a depressive episode and mood disorder 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". Epidemiological studies have found an incidence of depression among women which is double that of men.

CONCLUDING REMARKS

The consequences of the lack of recognition and treatment of a mood disorder can be: 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 for concurrent diseases, and finally the mood can become chronic and the clinical picture can worsen.

The pharmacological therapy of mood disorders consists of polytherapy with mood stabilisers (mainly: lithium, carbamazepine and valproate, gabapentin, oxcarbazepine, lamotrigine, topiramate, olanzapine, pipamperone) and antidepressants (mainly: SSRIS, SNRIS).

One should never use antidepressants alone and/or in combination with benzodiazepines (and also should never use benzodiazepines alone for a long time), in

order to avoid an increase in mood instability and evolution toward states of dysphoria (Agius 2011, Tavormina 2010).

Appropriate maintenance therapy, however, carefully assessed and chosen on a case by case basis, based on the clinical picture, should always include a mood stabiliser, and may when appropriate include a low/small dose of antidepressant.

The frequent necessity of the patient to resort to the use of benzodiazepines is a tangible sign of clinical deterioration, hence in such cases it becomes essential for the patient and the psychiatrist to consider the need for adjusting the dosage of maintenance therapy.

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