

Bipolar Disorder: Clinical Conundrums 1

INTRODUCTION

Bipolar disorder (BD) is a well-documented disorder with a high heritability.^[1] It was familiar to physicians from antiquity, but the clear description was provided in the mid-19th century. Over the next 150 years, the understanding, management and research of BD changed in significant ways. Mania may be the only disorder in the medical encyclopedia where patient “enjoys the sufferings” from active symptoms of his disorder! In this editorial, after charting a course of historical evolution, we make an attempt to examine the contemporary issues regarding diagnostic features from a clinical ground reality.

EVOLUTION OF THE DIAGNOSTIC ENTITY

After initial observations of Areteaus of Cappadocia in AD 150, scientific delineation of BD was done by two French psychiatrists, Falret and Baillarger in the 1850s^[2] – “folie circulaire” and “folie à double forme.” Kahlbaum in 1863 tried categorizing psychiatric illnesses based on symptoms, course, outcome, and etiology to construct a natural disease entity. He differentiated between disorders with continuous but remitting course and those with continuous and progressive course. Taking cue from Kahlbaum, Kraepelin later proposed his dichotomy, which had enduring validity lasting till date.

Emil Kraepelin in the early 20th century divided the psychotic illnesses based on disease course and outcome into two major groups – dementia praecox (schizophrenia) and manic-depressive insanity (MDI). Kraepelin’s MDI included manic-depressive psychosis and recurrent depressive disorders, which got later teased out into bipolar and unipolar disorders, the core criterion being episodic nature with a good outcome. Recovery and recurrence as a rule still hold high validity for this group of mood disorders. The description in the classificatory systems, International Classification of Diseases and Diagnostic and Statistical Manual (DSM), is greatly influenced by this dichotomy. DSM-5 delineated mood disorders into bipolar spectrum and depressive spectrum disorders.

PERSPECTIVE FROM THE CLINICAL PRACTICE

Described diagnostic criteria, specifiers, and concepts of spectrum disorders demand analytical evaluation from the perspective of the clinical practitioner.

COURSE AND OUTCOME

BD remains a recurrent, episodic psychiatric disorder with recovery being the rule, in a significant majority of patients if not all. Many patients can be promised with significant improvement from the acute episode within a specific period, with good clinical and functional outcomes after the episode resolution. Historically, even in the case of patients who were admitted during the years of 1875–1924 in North West Wales Asylum, (United Kingdom) with a retrospective diagnosis of BD, “almost all patients went home well.”^[3] It is a common clinical observation that in the disease course of BD, some patients do remain in the state of euthymia for months, extending to years, without any pharmacological or psychological interventions. This also is the case with many patients diagnosed with unipolar/recurrent depressive disorder. This remains one significantly unique and characteristic phenomenon of the chronicity of mood disorders when compared to other psychological/medical chronic illnesses.

BIPOLAR DISORDER IN DIAGNOSTIC AND STATISTICAL MANUAL 5

DSM-5 suffers from many a deficit in its delineation of the diagnostic criteria for BDs.

The episodic course of the disorder (A “clinical biomarker” with high diagnostic utility value) is totally ignored. History of the illness with clear episodicity remains an important clinical indicator in the diagnostic process. For example, a patient with 3–4 past episodes with a limited duration followed by total recovery in the past, say, 10–15 years will be diagnosed as having the mood disorder irrespective of current clinical presentation.

Family history (another clinical biomarker!), especially with a well documented high heritability of BD, finds no mention in the enlisting of diagnostic criteria of BD in DSM.

Deletion of mixed episode from DSM-5 is welcome. However, the inclusion of specifier “mixed feature” under major depressive disorder (MDD) remains incomprehensible to the clinical sense! How do I decide on pharmacotherapy for a patient with – MDD with mixed features specifier!!!

Irritability is being given almost equal weightage as elation, which seem to contribute to a modest extent in the over diagnosis of BD, as was revealed in the US-UK childhood bipolar study;^[4] there was a significant discordance observed between the USA and UK diagnosis when diagnosis of BD was based on “Irritability or Rage” as a prominent symptom. Aggressive outbursts (verbal/physical) alternating with spells of sad mood can be a common occurrence in adjustment problems, especially in adolescents, more specifically in those with obsessive compulsive personality disorder traits. Teenagers and parents walk in with presentations of “mood swings” and self-diagnosis of BD (of course with liberal help from “Google Doctor”). Over inclusive diagnosis of BD has immense therapeutic implications in the form of long-term, rather a life long, “Mood Stabilization.” Our clinical experience at Asha Bipolar Clinic has guided us to reformulate a few patients who were earlier diagnosed as BD as having underlying Obsessive-compulsive personality disorder. The existence of these traits increases the chance of both depression and irritability due to temperamental rigidity and neurotic perfectionism.^[5] A developmental drop in bipolar prevalence was observed wherein 18–24 years age group had 5.5%–6.2% prevalence, whereas 25–29 years age group had 3.1%–3.4% prevalence.^[6] This either suggests that there is a time-limited developmental bipolar variant or that it is actually a different disorder, which is related to personality development, mistakenly diagnosed as BD. The average duration of an episode in childhood BD is described as ranging from 24 to 36 months!!! The introduction of disruptive mood dysregulation disorder in the depressive spectrum is a timely decision in DSM-5.

At this juncture, it may be relevant to touch on bipolar spectrum disorder, which is introduced to correct the apparently prevalent under diagnosis of BD. “Tread with Caution” should be the approach with Spectrum concept!

BIPOLAR DISORDER-II

BD-II has unique conceptual issues compared to the BD-I.

Unlike in BD-I the diagnostic criteria never describe a single episode of hypomania (without at least one

episode of MDD) as being eligible for BD-II diagnosis nor do they describe a “recurrent hypomanic disorder” as being existent. The question from the clinical practitioner is-why is there a necessity for the depressive episode for diagnosing BD-II while the same is not required to make a BD-I diagnosis?

Functional disability in BD-II is described as “without marked sociooccupational dysfunction” in DSM-5. This may cause some ambiguity and clinical difficulty in distinguishing from hyperthymic temperament, especially in retrospective recall of episodes and in children and adolescents.^[7] Problems become worse with descriptions like “sub syndromal” hypomania! Hypomania is supposed to be milder and sub syndromal hypomania would be “milder – milder....”

When the symptoms are milder, clinical logic recommends requirement of a longer duration of symptom existence and persistence for making the diagnosis. Why is the duration required only 4 days for hypomania, when a duration of 7 days is mandatory for the diagnosis of mania? Why do the expert consensus advice of reducing hypomania duration criterion further down to only 2 days? This will only impair the overall reliability and discriminant validity of hypomania and BD-II constructs.

According to Judd’s study, the episode duration of depression and hypomania is at the ratio of 37:1, i.e., for every 37 days of time suffered from depression patient runs through only 1 day in the hypomanic episode.^[8] Such brief “episodes” with a description of “without marked sociooccupational dysfunction” is the clinical scenario described in the literature for BD-II. In such a scenario are we justified in advising, initiating, and maintaining long-term prophylaxis as per the algorithms described, very similar to BD I?

PREDICTIVE POWER IS A KEY ASPECT OF DIAGNOSIS

In the clinical practice, the most important feature of a diagnosis is its predictive power. Karl Leonhard famously said, “as I understand it, the diagnosis of a mental illness includes a prognosis.” The predictive power of a diagnosis is very important in the clinical practice as it influences the education of patient and caregivers, treatment options, and rehabilitation. The broadening of BD category by including atypical conditions will not only compromise the predictive power of the diagnosis but also removes it further away from the Kraepelinian dichotomy based wisely on the disease course and outcome.^[9]

CONCLUSION

We would like to emphasize a need to preserve the construct of BD based on Kraepelinian factors of disease course and outcome giving importance to predictive validity, recovery and recurrence as the rule, as this is the dominant concern in the clinical practice. Long-term naturalistic studies have to be taken into account to correlate research evidence and the clinical experience. Spectrum concept of BD^[10] has to be cautiously thought through and should await strengthening by clinically applicable biological research including the development of biomarkers, before we consider leaving the time-tested categorical constructs to embrace the newer dimensional constructs.


M. S. Reddy, M. Starlin Vijay, Swetha Reddy

Asha Bipolar Clinic, Asha Hospital, Hyderabad,
Telangana, India
E-mail: drmsreddy@gmail.com

REFERENCES

1. McGuffin P, Rijsdijk F, Andrew M, Sham P, Katz R, Cardno A, *et al.* The heritability of bipolar affective disorder and the genetic relationship to unipolar depression. *Arch Gen Psychiatry* 2003;60:497-502.
2. Mason BL, Brown ES, Croarkin PE. Historical underpinnings of bipolar disorder diagnostic criteria. *Behav Sci (Basel)* 2016; doi: 10.3390/bs6030014.
3. Healy D. From mania to bipolar. In: Yatham LN, Maj M, editors. *Bipolar Disorder: Clinical and Neurobiological Foundations*. Wiley-Blackwell; 2010. p. 1-7.
4. Dubicka B, Carlson GA, Vail A, Harrington R. Prepubertal mania: Diagnostic differences between US and UK clinicians. *Eur Child Adolesc Psychiatry* 2008;17:153-61.
5. Reddy MS, Vijay MS, Reddy S. Obsessive-compulsive (Anankastic) personality disorder: A poorly researched landscape with significant clinical relevance. *Indian J Psychol Med* 2016;38:1-5.
6. Cicero DC, Epler AJ, Sher KJ. Are there developmentally limited forms of bipolar disorder? *J Abnorm Psychol* 2009;118:431-47.
7. Angst J. Bipolar disorders in DSM-5: Strengths, problems and perspectives. *Int J Bipolar Disord* 2013;1:12.
8. Judd LL, Schettler PJ. The long-term course and clinical management of bipolar I and bipolar II disorders. In: Yatham LN, Maj M, editors. *Bipolar Disorder: Clinical and Neurobiological Foundations*. West Sussex, UK: Wiley-Blackwell; 2010. p. 17-30.
9. Baldessarini RJ. A plea for integrity of the bipolar disorder concept. *Bipolar Disord* 2000;2:3-7.
10. Reddy MS. The bipolar spectrum. *Indian J Psychol Med* 2012;34:1-4.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Access this article online	
Website: www.ijpm.info	Quick Response Code 
DOI: 10.4103/IJPSYM.IJPSYM_300_17	

How to cite this article: Reddy MS, Vijay MS, Reddy S. Bipolar disorder: Clinical conundrums 1. *Indian J Psychol Med* 2017;39:389-91.