

Commentary

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## Bipolar Disorder: an impossible diagnosis

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### Abstract

Following the recent debates on the discrepancy between the predominant weight of bipolar disorder (BPD) in the clinical reality and its relatively low prevalence figures emerging from epidemiological surveys, the present paper contends the ability of current operational diagnostic system to properly detect the clinical entity of bipolar disorder.

As an episode of mania/hypomania is the necessary requirement for a diagnosis of bipolar disorder to be made, in this editorial we maintain that: a) the most severe forms of mania, characterized by cloudy consciousness, mood incongruent delusions, and physical symptoms are likely to escape DSM IV criteria, that are shaped around hypomania or mild mania; b) the impossibility to diagnose mania when this occurs during antidepressant treatments impedes diagnosing those cases whose natural illness pattern is Depression followed by Mania (known as DMI pattern); c) given that approximately 50% of cases have their onset of BPD with affective episodes other than mania/hypomania any prevalence figure necessarily underestimates BPD; d) the sub-threshold forms of BPD, well described in the concept of Bipolar Spectrum, are beyond the possibility to be recognized using operational diagnoses in spite of their utmost clinical relevance.

### Commentary

Two commentaries have recently appeared on this journal pointing out the discrepancy between the predominant weight of bipolar disorder in the clinical reality and its relatively low prevalence figures as emerging from the epidemiological surveys [1,2]. The ability of lay interviewers to properly detect patients suffering from Bipolar Disorder (BPD) has been questioned. Moreover, the authors conclude that the current diagnostic thresholds for hypomania and mixed states are unsatisfactory.

In this editorial we will contend that DSM IV, as well as other operational diagnostic systems, is unable to diagnose the clinical entity of BPD.

This issue is based on four points.

#### Mania

It is clear that the symptoms chosen by DSM IV as descriptors of a manic state (*Self esteem or grandiosity, Decreased need for sleep, More talkative than usual, Flight of ideas or pressure to keep talking, Distractibility, Increase in activities, Excessive involvement in activities with potentially painful con-*

sequences)[3] are shaped around a prototype of cheerfulness, joy, hyperactivity, grandiosity, elation, inconsideration of the consequences that considers mania as opposite to depression. This contrasts with the classical descriptions of mania as they come from the original accounts of the leading psychopathologists. In a textbook which constituted the basic reading of a couple of generations of psychiatrists, severe mania is described as follows: "Manic excitement in its most severe form leads to confusion, in which the typical symptoms of mania are obscured. Consciousness, which is clear in the less severe states, becomes clouded, illusions and hallucinations may be observed, and the condition may resemble a delirium. These states are seriously debilitating and may endanger life." (Mayer-Gross, Slater & Roth, 1960)[4]. Such a presentation would not meet the DSM IV criteria for manic episode. Even other typical descriptions of the manic episode, as those reporting aketetic mania, manic stupor, the presence of symptoms later referred to as first rank symptoms, pseudoparanoic presentations of mania, all described by Kraepelin [5] as varieties of the ever changing paradigm of mania, would be difficult to be included in the DSM IV category of Manic Episode. Even more astonishing, what has represented for years the model of the natural course of the manic episode, brilliantly described by Carlsson and Goodwin in the early 70s [6], with their classical three stages of Mania, would now encounter difficulties in being diagnosed by DSM IV criteria. In fact only stage I, and partially stage II, would fully meet the criteria for mania. The following is another classical description of severe mania that would probably escape DSM IV requirements: "In the more acute manic reactions the patient, driven by a greater pressure of activity, terror and excitement, becomes violent, attacks his neighbours or begins to shout all kinds of accusations against his alleged persecutors..... Distortions, misinterpretations and ideas of reference are now elaborated into delusions of persecution accompanied by violence and panic. The patient runs down the street nude, sets fire to the house, starts an argument with the police, .....If crossed or interfered with in any way he becomes abusive, destructive.." (Campbell, 1953)[7].

Even with the understanding that operational diagnostic criteria are aimed at diagnosing mania and not at describing the entire variety of its clinical presentations, it seems that DSM IV misses some of the most typical features of mania (e.g. lability of affect, rapid variations of mood, coexistence of different emotional states). It is only able, therefore, to detect and classify a limited number of the clinical presentations of Mania, and possibly not the actually typical ones. In particular, it seems that diagnostic criteria fail to consider the most severe forms of mania, where the initial features of cheerfulness and grandiosity give way to psychotic ideation, dysphoric affect, mood incongruent delusions and clouding of conscience.

The problem would be even greater with mixed states.

#### **Antidepressant Induced mania**

DSM IV states that the manic presentation secondary to drug treatment cannot be diagnosed as Manic episode (criterion E): *The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment)*[3].

On one hand, a largely agreed position denies that mania might be induced, if not in people already vulnerable (predisposed) to BPD [8,9]. Even more important, the impossibility to diagnose Mania when it occurs during AD treatment surreptitiously reduces the rate of true BP. It is in fact well known that approximately 50% of patients have the so-called DMI (Depression-Mania-Interval) pattern, where the manic episode *naturally* follows the depressive one [10]. In spite of the reported undertreatment of depression [11], in the western world patients suffering from severe depression are likely to receive some kind of antidepressant treatment. In this case, even the Mania episode that would have occurred anyway, could not be diagnosed as Manic episode since it started during the course of AD treatment [12]. Regardless of the existence of induced Mania, it is therefore clear that a consistent part of patients are prevented from being diagnosed as BPD simply because they have depression before mania.

#### **False Unipolars**

It is obvious that the diagnosis of BP is only possible after the occurrence of an episode of Mania/Hypomania. It is also well known that the onset of BPD occurs with Mania/hypomania in about a half of the cases. In the remaining cases, being the first episode(s) depressive (or even anxious), the initial diagnosis is unipolar depression, or other, certainly not BPD. The rate of patients that move from the diagnosis of Unipolar to that of BP is 15–30% in the literature, depending on the length of the observation period [13–15]. As the first mania may occur at any age [16], it is clear that the age of the sample conditions the rate of UP shifting to BP in epidemiological studies. For the clinician, treating a potentially BP patient poses special problems, because of the risk of switching into mania, the higher propensity to recurrences [17], the increased risk of suicide [18–20], the slower response to ADs [21]. The clinician, however, has some help in suspecting the potentially bipolar patient, even in absence of previous mania: a family history for BP, an earlier onset, more rapid recurrences, the presence of delusions, post-partum depressions, a depressive presentation with racing thoughts and/or melancholic features are all factors that have been associated with increased risk of switching to mania in the future. [14,22]. We are aware that this is a problem intrinsically connected to the distinction Unipolar-Bipolar, that none of operational diagnostic criteria

can solve. It is worth reminding, however, that the category "Major Depressive Disorder" should logically be substituted by "Non Bipolar Affective Disorder", in which "non bipolar should" be read as "not yet bipolar". A transitory category, similar to that of schizophreniform disorder for schizophrenia, would probably help.

### Bipolar Spectrum

Following Klerman's classic paper on the BP Spectrum [23], several authors agree on the existence of a continuum of bipolarity, ranging with continuity from the minor, normal forms of hyperthymic temperament to the most severe cases of delusional mania. In this regard the threshold chosen by DSM IV for the diagnosis of BP would be too high, thus diagnosing as UP cases that closely resemble BPD under several clinical variables [24-26]. While this position clearly affects the epidemiological figures, it also has some relevant repercussions on the clinical practice. As said before, the patients prone to bipolarity exhibit specific risks, respond differentially to treatments, have some peculiarities that distinguish them from the true unipolars and give them some clinically diagnosable specificity. Recognizing and giving the necessary weight to the subclinical aspects of bipolarity may really improve the clinical practice. This notwithstanding, DSM IV again does not help recognizing such cases. In this regard, we agree with Carta and Angst's [1] position that the threshold currently adopted for hypomania and mixed state is too high.

As said before, we do not question the particular criteria adopted by DSM IV, that can obviously be improved, better refined or amended, but rather the possibility to properly detect the distinction between Bipolar and unipolar by rigid operational diagnostic criteria.

Quoting Kraepelin (1921)[5], "*The delimitation of the individual forms of the malady [manic depressive insanity] is in many respects wholly artificial and arbitrary. Observation not only reveals the occurrence of the gradual transitions between all the various states, but it also shows that within the shortest space of time the same morbid case may pass through most manifold transformations*"

If, as Kraepelin and many others affirm, the essential of BPD does not reside in the association of different mood states in the same individual in different periods of his life, but rather in the exceptional fluidity of affect, in the everchanging movement of emotions, in the instability and variability of mood, any still categorization is destined to fail. Freezing the emotional movement of manic depressive illness in still photographs, as it is unavoidable with diagnostic operational criteria, loses the core of the disorder and gives a false representation of it.

### Abbreviations

BPD: as Bipolar Disorder; UP: as Unipolar; AD: as Antidepressant

### Competing interests

The authors declare that they have no competing interests.

### Authors' contributions

CF had the original ideas, and revised the final manuscript, SGA, MAS, LF contributed in equal parts in writing the paper. All the authors read and approved the final manuscript

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The three literal citations to classical authors are due to Goodwin and Jamison as cited in references [10], as authors consulted in the Italian translations.

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