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UNDERSTANDING BIPOLARITY: DO WE HAVE A NEW PANDEMIC OF BIPOLAR MOOD DISORDERS?

INTRODUCTION

Mental disorders are branded to be diseases of the modern world. Some people complain that suddenly everybody is being diagnosed with Bipolar disorder. In recent decades psychiatrists are criticised for lowering the threshold for disease and including variants of normal behaviour into their lists of treatable illnesses.

The Anti-psychiatry campaign gained momentum in the 1960s and is still encouraged by some advocacy groups. Before the publication of DSM 5 in 2013, a few experts, who were partial to the process of DSM IV workshops, now publicly criticised the processes of DSM 5.

Medical Insurers are alarmed by the steady increase in the numbers of people using resources for the treatment of mental disorders.

Some of the caution is warranted, but until very recently mental disorders were neglected and underdiagnosed. Many people with Anxiety disorders were subjected to very expensive diagnostic and treatment procedures, even hysterectomies and colectomies. Mental disorders were also grossly stigmatised and some people don't understand that it's an illness which anyone may suffer from and which is treatable.

Bipolar disorders are at the forefront of this debate, but many critics are misinformed and don't understand the context for this rise in numbers.

I will explain the perceived rise in incidence of bipolar illness and the caution which should be taken (and is) when making the diagnosis of a long-term disorder, because it may stigmatise a person for the rest of their lives (in terms of the Biopolitics of the insurance industry). Some people may encourage their doctors to make a diagnosis in order use the resources on their medical aid, but then again to change the diagnosis when they want to extend their insurance… this is not good clinical practice, in fact it's fraudulent.

Psychiatric medicines are of high schedule due to potential risk and long term side effects. It should only be used when the benefit of taking it outweighs the potential risks and when a definite diagnosis is confirmed.

The incidence of Bipolar Type I is very consistent at 1,5%-2% in the population, and the clinical picture is very distinct. The incidence of Bipolar Type II has increased, but only because 40% of patients who were previously diagnosed with unipolar depression are now identified to suffer from a bipolar illness. In DSM IV Major Depression and Bipolar disorder were grouped together as mood disorders, but DSM 5 classifies Bipolar disorders in a different category.

A Major Depressive episode is much more serious than just "a bout of depression".

Thirdly some people who are not suffering from a Major mental disorder are identified to have traits of bipolarity, but they should only be diagnosed with a disorder when the symptoms cross the threshold for a disorder: criterion C/D/E of diagnostic criteria.

To explain that there are differential grades of severity in the spectrum of bipolar disorders, I'll discuss the clinical manifestations of the different diagnoses. It's like understanding the different stages in the diagnosis of cancer. We know all cancers are not equal in severity and risk of recurrence.

WHAT IS BIPOLAR DISORDER?

Historically these disorders were called Manic-Depressive illness or Affective Psychosis. Until 2013 the rule was that you must have a Major Depressive episode somewhere in the personal history before you could diagnose Bipolar disorder, but since DSM 5 the Bipolar disorders are separated from the other mood disorders and a variant of Bipolar disorder with only manic episodes was identified.

Bipolar type I disorder is a serious mental illness, with major depressive and/or manic episodes. Manic episodes are a serious condition which last at least one week and the symptoms so severe that hospitalisation is needed, to protect patients from hurting themselves or others. Manic episodes are commonly manic psychoses and many patients end up in involuntary care to stabilise the psychotic symptoms. The incidence is 1,5%-2% in the population, this number has been constant for many years, and the clinical picture is very distinct.

Bipolar Type II disorder is also a serious mental illness, but many patients receive voluntary treatment or can be treated as outpatients, provided the suicide risk is monitored. The reason for the increase in incidence is because about 40-50% of patients who present with Major Depression are now identified to suffer from a bipolar illness.

A Major Depressive episode is much more serious than just "a bout of depression". You need to suffer from serious symptoms for consecutive days for at least a week. Symptoms of a Major Depressive episode include mood symptoms, cognitive symptoms and vegetative/bodily symptoms. Bipolar depression is more difficult to treat than unipolar depression, because treatment with the usual antidepressants may worsen the illness.

WHAT IS BIPOLARITY?

According to the DSM diagnostic criteria a Bipolar disorder can only be diagnosed if the symptoms are severe enough and last long enough to cross the threshold for a "Major Axis I Disorder." The continuous presence of symptoms should also cause functional impairment on multiple levels in social and daily functioning.

People who suffer with traits of bipolarity, who never suffered with an episode of a Major Mood disorder, should not be diagnosed with Bipolar Disorder.

Traits of bipolarity consist

mostly of: Impulsivity, labile Affect and emotional dysregulation.

Many other disorders should be considered in the differential diagnosis, including personality disorders and ADHD.

Although everything is done to fight the stigmatisation of psychiatric diagnosis, we must understand that being diagnosed with a chronic mental disorder has many socio-political implications and the diagnosis should not be made too easily. Patients who don't feel comfortable with a specific diagnosis or treatment should ask for a second opinion.

DIFFERENTIAL DIAGNOSIS AND CO-MORBIDITIES

In patients who present with features of Bipolarity, but don't qualify for a formal diagnosis, the differential diagnosis should be considered, because many other mental disorders may present with impulsivity, mood dysregulation and affective lability. The differential diagnosis of Bipolar disorders includes: major depression, various anxiety disorders, substance use disorders, personality disorders (i.e. borderline personality disorder,) and ADHD. People who present with prominent irritability don't necessarily suffer from a Bipolar disorder.

People with Bipolar disorder may have other comorbidities which complicates the diagnosis and may cause poor response to treatment. Some comorbidities need separate attention in the management protocols.

Patients who don't feel comfortable with a specific diagnosis or treatment should ask for a second opinion.

SUMMARY

Mood disorders and Bipolar disorders have many variants and should not all be treated as the same illness, like different types and different grades of cancer, their prognosis also differs. Patients need to understand exactly what a specific diagnosis means and what the future implications of their diagnosis and long term treatment are. The diagnosis should not be made without careful consideration; equally if you have a serious illness you shouldn't deny it, but get early and optimal treatment to prevent further complications.

Early treatment of most mental disorders can prevent progression to more complicated illnesses and prevent brain damage which occurs with multiple relapses. MHM

References are available on request.