Psychiatria Danubina, 2014; Vol. 26, Suppl. 1, pp 6–9 *Conference paper*

TREATING THE BIPOLAR SPECTRUM MIXED STATES: A NEW RATING SCALE TO DIAGNOSE THEM

Giuseppe Tavormina

"Psychiatric Studies Center" (Cen.Stu.Psi.), Provaglio d'Iseo (BS), Italy

SUMMARY

The mixed states are the most serious clinical state in the bipolar spectrum, having the major risk of sucidality among all subtypes of the spectrum. The aim of this study is to help diagnosis and treatment of the patients having bipolar disorder mixed state, giving to psychiatrists and physicians a new efficacy rating scale focusing on this illness.

Key words: *bipolar spectrum disorders – mixed states – mixed state rating scale*

* * * * *

BACKGROUND

It is essential to remark once again what has been described in previous papers: that the mood in a person who is euthymic is stable, while in mood disorders the mood "swings" between depression and euphoria/ irritability/hypomania, and therefore in mood disorders there is "an unstable mood". This relates to the important topic of the "instability of mood" more the "depression": a depressive episode is only one phase of a broader "bipolar spectrum of mood", in which the instability of the mood is the main component.

The disorders of the bipolar spectrum (including sub-threshold forms) are really very common, more so than normally considered, even if they are pathologies which are often underestimated or not diagnosed or mistreated (Agius 2007, Tavormina 2007). The consequence of this inadequate diagnosis and treatment can lead to various issues of public health, with serious consequences including abuse of substances, business difficulties, suicidal risk, family massacres, rapes, etc., (Rihmer et al. 2009, Tavormina 2010, Tavormina 2012, Tavormina 2013).

CLINICAL EVALUATION

The dysphoric component of the mood (mixed states) is quite frequent within all the subtypes of the bipolar spectrum (approximatively 30% of all mood spectrum: Tavormina 2010, Tavormina 2013).

Following the full-spectrum here described (Tavormina & Agius 2007b):

- Bipolar I;
- Bipolar II;
- Cyclothymia;
- Irritable Cyclothymia (rapid cycling bipolarity);
- Mixed Dysphoria (depressive mixed state);
- Agitated depression;
- Cyclothymic temperament;
- Hyperthymic temperament;
- Depressive temperament;
- Brief recurrent depression;
- Unipolar depression.

We have to show that the dysphoric-mixed component of the unstable mood is usually present in Irritable Cyclothymia (following from, and/or developing to, rapid cycling bipolarity), in Mixed Disphoria (typical depressive mixed state), in Agitated Depression and in the Cyclothymic Temperament.

Following the schema of Akiskal for bipolar spectrum (Akiskal & Pinto 1999):

1. schizobipolar disorder;
2. core manic-depressive illness;
3. depression with protracted hypomania;
4. depression with discrete spontaneous hypomanic episodes (Bipolar II);
5. depression superimposed on cyclothymic temperament (Unstable Bipolar II);
6. depression with induced hypomania (i.e., hypomania occurring solely in association with antidepressant);
7. prominent mood swings occurring in the context of substance or alcohol use or abuse;
8. depression superimposed on a hyperthymic temperament (Bipolar IV).

The dysphoric-mixed component of the instable mood is depicted in the sub-groups n 3,5,7 and 8. I did not incluse inside the "mixed states group" the subgroup number 6 of Akiskal, even if it has mixed traits (this shows the bipolarity induced by antidepressants), because in my opinion it is "not-pure disorder" sub-type of bipolarity for the reason the bipolarity is induced by antidepressants.

The symptoms to note carefully on diagnosing mixed states are the following (at least two of these to be present at the same time - Tavormina 2013):

- overlapping depressed mood and irritablity;
- reduced ability to concentrate and mental overactivity;
- high internal and muscular tension, gastritis, colitis, headaches, or other somatic symptoms (for ex.: increasing of eczema or psoriasis);

- comorbidity with anxiety disorders (PAD, GAD, Social phobia, OCD);
- insomnia (mainly fragmentary sleep and/or low quality of sleep);
- disorders of appetite;
- a sense of despair and suicidal ideation;
- hyper/hypo-sexual activity;
- substance abuse (alcohol and/or drugs);
- antisocial behaviour.

Table 1. G.T. Mixed States Rating Scales or G.T. MSRS

Self-administered rating scale		
Has there ever been a period of time during last three months when you frequently were and/or presented/felt	Yes	No
1) Hyperactivity (euphoria) quickly alternating with periods of psychomotor retardation (apathy)? If Yes, for how many days/weeks?	Yes	No
2) Depressed mood togheter with irritability and/or internal tension? If Yes, for how many days/weeks?	Yes	No
3) Substance abuse (alcohol and/ or drugs)? If Yes, for how many days/weeks?	Yes	No
4) Disorders of appetite? If Yes, for how many days/weeks?	Yes	No
5) A sense of despair and suicidal ideation?	Yes	No
6) Anhedonia and widespread apathy?	Yes	No
7) Delusions and hallucinations?	Yes	No
8) Hyper or hypo-sexual activity? If Yes, for how many days/weeks?	Yes	No
9) Insomnia (or sleep fragmentation) or hypersomnia? If Yes, for how many days/weeks?	Yes	No
10) Reduced ability to concentrate and mental overactivity? If Yes, for how many days/weeks?	Yes	No
11) Gastrointestinal disorders (colitis, gastritis), headaches, and various somatic symptoms (muscolar tensiouness; tachicardia)? If Yes, for how many days/weeks, and what of those symptoms?	Yes	No
Additional point Could it be considered that, at the age of about 18-20 years (if you are more then 20 years old; if you are younger, please consider the answer as "during actual last years"), you were (choose only one of these three following answers): - 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, and also with anxiety simptoms (panic, fobia between persons, claustrophobia)?		
Scores *- The "Additional Point" helps to focus about the Temperaments;* *- Mixed states diagnosis if at least two YES are present;* *- Double scores in the points 1-2-3-4-8-9-10-11 if at least 50% of the month is involved;* *- Medium-light level of mixed state: from 2 to 6 scores;* *- Medium level of mixed state: from 7 to 12 scores;* *- High level of mixed state: from 13 to 19 scores.* The positive result following to "G.T. MSRS" will conduct to do a generic diagnosis for mixed states sub-types of bipolar spectrum disorders (following Akiskal's scheme or Tavormina's scheme for bipolar disorders). The clinician will need of special care to do the correct sub-diagnosis of sub-group of mixed state.		

Besides, the "mixity" of depressive phases causing suicidality can be summarised in the following symptoms (Akiskal 2007):

- presence of agitation and restlessness;
- irritability and aggression (these typical of "agitated depression") and impulsivity;
- comorbidity with anxiety and panic disorders.

In consequence of all this, we can understand how mixed symptoms or traits can insidiously infiltrate into the mood and life of the patients, giving to physicians great difficulties in diagnose them.

As has been previously written (Tavormina 2007, Tavormina 2012, Tavormina 2013), it is essential at the beginning of the clinical interview to evaluate the clinical situation present (the phase of acuteness last) and assess what alerted the psychiatrist to the possibility of 'mixed state',to assess when it presented acutely,and when these symptoms first began.

It is crucial, when making a correct diagnosis of bipolar spectrum disorders, to investigate the patient's personal past history of illness, his full family history regarding mood disorders, to assess 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).

The co-presence of various types of somatisation symptoms, as well as the abuse of substances, should suggest indisputably the possibility of a "mixed state" of the bipolar spectrum.

PROJECT

As described, the difficulties for the clinicians to do a correct diagnosis of the mood disorders they are valuing, above all when mixed states are present, induce them to frequently prescribe antidepressants drugs alone or toghether with benzodiazepines (sometimes because the patients mainly focus their own symptoms on depressive uneasiness), and not to put emphasis on the increasing dysphoria following this inadequate treatment. A correct maintenance therapy, assessed and chosen from case to case, based on the clinical picture, should always include at least one or two mood stabilisers together with low doses of antidepressants (above all in maintainance therapy).

For this reason, the presence of a new rating scale, mainly focused on mixed states symptoms, is crucial: none of other actual rating scales for mood disorders, despite being very useful (the "Bech-Rafaelsen Mania Scale"; the "Manic-State Rating Scale, MSRS"; the "Mood Disorder Questionnaire, MDQ"; the "Young Mania Rating Scale, YMRS"), are specific to all typologies of symptoms of the mixed state disorders, and so are too generic (as the MDQ) or too specific only for mania and bipolar I or II (all the others).

The table 1 depicts the new rating scale for mixed state (the "G.T. Mixed States Rating Scales", or "G.T. MSRS": a self-administered rating scale) and its modalities of administration and scores.

The positive result following to "G.T. MSRS" will enable a diagnosis for mixed states sub-types of bipolar spectrum disorders (the sub-types n I ½ , II ½ , III ½ and IV of the Akiskal's sheme, in the Table 1; the sub-types cyclothymia, irritable cyclothymia, rapid cycling bipolarity, mixed dysphoria, agitated depression and cyclothymic temperament of the Tavormina's scheme, before described). The clinician will need of special care to do the correct sub-diagnosis of sub-groups of mixed state.

CONCLUDING REMARKS

The consequences of the lack of recognition and treatment of mood disorder mixed states can lead to a 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 those for concurrent diseases: if unrecognised, the mood may become chronic and the clinical picture can worsen year by year. But the clinician needs to have all the modalities to enable him to make a correct diagnosis wherever possible: for this reason the "G.T. MSRS" has been created to improve the clinical activity of psychiatrists.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Agius M, Tavormina G, et al.: The management of bipolar spectrum disporders – CEPIP, summer 2013 – SEPT.*
2. *Agius M, Tavormina G, Murphy CL, Win A, Zaman R: Need to improve diagnosis and treatment for bipolar disorder. Br J Psych 2007; 190:189-191.*
3. *Agius M, Zaman R, et al.: Mixed affective states: a study within a community mental health team with treatment recommendations. European Psychiatry 2011; 26(suppl 1):P01-145.*
4. *Akiskal HS, Pinto O: The evolving bipolar spectrum: Prototypes I, II, III, IV. Psychiatr Clin North Am. 1999; 22:517-534.*
5. *Akiskal HS: Targeting suicide prevention to modifiable risk factors: has bipolar II been overlooked? Acta Psychiatr Scand 2007; 116:395-402.*
6. *Akiskal HS: The prevalent clinical spectrum of bipolar disorders: beyond DSM-IV. J Clin Psychopharmacol 1996; 16 (suppl 1):4-14.*
7. *Rihmer Z, Akiskal HS, et al.: Current research on affective temperaments. Current Opinion in Psychiatry 2009; 22:0-0.*

8. *Tavormina G, Agius M: A study of the incidence of bipolar spectrum disorders in a private psychiatric practice. Psychiatr Danub 2007a; 19:370-4.*
9. *Tavormina G, Agius M: An approach to the diagnosis and treatment of patients with bipolar spectrum mood disorders, identifying temperaments. Psychiatr Danub 2012; 24(suppl 1): 25-27.*
10. *Tavormina G, Agius M: The high prevalence of the bipolar spectrum in private practice. J Bipolar Dis: Rev & Comm 2007b; 6:19.*
11. *Tavormina G: A long term clinical diagnostic-therapeutic evaluation of 30 case reports of bipolar spectrum mixed states. Psychiatr Danub 2013; 25(suppl 2):190-3.*
12. *Tavormina G: An early diagnosis of bipolar spectrum disorders needs of valuing the somatisation symptoms of patients. J Int Clin Psychopharmacol 2012; 28:e59-e60.*
13. *Tavormina G: Are somatisations symptoms important evidence for an early diagnosis of bipolar spectrum mood disorders? Psychiatr Danub 2011a; 23(suppl 1):S13-4.*
14. *Tavormina G: The bipolar spectrum diagnosis: the role of the temperaments. Psychiatr Danub 2009; 21(suppl 2): S160-1.*
15. *Tavormina G: The temperaments and their role in early diagnosis of bipolar spectrum disorders. Psychiatr Danub 2010; 22(suppl 1):S15-17.*
16. *Tavormina G: The temperaments: its knowledge is a crucial way in early diagnosis of bipolar disorders. European Psychiatry 2011b; 26(suppl 1):P01-199.*

Correspondence:

Giuseppe Tavormina, M.D.
President of "Psychiatric Studies Center" (Cen.Stu.Psi.)
Piazza Portici,11, 25050 Provaglio d'Iseo (BS), Italy
E-mail: dr.tavormina.g @libero.it